McChrystal Group

After-Action Review of Recovery and Repopulation Efforts for the Eaton and Palisades Fires

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Executive Summary

Purpose and Scope

On March 18, 2025, the Los Angeles County (County) Board of Supervisors directed the retention of an independent consultant to conduct an after-action review (AAR) of recovery and repopulation efforts and other related issues following the January 2025 Eaton and Palisades Fires. The review examines the County's performance in six critical focus areas: communications; volunteer and donations management; recovery; repopulation; shelter, housing, and people at higher risk; and public health and access and functional needs. It covers the period from January 7, 2025, to March 31, 2025, focusing on short-term recovery and repopulation operations, many of which remained active well beyond that period.

This report is not an investigation and does not assign blame. It does not assess liability or evaluate individual performance, nor does it intend to state legal conclusions or evaluate legal compliance. It evaluates systems, processes, coordination structures, and operational capabilities, and it recommends the corrective and sustainment actions needed to strengthen the County's readiness for future disasters.

This review follows the earlier *After-Action Review of Alert Notification Systems and Evacuation Policies for the Eaton and Palisades Fires* (2025), which examined alerts, warnings, and evacuation operations during the same fires. This report does not address topics covered in other ongoing reviews, including fire cause and ignition, fire behavior, and immediate suppression operations. Findings are based on evidence gathered for this review, including working group sessions with County and partner stakeholders, stakeholder interviews, internal and public surveys, and County plans, policies, procedures, and response documentation.

As required by the Board's direction, the review also assessed relevant recommendations from the *After-Action Review of the Woolsey Fire Incident* (2019) to ascertain if additional recommendations should be implemented since the report was submitted to the Board.

What the Review Found

This review examined how the County managed recovery and repopulation following the January 2025 Eaton and Palisades Fires across six critical focus areas: communications, volunteer and donations management, repopulation, recovery, shelter and housing, and public health and access and functional needs. It identified 26 substantive findings and 25 actionable recommendations.

County personnel and their partners repeatedly built effective structures in real time. This included an enhanced Coordinated Joint Information Center (CJIC), a unified access pass system, a recovery task force network, a rapid needs assessment, a cash donation pathway, and

one of the fastest debris removal operations on record. But many of those structures depended on improvisation and individual relationships rather than standing plans, codified authorities, and rehearsed systems. The County currently lacks an updated Los Angeles County Operational Area Recovery Plan (Recovery Plan), a formal repopulation decision framework, a countywide volunteer and donations model, and integrated data for reaching vulnerable populations at higher risk. The review did not identify evidence that County agencies intentionally withheld services from any population. Where gaps were identified, they reflected structural or resource-related challenges rather than intentional actions and are addressable through targeted organizational improvements.

The recommendations in this AAR incorporate what the County's workforce demonstrated it can do under pressure into the County's existing planning framework, so the next disaster is met with updated and enhanced plans with clear authorities.

None of these findings should obscure the review's clearest observation that Los Angeles County employees and their partners carried this recovery. Under extraordinary pressure and on compressed timelines, they developed structure and processes concurrently with operational implementation, in real time. Debris teams stood up a Right of Entry (ROE) process quickly and updated it frequently. Recovery center staff solved site problems on their own initiative. Communicators translated technical information into plain language and created visuals, dashboards, and maps because no better tools existed. Donation coordinators routed offers before any model existed to guide them. Where standard processes could not be delivered for residents, staff developed workarounds and, in some cases, set new precedents to keep recovery moving. Many continued to serve while personally affected by the same fires, displaced from their own homes and neighborhoods. This report's recommendations target systems, not the people who outperformed them.

> **IN THE COMMUNITY'S WORDS**
>
> *"I have nothing but good things to say about the County staff. They were very helpful, supportive, and empathetic*."
>
> — Public survey respondent

How to Read This Summary

This summary is organized by the six critical focus areas used throughout the report, so that each section corresponds directly to a chapter in the Findings and Recommendations section. Each focus area section presents what the review found, followed by that area's proposed recommendations. Two consolidated tables at the end of this summary list every finding and every recommendation, with lead and supporting agencies and proposed implementation horizons. The body of the report includes complete findings and recommendations, with supporting evidence and implementation details.

How to Read the Identifiers

Findings and recommendations are cited by a short code: the focus area, the item type (F for finding, R for recommendation), and the item number. For example, COM-R3 is the Communications focus area, Recommendation #3.

Code	Critical Focus Area	Example
COM	Critical Focus Area #1: Communications	**COM-F1 / COM-R1**
VDM	Critical Focus Area #2: Volunteer and Donations Management	**VDM-F1 / VDM-R1**
RCV	Critical Focus Area #3: Recovery	**RCV-F1 / RCV-R1**
REP	Critical Focus Area #4: Repopulation	**REP-F2 / REP-R1**
SHP	Critical Focus Area #5: Shelter, Housing, and People at Higher Risk	**SHP-F1 / SHP-R1**
PHA	Critical Focus Area #6: Public Health and Access and Functional Needs	**PHA-F1 / PHA-R1**

Figure 1: How to read critical focus area identifiers

Every recommendation carries a proposed implementation horizon. Near-Term actions (11) are generally low- or moderate-cost and largely codify practices already demonstrated during the incident. Mid-Term actions (9) require plan development, program builds, or multi-agency agreements. Long-Term actions (5) involve higher costs, technology platforms, multi-year data and partner integration, or sustained investment.

Critical Focus Area	Findings	Recommendations	Near-Term	Mid-Term	Long-Term
#1: Communications	4	4	3	0	1
#2: Volunteer and Donations Management	2	2	1	1	0
#3: Recovery	4	4	1	2	1
#4: Repopulation	2	1	0	1	0
#5: Shelter, Housing, and People at Higher Risk	8	8	1	5	2
#6: Public Health and Access and Functional Needs	6	6	5	0	1
Total	**26**	**25**	**11**	**9**	**5**

Figure 2: Table of total Finding and Recommendation counts and implementation horizons

Implementation Considerations

These recommendations assign new or expanded responsibilities to County departments. They include standing coordination roles, plan development and ongoing maintenance, recurring training and exercises, formal agreements with external partners, and technology platforms with ongoing operating costs.

This report also identifies federal, state, local, and private-sector funding pathways in the County Funding and Program Expansion section that could support these actions. It does not evaluate the County's fiscal position, assess competing budget priorities, or recommend a specific level of appropriation.

Critical Focus Area #1: Communications

What the Review Found

Recovery generated an enormous demand for answers residents could act on, such as access passes for impacted areas of the Palisades Fire, checkpoints, road status, health precautions, shelter locations, and benefit programs. The County's communicators worked hard and often effectively, but the system they operated within was fragmented. The Los Angeles County CJIC provided important support as the incident moved into recovery, yet early scaling, liaison staffing, and integration of department-owned content did not keep pace with demand, and the CJIC did not consistently hold final publication authority for cross-departmental information (COM-F1). Operational decisions were made, but repopulation decisions were not consistently translated into clear, resident-ready instructions (COM-F2). A further gap appeared in custody-related communications, which lacked a predictable notification pathway for families, caregivers, and oversight stakeholders during fire-related impacts to custodial settings (COM-F4).

Against these gaps stands a clear success: the Los Angeles Regional Interoperable Communications System (LA-RICS) remained available for incident interoperable radio communications under extreme regional demand, carrying 51,600 minutes of talk time on the peak day of the fires while maintaining 100% availability, with improved coverage over prior large-fire incidents (COM-F3).

Recommendations

Recommendation	Action	Horizon
COM-R1	Formalize CJIC scaling procedures, publication authority, and recovery website integration.	Near-Term
COM-R2	Standardize resident-facing repopulation and checkpoint communications.	Near-Term
COM-R3	Sustain LA-RICS infrastructure practices and support expanded adoption.	Long-Term
COM-R4	Establish scalable custody-related emergency communications protocols.	Near-Term

Figure 3: Critical Focus Area #1 Recommendations table

Critical Focus Area #2: Volunteer and Donations Management

What the Review Found

Public generosity following the fires was immediate and substantial, and the County had to assemble the machinery to receive it while the incident was still unfolding. County staff moved quickly, centralizing donation inquiries, building tracking tools, and steering donors away from unmanaged intake of physical goods. But no formal countywide volunteer and donations management (VDM) model existed, leaving departments and Board offices to manage donation and volunteer inquiries through improvised routing and depend on individual relationships rather than institutional pathways for donation coordination (VDM-F1).

Timing was the central problem for financial giving. Public interest in donating arrived immediately, but the County's cash donation system was not activation-ready when giving interest peaked; the public contact website came online January 21, merchant identification was established February 10, and the live donation link was added February 11 (VDM-F2). The late launch reduced the County's ability to capture the earliest and most generous giving window, although the available information does not quantify the amount missed. This finding aligns with a recommendation from the *AAR of the Woolsey Fire Incident* to implement a comprehensive VDM program, indicating that the underlying capability gap was present in this event as well.

Recommendations

Recommendation	Action	Horizon
VDM-R1	Formalize a countywide VDM model and establish a dedicated EOC VAL.	Mid-Term
VDM-R2	Maintain an activation-ready cash donation package.	Near-Term

Figure 4: Critical Focus Area #2 Recommendations table

Critical Focus Area #3: Recovery

What the Review Found

Recovery is a distinct operational discipline, and the County performed substantial recovery work without codified recovery doctrine. The County had recovered from major wildfires before, but that experience lived as institutional knowledge rather than in a formal plan. Multiple Recovery Task Forces were established by January 15, but no written activation guidance defined their missions, rosters, lead responsibilities, or training expectations, and task force leads received no preparation for roles they were asked to improvise (RCV-F1). Disaster Recovery Centers (DRCs) opened to the public on January 14, one week after ignition, yet they lacked a single point of oversight, with County staff buying printers, moving tables, and resolving site problems on personal initiative (RCV-F3).

Debris removal illustrates both an achievement and exposes potential policy gaps. The debris removal process moved quickly: roughly 4,000 ROE forms were collected within the first week, more than 2.6 million tons of fire debris were removed, and more than half of surveyed residents reported the process moved faster than the County's stated timeline. That result was produced without pre-positioned contracts or pre-built tools, a formal debris management plan, or pre-negotiated landfill agreements, with federal contracting capacity serving as the foundation of effort (RCV-F2). On the resident side, fragmented eligibility and documentation requirements across programs forced residents to verify identity and ownership repeatedly and make duplicative trips to access benefit programs while displaced (RCV-F4).

Recommendations

Recommendation	Action	Horizon
RCV-R1	Update the County Recovery Plan.	Mid-Term
RCV-R2	Codify debris operations in a Disaster Debris Management Plan.	Mid-Term
RCV-R3	Formalize DRC Coordinator and DRC Supervisor roles.	Near-Term
RCV-R4	Develop a one-stop web platform for post-disaster services.	Long-Term

Figure 5: Critical Focus Area #3 Recommendations table

Critical Focus Area #4: Repopulation

What the Review Found

Repopulation decisions moved through a daily Incident Management Team (IMT) and Unified Command rhythm in which law enforcement, fire, public works, public health, utilities, and emergency management reviewed conditions together, and reopening proceeded only with multi-agency agreement rather than on fire containment alone. The County also used phased, zone-based reopening with controlled checkpoints instead of area-wide release, which managed traffic and preserved room for responders and utility crews while giving residents a path back into their neighborhoods.

The weaknesses were in standardization and clarity. At the outset, multiple entities in the Palisades Fire burn area issued separate access passes with different formats, colors, and eligibility criteria before converging on a unified design. Additionally, checkpoint credentialing and information were inconsistent across the two fire footprints, leaving residents confused about whether they were eligible to return, where to obtain passes for the Palisades Fire-impacted areas, and which credentials would be honored (REP-F1). Internally, the command rhythm worked, but externally and among supporting agencies, repopulation decision authority was not clearly understood, including who held final decision authority, the Los Angeles County Office of Emergency Management's (OEM) role, and what authority or approval capability the Los Angeles County Department of Public Health (DPH) representatives had when participating in repopulation and public health discussions (REP-F2). The result was a process that functioned operationally while remaining difficult for residents and partner agencies to follow. The resident-facing dimension of the access pass finding is addressed through the communications recommendations above; the decision-authority dimension is addressed in this focus area.

Recommendations

Recommendation	Action	Horizon
REP-R1	Codify informal repopulation decision functions in a formal Repopulation Plan, including a single access credential standard and clear authority, approval, and escalation pathways.	Mid-Term

Figure 6: Critical Focus Area #4 Recommendations table

Critical Focus Area #5: Shelter, Housing, and People at Higher Risk

What the Review Found

Sheltering had to potentially serve a displaced population the size of a mid-sized city, and the residents most affected by the system's gaps were those least able to manage them. Multiple evacuation shelters opened on the incident's first day, and 87% of surveyed shelter users reported staying three days or fewer. Shelter governance and site planning gaps limited coordination and timely placement near impacted communities, and when pre-planned sites became unavailable, the County had few pre-vetted alternatives nearby (SHP-F1). The County lacked a sufficient number of trained and experienced shelter leaders and staff, requiring reliance on state teams to fill the staffing gap (SHP-F2). Shelter and housing options were not consistently equipped for the full range of medical, mobility, personal care, and continuity needs (SHP-F3); shelter transition and demobilization lacked a formal multi-agency protocol (SHP-F4); and public-facing information on shelters, housing, transportation, and animal sheltering was fragmented across sources (SHP-F5).

This review found structural gaps related to populations who depend on systems working before an incident begins. The fires affected 370 children connected to County child welfare cases across the two burn areas; those children were kept safe, but relocation tracking for children in care was not standardized, relying on spreadsheets, provider updates, and staff coordination rather than a real-time location system (SHP-F6). Planning and communication for individuals in custody and justice-involved populations need further development (SHP-F7), and justice-involved adults and youth in contracted or community-based housing lacked a countywide coordination model (SHP-F8). Among survey respondents identifying access and functional needs (AFN) during repopulation, nearly half reported those needs were not met at all. These are the residents for whom coordination gaps create the greatest risk of adverse consequences.

Recommendations

Recommendation	Action	Horizon
SHP-R1	Institutionalize a shelter governance and readiness model.	Mid-Term
SHP-R2	Establish a formal shelter staffing readiness program.	Mid-Term
SHP-R3	Strengthen AFN requirements in shelters and establish an AFN Coordinator.	Mid-Term
SHP-R4	Establish a formal shelter transition and demobilization protocol.	Near-Term
SHP-R5	Establish a single multilingual shelter and housing information system.	Long-Term
SHP-R6	Create a real-time dashboard and readiness standards for children in care.	Mid-Term
SHP-R7	Jointly update shelter plans for custody and justice-involved populations.	Mid-Term
SHP-R8	Adopt a justice-involved community housing coordination framework.	Long-Term

Figure 7: Critical Focus Area #5 Recommendations table

Critical Focus Area #6: Public Health and Access and Functional Needs

What the Review Found

DPH issued Health Officer Orders, distributed protective equipment, built environmental dashboards, supported recovery centers, and coordinated soil and lead testing communication. However, DPH's wildfire-specific Los Angeles County Emergency Support Function (LAC-ESF) #8 responsibilities had not been translated into an annex, role matrix, or decision-support protocol before the incident. DPH staff were present in recovery and repopulation discussions, but decision-making authority appeared to rest at a higher organizational level. As a result, consultation triggers, approval, and escalation pathways were not consistently engaged early enough in decisions involving reentry, debris staging, cleanup standards, environmental testing, and health-related public messaging (PHA-F1).

At the time of the fires, no wildfire personal protective equipment (PPE) stockpile or distribution model was in place. The resulting gap was addressed through leftover Coronavirus Disease 2019 (COVID-19)-era equipment and donated reentry kits (PHA-F2). In addition, while public health

messaging on smoke, ash, and cleanup became more effective over time, no operational communications playbook existed to translate technical findings into clear, actionable guidance for the public (PHA-F3).

Two mechanisms created during this incident proved their value and should be formalized: the Rapid Needs Assessment, which gathered 2,306 responses across the Eaton and Palisades areas and gave decision-makers real-time visibility into resident needs, and the Health and Social Services Task Force, which became the recovery's key cross-departmental coordination mechanism (PHA-F4).

Support for AFN populations rested on plans, policies, and procedures that need to be updated. AFN preparedness lacked a permanent lead and a formal emergency liaison role, leaving coordination dependent on existing relationships, informal escalation, and real-time problem-solving (PHA-F5). Residential care emergency coordination was fragmented across facility types, licensing authorities, and operational responsibilities; the County lacked real-time visibility into long-term care bed availability and facility status, so evacuating facilities competed for the same receiving beds; and residential care evacuation planning was compliance-based, built for single-site disruptions rather than simultaneous regional evacuations (PHA-F6).

Recommendations

Recommendation	Action	Horizon
PHA-R1	Adopt a Public Health Response and Recovery Role Annex.	Near-Term
PHA-R2	Institutionalize a PPE readiness playbook.	Near-Term
PHA-R3	Develop and exercise a public health communications playbook.	Near-Term
PHA-R4	Institutionalize the Health and Social Services Task Force and maintain a standing Rapid Needs Assessment toolkit.	Near-Term
PHA-R5	Designate a year-round AFN lead and liaison role.	Near-Term
PHA-R6	Establish a residential care emergency coordination program with real-time capacity visibility and a regional planning standard.	Long-Term

Figure 8: Critical Focus Area #6 Recommendations table

Findings Table

The table below lists all 26 findings with a one-line statement of each, so a reader who encounters a finding code does not need to search the full report. Findings are listed in identifier order within each critical focus area. Complete findings, with supporting evidence, appear in the Findings and Recommendations section under each critical focus area.

Critical Focus Area	Finding	What It Found
#1: Communications	**COM-F1**	CJIC scaling, integration, and publication authority did not keep pace with recovery needs.
	COM-F2	Repopulation decisions were not translated into resident-ready instructions.
	COM-F3	LA-RICS performed effectively and provided an incident interoperable communications backbone.
	COM-F4	Custody communications lacked a predictable family notification pathway.
#2: Volunteer and Donations Management	**VDM-F1**	No formal countywide volunteer and donations management model existed, and partner coordination depended on individual relationships.
	VDM-F2	The cash donation system was not activation-ready when giving interest peaked.
#3: Recovery	**RCV-F1**	The County lacks an updated Recovery Plan.
	RCV-F2	The debris removal process functioned at a rapid pace without pre-positioned contracts or tools.
	RCV-F3	DRCs lacked a single point of oversight.
	RCV-F4	Residents made duplicative trips to access benefit programs.
#4: Repopulation	**REP-F1**	Access pass systems and checkpoint practices confused residents.
	REP-F2	Repopulation decision authority was not clearly understood across all agencies.
#5: Shelter, Housing, and People at Higher Risk	**SHP-F1**	Shelter governance and site planning gaps limited timely placement.
	SHP-F2	Shelter staffing relied on too few experienced leaders and FAST personnel.
	SHP-F3	Shelter and housing options were not consistently equipped for the full range of AFN needs.

Critical Focus Area	Finding	What It Found
	SHP-F4	Shelter transition and demobilization lacked a formal protocol.
	SHP-F5	Public shelter and housing information was fragmented.
	SHP-F6	Relocation tracking for children in care was not standardized.
	SHP-F7	Custody and justice-involved planning and communication need development.
	SHP-F8	Justice-involved community housing lacked a countywide coordination model.
#6: Public Health and Access and Functional Needs	**PHA-F1**	DPH's LAC-ESF #8 responsibilities were not sufficiently operationalized before the incident.
	PHA-F2	No PPE stockpile or distribution model existed at the time of the fires.
	PHA-F3	Public health messaging lacked an operationalized communications playbook.
	PHA-F4	The Rapid Needs Assessment and the Health and Social Services Task Force proved valuable and should become standing capabilities.
	PHA-F5	AFN preparedness lacked a standing year-round lead.
	PHA-F6	Residential care emergency coordination was fragmented, lacked real-time capacity visibility, and relied on compliance-based facility planning.

Figure 9: Comprehensive AAR Findings table

Recommendations Table

The table below lists all 25 recommendations with an action summary, the designated lead agency, supporting agencies, and the proposed implementation horizon. Recommendations are listed in identifier order within each critical focus area. Complete recommendations, with implementation details, appear in the Findings and Recommendations section under each critical focus area.

Critical Focus Area	Rec.	Action Summary	Lead Agency	Supporting Agencies	Horizon
#1: Communications	**COM-R1**	Formalize CJIC scaling procedures, publication authority, and recovery website integration.	CEO Countywide Communications	OEM; department PIO teams	Near-Term
	COM-R2	Standardize resident-facing repopulation and checkpoint communications.	LASD	OEM; CEO Countywide Communications; DPH; County operational partners	Near-Term
	COM-R3	Sustain LA-RICS infrastructure practices and support expanded adoption.	LA-RICS Authority	LASD; LACoFD; OEM; subscriber and user agencies	Long-Term
	COM-R4	Establish scalable custody-related emergency communications protocols.	LASD Custody Operations, Probation (independently)	OEM	Near-Term
#2: Volunteer and Donations Management	**VDM-R1**	Formalize a countywide VDM model and establish a dedicated EOC VAL.	CEO	OEM; ENLA/VOAD; nonprofit, community, and philanthropic partners	Mid-Term
	VDM-R2	Maintain an activation-ready cash donation package.	CEO	ISD	Near-Term
#3: Recovery	**RCV-R1**	Update the County Recovery Plan.	OEM	—	Mid-Term

Critical Focus Area	Rec.	Action Summary	Lead Agency	Supporting Agencies	Horizon
	RCV-R2	Codify debris operations in a Disaster Debris Management Plan.	DPW	—	Mid-Term
	RCV-R3	Formalize DRC Coordinator and DRC Supervisor roles.	OEM	—	Near-Term
	RCV-R4	Develop a one-stop web platform for post-disaster services.	OEM	CEO Countywide Communications; ISD	Long-Term
#4: Repopulation	**REP-R1**	Codify informal repopulation decision functions in a formal Repopulation Plan, including a single access credential standard and clear authority, approval, and escalation pathways.	LASD	OEM; unified command partner agencies	Mid-Term
#5: Shelter, Housing, and People at Higher Risk	**SHP-R1**	Institutionalize a shelter governance and readiness model.	DPSS	OEM; Red Cross; homelessness and housing partners	Mid-Term
	SHP-R2	Establish a formal shelter staffing readiness program.	DPSS	OEM	Mid-Term
	SHP-R3	Strengthen AFN requirements in shelters and establish an AFN Coordinator.	OEM	Aging & Disabilities; DPSS	Mid-Term
	SHP-R4	Establish a formal shelter transition and demobilization protocol.	DPSS	HSH; Red Cross; DMH; DPH; DHS; DCFS; 211LA	Near-Term
	SHP-R5	Establish a single multilingual shelter	OEM	CEO Countywide Communications; DPSS; ISD; 211LA	Long-Term

Critical Focus Area	Rec.	Action Summary	Lead Agency	Supporting Agencies	Horizon
		and housing information system.			
	SHP-R6	Create a real-time dashboard and readiness standards for children in care.	DCFS	OEM; contracted providers	Mid-Term
	SHP-R7	Jointly update shelter plans for custody and justice-involved populations.	Probation	LASD; OEM; DMH; EMS; DPH; LACOE; LACoFD; JCOD; DYD; housing and contracted-service partners	Mid-Term
	SHP-R8	Adopt a justice-involved community housing coordination framework.	JCOD	DYD; Probation; OEM; DMH; DPH; EMS; contracted providers	Long-Term
#6: Public Health and Access and Functional Needs	**PHA-R1**	Adopt a Public Health Response and Recovery Role Annex.	OEM	DPH Emergency Preparedness and Response Division; County departments	Near-Term
	PHA-R2	Institutionalize a PPE readiness playbook.	OEM	ISD; CEO donations management; DPH	Near-Term
	PHA-R3	Develop and exercise a public health communications playbook.	DPH	CJIC; AQMD; OEM	Near-Term
	PHA-R4	Institutionalize the Health and Social Services Task Force and maintain a standing Rapid Needs Assessment toolkit.	DPH	DMH; DPSS; DHS; Aging & Disabilities; OEM; 211LA; community partners	Near-Term
	PHA-R5	Designate a year-round AFN lead and liaison role.	Aging & Disabilities	OEM; DPH	Near-Term

Critical Focus Area	Rec.	Action Summary	Lead Agency	Supporting Agencies	Horizon
	PHA-R6	Establish a residential care emergency coordination program with real-time capacity visibility and a regional planning standard.	EMS/MHOAC	DPH HFID; OEM; Aging & Disabilities; Long-Term Care Ombudsman; CDPH; CDSS	Long-Term

Figure 10: Comprehensive AAR Recommendations table

Introduction

Purpose of the After-Action Review

This AAR provides a comprehensive independent review and evaluation of the County's recovery and repopulation response, other related issues, and associated policies and procedures, following the January 2025 Eaton and Palisades Fires. It examines how the County, working with its partners, coordinated recovery operations, supported impacted communities, communicated with residents, managed repopulation and access, addressed evacuation sheltering and safe housing needs, supported public health activities, and identified opportunities to strengthen future recovery and resilience efforts. It analyzes the role of various County departments and does not evaluate the actions or resources of federal, state, or incorporated city partners.

The Los Angeles County Board of Supervisors directed County Counsel pursuant to a Board Motion adopted March 18, 2025[1], in consultation with relevant County departments, to retain a consultant with subject-matter expertise to conduct the independent *AAR of Recovery and Repopulation Efforts for the Eaton and Palisades Fires*. This review aims to identify how issues were handled, lessons learned, best practices, regulatory prevention requirements, and areas needing improvement. It also recommends corrective actions and improvements to the County's existing capabilities to support a more robust response in future emergencies by providing actionable recommendations to help the County strengthen its policies, procedures, and protocols related to emergency response, recovery, and repopulation.

As with all AARs, this report is not an investigation and is not intended to assign blame. Its purpose is to provide a fact-based assessment of recovery and repopulation systems and offer actionable recommendations to help the County strengthen coordination, improve services to residents, clarify roles and responsibilities, and prepare for future climate-related disasters. This review did not identify evidence that County agencies intentionally withheld services from any populations. Rather, the findings point to gaps in planning, coordination, data visibility, staffing, and role clarity that limited the County's ability to consistently identify, reach, and support those populations during a catastrophic, multi-jurisdictional incident. This review is intended to help County leaders, emergency managers, partner agencies, and community stakeholders translate lessons learned into lasting improvements.

[1] *LA County Board Motion*. Last referenced September 8, 2026. As directed by County Counsel, McChrystal Group's activities and work product pertaining to the AAR are confidential and subject to the attorney–client privilege (and attorney work product doctrine), and, notwithstanding the AAR, privilege is not waived; rather, privilege is expressly preserved.

Scope of the Review

The scope of this AAR focuses specifically on the County's response in six (6) key focus areas:

- **Communications**
  This includes multi-jurisdictional coordination and public communications for the Eaton and Palisades Fires, including strategic communications among first responders, law enforcement, municipal governments, and impacted communities; repopulation notifications and procedures; road closure communications; LA-RICS performance for interoperable public safety communications and mutual aid; and communications to impacted members of the public involving individuals in County custody, with families, and caregivers, County leadership, and with the public.
- **Volunteer and Donations Management**
  This includes evaluation of best practices for a comprehensive system to receive, manage, and distribute public donations and to direct potential volunteers to appropriate opportunities and organizations.
- **Recovery Process**
  This includes multi-jurisdictional and multi-agency coordination and best practices for initial and short-term recovery; debris removal, including watershed debris removal; DRCs; identifying and validating ownership for impacted residents and properties to receive services; utility restoration; and post-disaster benefits.
- **Repopulation Process**
  This includes evaluation of the access and reentry process, road closure and reopening decision-making and processes, and County repopulation plans.
- **Shelter, Housing, and People at Higher Risk**
  This includes evaluation of evacuation shelter locations, shelter resources, shelter partner coordination, and resources for older adults and the disability community. It also includes evacuation and safe housing strategies for individuals in skilled nursing facilities (SNFs), group homes, senior living facilities, County jails, juvenile halls and camps, justice-involved housing programs, and children under the care of the Department of Children and Family Services (DCFS).
- **Public Health and Access and Functional Needs**
  This includes evaluation of the DPH's and supporting agencies' roles in response and recovery, including the impact of the local health emergency declaration, post-fire PPE coordination, and coordination with SNFs and state or local partners on evacuation planning.

This review addresses issues not covered by the prior McChrystal Group *AAR of Alert Notification Systems and Evacuation Policies for the Eaton and Palisades Fires*, including recovery and repopulation efforts and strategies, existing prevention regulations, and related County procedures.

The review covers the period from January 7, 2025, to March 31, 2025, with the evaluation focusing on short-term recovery operations. Short-term recovery operations began concurrently with or shortly after the commencement of response operations. Although categorized as short-term recovery, many recovery functions remained active well beyond the initial response period and continued for months following the incident.

Data for this review was collected through group meetings and interviews with County staff, third-party emergency service personnel, and community stakeholders, as well as a review of County plans, policies, and response documentation.

What This Review Does Not Cover

This AAR is not an investigation, audit, legal review, or determination of fault. It does not assess civil or criminal liability, evaluate individual performance, or seek to assign blame for decisions made during the incident. Instead, it evaluates systems, processes, coordination structures, communication pathways, and operational capabilities to identify what was or was not in place, what worked, what could be enhanced, what did not work as intended, and most importantly, policies, procedures, and actions that can be modified now to better position the County's and its partners' response and recovery effectiveness before the next major disaster.

This AAR also does not attempt to answer every question raised by the Eaton and Palisades Fires, nor does it seek to document every experience of affected residents, first responders, partner agencies, or County departments. It does evaluate repeated and crosscutting themes related to the six (6) focus areas outlined above. Several related reviews are being conducted or have been conducted by other entities, including reviews associated with the Honorable Robert Garcia of the House of Representatives, Governor's Office through the Fire Safety Research Institute at UL Research Institutes, Citygate Associates review initiated by Los Angeles County Fire Department (LACoFD), the California Attorney General, the California State Auditor, and the previous *AAR of Alert Notification Systems and Evacuation Policies for the Eaton and Palisades Fires* conducted by McChrystal Group. Those separate efforts address topics such as ignition, fire behavior, immediate response operations, evacuation alerts, and other incident-specific issues that are either outside of, or-partially overlap with, the scope of this AAR. Where those topics are referenced in this report, they are included only to provide context for recovery, repopulation, public health, sheltering, donations, communications, funding, and related systems reviewed here.

The County's emergency planning for people with disabilities and AFN has also been shaped by prior legal and oversight frameworks outside of this review's scope. The review team also examined other after-action reports from prior incidents in Los Angeles County and elsewhere for reference and comparison. This review did not assess compliance with those frameworks, and only the *AAR of the Woolsey Fire Incident* was evaluated for recommendation status and whether additional recommendations should be implemented, as required by the Board's direction.

Methodology

This AAR was conducted as an independent review of Los Angeles County's recovery and repopulation systems following the January 2025 Eaton and Palisades Fires. The review was designed to identify how recovery, repopulation, and related issues were handled, document lessons learned and best practices, identify areas needing improvement or enhancement, and develop corrective actions and cost considerations where appropriate. Consistent with the Board-directed scope, the review focused on communications; volunteer and donations management; recovery services and debris removal; shelter, housing, and support for people at higher risk; public health; review of relevant recommendations from the *AAR of the Woolsey Fire Incident*; and County program and funding expansion.

The methodology followed the same general approach used in McChrystal Group's prior *AAR of Alert Notification Systems and Evacuation Policies for the Eaton and Palisades Fires*, which combined document review, stakeholder interviews, operational data review, community input, timeline development, and final synthesis. That approach was expanded for this review to account for the broader recovery and repopulation scope and the larger number of County departments, community-based organizations (CBOs), and partner agencies involved in post-fire recovery operations.

Data Collection

McChrystal Group collected and reviewed documents, policies, procedures, operational records, coordination logs, public-facing communications, survey data, working group notes, and other materials relevant to the AAR's focus areas. The review included information from County departments, Supervisorial District 3 (SD3) and Supervisorial District 5 (SD5) staff, other relevant state and local agencies, CBOs, and additional partners identified through the project scope.

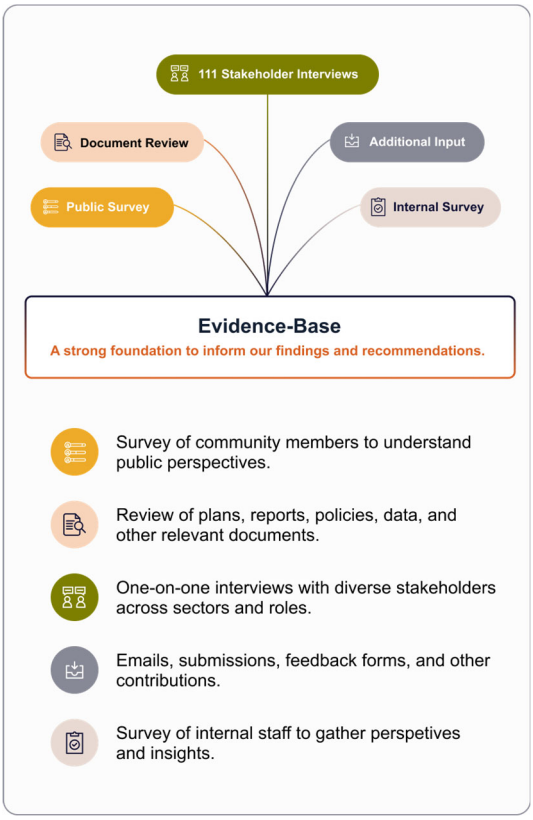


Figure 11: Evidence Collection Methodology

The data collection process was designed to build a comprehensive evidentiary base rather than rely on any single source of information. Documents and operational records were used to establish process, chronology, decision points, and formal roles. Interviews, working group discussions, internal survey responses, and public survey data were used to understand how those processes functioned in practice and how residents, departments,

and partner organizations experienced recovery and repopulation operations. Where possible, observations were tested across multiple sources before being incorporated into findings.

Working Group Structure

The review used a two-tiered working group structure consisting of a Primary Working Group and focus area-specific Sub-Working Groups. The Primary Working Group served as the steering committee for the AAR and was convened on November 6, 2025, to orient key County stakeholders to the review, validate the proposed working group structure, establish project priorities, and provide strategic direction for the overall process.

The Sub-Working Groups served as the primary forums for substantive discussion of recovery and repopulation processes. The Sub-Working Groups were organized around major functional areas, including Communications, Volunteer and Donations Management, Recovery, Repopulation, Public Health and AFN, and Shelter, Housing, and Special Populations. This structure created focused spaces for stakeholders to examine operational issues in detail on a monthly cadence.

Sub-Working Group sessions were used to validate lines of inquiry, identify relevant documents and stakeholders, clarify operational roles and decision points, surface conflicting perspectives, and test emerging themes. The structure also supported coordination across data collection workstreams, including operational documentation, policies and procedures, stakeholder interviews, community surveys, coordination logs, and after-action notes. The project scope required facilitation, moderation, and action-item tracking for these meetings.

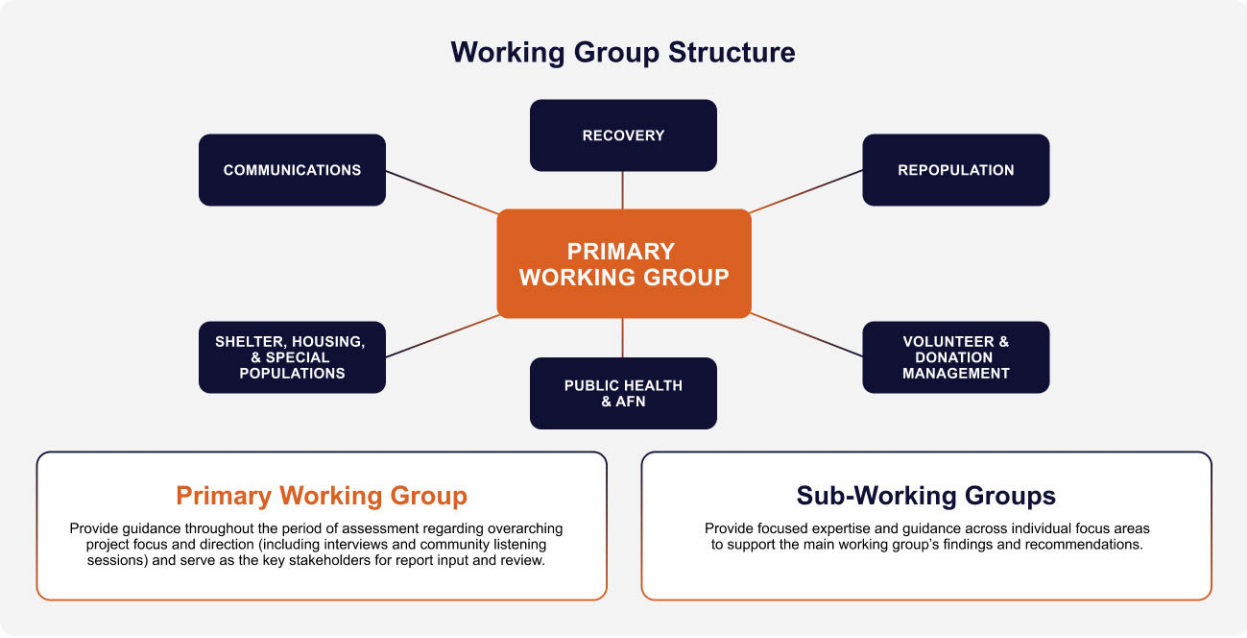


Figure 11: AAR Working Group Structure

County Internal Survey and Stakeholder Interviews

In addition to interviews and facilitated working group discussions, the review team distributed an internal, confidential survey to County Sub-Working Group participants and key external stakeholders, as noted in *Appendix 2*. The internal survey provided a standardized mechanism for gathering feedback across participants and helped identify recurring themes, areas of agreement, and issues requiring further inquiry. The internal survey also helped streamline stakeholder identification for interviews.

Stakeholder interviews were conducted with County departments, CBOs, and partner agencies involved in recovery and repopulation operations. McChrystal Group conducted interviews with 111 stakeholders and stakeholder groups, represented by the groups identified in *Appendix 2*. Individuals were granted anonymity to allow for a candid discussion to gather operational perspectives, clarify decision processes, identify implementation challenges, and understand how coordination occurred across departments, jurisdictions, and partner organizations. Internal survey results were analyzed alongside interview data, Sub-Working Group discussions, and documentary evidence to ensure findings reflected broader patterns rather than isolated observations.

Public Survey

As part of this project review, McChrystal Group launched a public community survey on March 11, 2026, to gather feedback anonymously from residents impacted by the January 2025 Eaton and Palisades Fires. The survey was designed to be anonymous to protect residents from providing personally identifiable and health information. The survey evaluated the County's recovery and repopulation efforts and sought input from residents who evacuated, experienced property damage, used disaster shelters, accessed debris removal or recovery services, required AFN support, sought information about someone in County custody, were unhoused at the time of the fires, attempted to volunteer or donate, or wished to share observations as residents who were not directly impacted.

The survey remained open through June 22, 2026. The County helped distribute the survey link through press releases and its social media pages and posted information about the survey and its link on its official government web pages at LA County Recovers and Eaton & Palisades Fires After Action Reviews. McChrystal Group team members also participated in several community events to help reach participants.

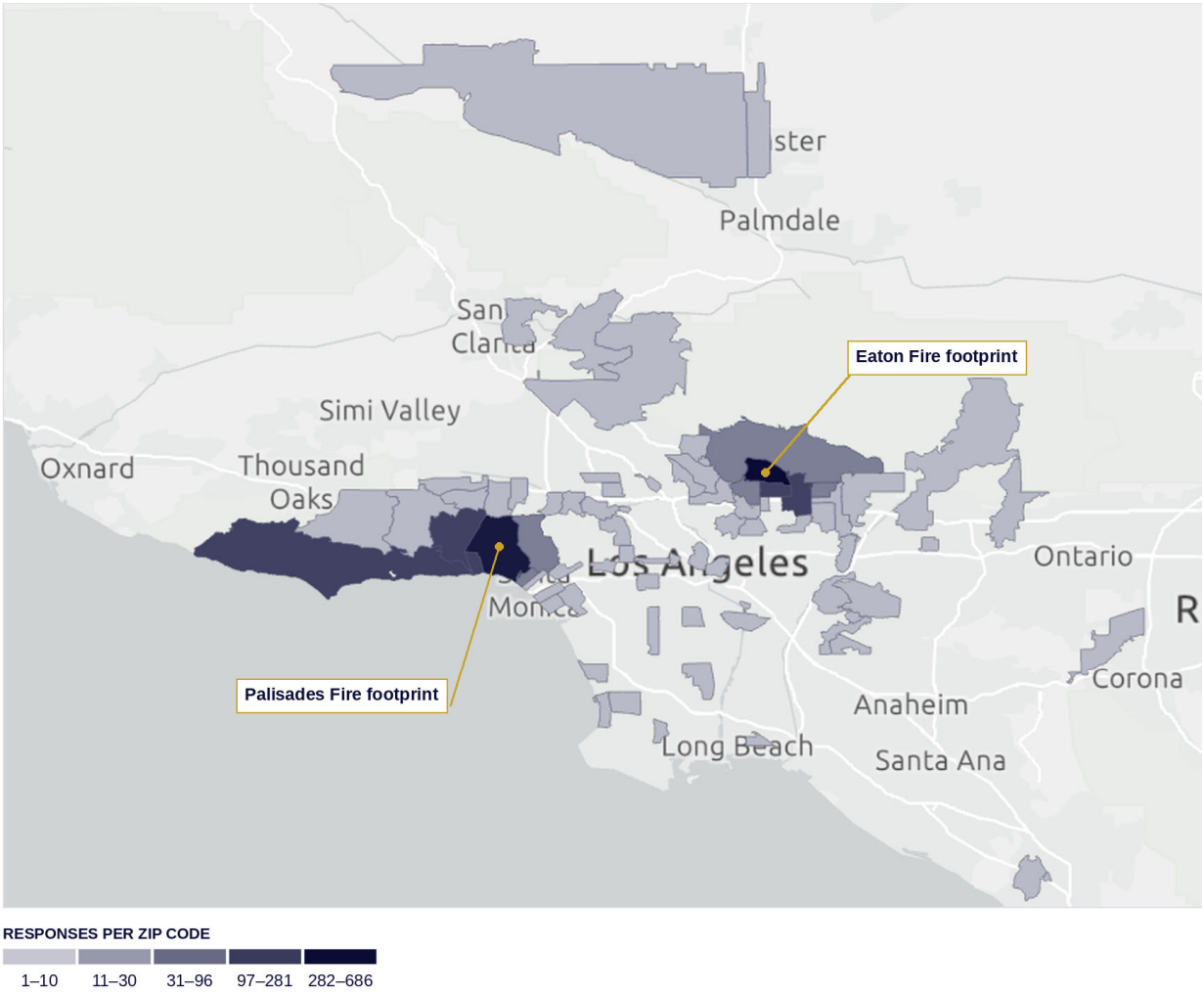


Figure 12: Survey Responses by ZIP Code

The survey was designed to take less than 10 minutes to complete and used an adaptive structure, so respondents were asked only the questions relevant to their experience. This reduced respondent burden while still capturing information across the major topics included in the review. The survey was available in English, Spanish, and Armenian and could be translated into additional languages to support broader participation. To improve access, responses could also be submitted on behalf of another person, including a friend, neighbor, family member, or individual in care. This accommodation helped capture experiences from residents who may have faced barriers to completing the survey independently.

The survey generated exactly 1,500 responses. The review team analyzed both structured survey responses and open-text comments. Quantitative response data were reviewed to identify patterns in resident experience, including satisfaction, perceived clarity, accessibility, timeliness, and ease of use across County recovery and repopulation decisions, actions, and services. Open-text responses were reviewed through qualitative thematic analysis to identify recurring issues, resident-identified strengths, gaps in County services, and recommendations for improvement.

Public survey results were not treated as the sole basis for findings, but they provided an important source of resident experience and were used alongside interviews, working group discussions, and operational records.

Survey Compositions and Limitations

Respondents in the Eaton Fire footprint accounted for 985 of the 1,500 responses. In the Palisades Fire footprint, there were 417 responses. In addition, 98 respondents came from all other County areas combined. Results in this report are described by fire footprints. Respondents were also predominantly homeowners (1,123 of 1,500), and 41% of respondents were aged 65 and over. The survey began March 11, 2026, and closed June 22, 2026, 14 to 17 months after the fires, so responses reflect recalled experience rather than contemporaneous reporting. Survey results were not treated as the sole basis for any finding in this report.

How Survey Results are Reported

Percentages are reported only where the responding subgroup is large enough to support them. Where a subgroup is smaller than 30 respondents, results are reported as counts and identified as illustrative rather than representative. The base size for each result is stated at first use within a section. Where the underlying County program differed between the two burn areas, results are reported by fire footprint rather than countywide. This applies in particular to access passes and checkpoint credentialing: multiple entities issued separate access passes in the Palisades Fire footprint before converging on a unified design, and the Eaton Fire footprint did not operate the same pass system.

Community Engagement

McChrystal Group attended five community meetings and gatherings in SD3 and SD5, the two districts most impacted by the fires. The purpose of the attendance was to publicize, explain, and disseminate McChrystal Group’s public survey for this AAR.

Two community meetings were attended in person, and two were attended virtually. At in-person meetings, McChrystal Group set up a table outside the meeting to explain the purpose of the public survey, handed out flyers with the survey QR code, and presented to attendees on the survey's purpose and target audience.

For meetings attended virtually, McChrystal Group gave the same presentation, shared the survey QR code and link, and provided the link to the community meeting leader to distribute across their network. McChrystal Group staff also attended a large farmer’s market gathering where many Altadena residents shop.

The community meetings and gatherings were attended on the following dates for each district:

District 3	• April 15, 2026, virtually from 9:00 a.m. – 10:00 a.m. at the Malibu Community Long Term Recovery Group • April 15, 2026, virtually from 10:00 a.m. – 12:00 p.m. at the Topanga Emergency Management Task Force Quarterly Meeting • April 15, 2026, in-person from 6:00 p.m. – 7:30 p.m. at the Topanga Town Council Meeting
District 5	• May 19, 2026, in-person from 7:00 p.m. – 9:00 p.m. at the Altadena Town Council Meeting
	• June 20, 2026, in-person from 7:30 am – 12:30 pm, to promote survey participation at the Pasadena Farmers Market at Victory Park *(a large number of Altadena residents attend this market given Altadena farmers' markets were temporarily suspended following the Eaton Fire).*

Figure 14: AAR community meetings by district

Altadena Libraries also emailed information about the survey to residents through its Altadena Connections newsletter, and information about the survey was posted at the Altadena Sheriff's Station, Malibu Lost Hills Sheriff's Station, Bob Lucas Memorial Library & Literacy Center, Charles S. Farnsworth Park, and the Altadena and Calabasas One-Stop Permit Centers (OSPCs).

Analytical Approach for the AAR

McChrystal Group's review team analyzed information by both focus area and major theme. Focus-area analysis examined specific processes, roles, decision points, coordination mechanisms, and resident-facing outcomes within each functional area. Cross-cutting analysis of the County's structure examined recurring issues related to governance, staffing, role clarity, coordination rhythms, information flow, data visibility, accessibility, public communication, technology, and interagency coordination.

McChrystal Group's review team included emergency management practitioners, qualitative researchers, survey and assessment specialists, data analysts, and personnel experienced in data engineering, data synthesis, statistical analysis, and visualization. The team developed structured datasets to organize survey results, interview themes, working group inputs, operational documentation, and focus-area evidence. The team reviewed quantitative and qualitative information together to distinguish isolated concerns from recurring operational patterns and identify where findings were supported across multiple data sources.

The review team applied a functional structure to the analysis rather than a purely chronological approach. This allowed the report to examine systems and capabilities, including communications, repopulation and access, recovery services, volunteer and donations management, shelter and housing, public health, *AAR of the Woolsey Fire Incident*

recommendation implementation, and County program and funding expansion, without repeating the same incident narrative across sections. The functional structure also supported development of specific recommendations tied to responsible entities, implementation mechanisms, and measurable improvement opportunities.

Findings were developed where evidence indicated a recurring operational pattern, a material process gap, a documented strength, or a decision point with broader implications for future recovery and repopulation operations. Findings identify system conditions, role and process issues, capability gaps, and practices that should be sustained or improved.

Recommendations were developed to be actionable and directly tied to the findings they address. Where possible, recommendations identify an implementation mechanism, responsible owner or partner, and measurable indicator of progress or completion. Recommendations were also reviewed for duplication, feasibility, and consistency with the AAR scope.

Review of Prior AAR Recommendations for Woolsey Fire

As required by the March 18, 2025 Board Motion, this review included a focused assessment of the recommendations issued in the Los Angeles County *AAR of the Woolsey Fire Incident*. The review team evaluated each of the 85 Woolsey recommendations against the scope of this AAR, with particular attention to recommendations related to repopulation, recovery transition, debris management, volunteer and donations management, public information, public health, sheltering, support for people at higher risk, and interagency coordination. Each recommendation was categorized based on its relevance to the six critical focus areas in this report and the County's reported implementation progress, as supplemented by evidence collected through document review, working group discussions, interviews, surveys, and operational records for the Eaton and Palisades Fires.

Of the 85, the review team determined that 30 had been implemented prior to the January 2025 fires and 6 were in progress; 13 fall directly within the scope of this AAR; 20 were evaluated in the County's prior *AAR of Alert Notification Systems and Evacuation Policies for the Eaton and Palisades Fires*; 15 have no confirmed update and require follow-up by the responsible agency; and 1 remains uncategorized. This section does not restate each recommendation individually. The recommendations that remain operationally relevant to recovery and repopulation are addressed within the critical focus area findings to which they relate.

Limitations and Assumptions

This review reflects the information available to the McChrystal Group review team during the assessment period. While the review incorporated documents, interviews, working group discussions, internal survey results, public survey responses, and other materials, the findings should be understood as an assessment of systems, processes, and operational patterns rather

than an exhaustive reconstruction of every individual action taken during recovery and repopulation.

The review does not assess the cause or origin of the fires, firefighting tactics, individual performance, or issues outside the Board-directed recovery and repopulation scope contained in the March 18, 2025 Board Motion. Community and stakeholder perspectives were important inputs, but findings were developed only where those perspectives were supported by broader evidence or reflected a recurring pattern across sources.

Final Report Compilation

Following data collection, document review, interviews, working group meetings, internal survey analysis, public survey analysis, and qualitative synthesis, McChrystal Group developed the findings and recommendations contained in this report. Draft findings were reviewed for scope alignment, evidentiary support, internal consistency, and implementation relevance. The final report provides County leaders, departments, partner agencies, and community stakeholders with a clear account of recovery and repopulation strengths, gaps, and recommended corrective actions to improve future disaster recovery operations.

Appendix 7: McChrystal Group Team contains profiles of the team members who worked on and prepared this AAR. They include professionals with extensive experience in emergency management, emergency recovery operations, wildfires, law enforcement response, radio communications, public health, and AFN populations.

Incident Overview

Purpose of this Overview

This section provides a high-level overview of the operating environment that shaped Los Angeles County's recovery and repopulation efforts following the January 2025 Eaton and Palisades Fires. It does not reconstruct the full incident timeline, reassess alert and evacuation decisions, or repeat analysis addressed in McChrystal Group's prior *AAR of Alert Notification Systems and Evacuation Policies for the Eaton and Palisades Fires*.

Instead, this overview explains the conditions under which the County, cities, state and federal partners, utilities, nonprofit organizations, CBOs, and residents moved from emergency response into reentry, resident services, debris removal, public health risk reduction, housing support, donations management, and longer-term recovery.

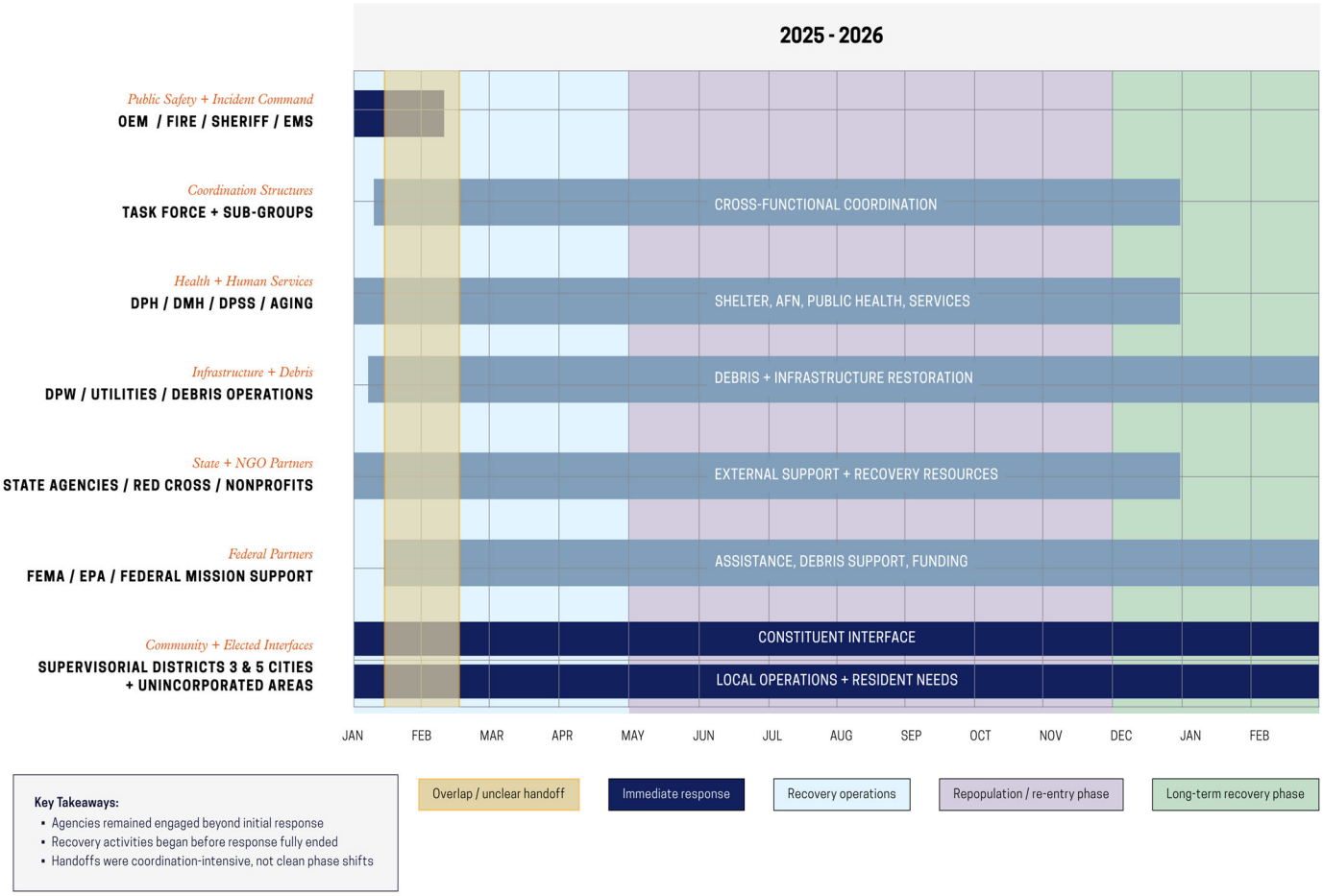


Figure 15: Response to Recovery Transition and Agency Coordination

From Response to Recovery

On January 7, 2025, extreme winds and multiple fast-moving brush fires created catastrophic conditions across Los Angeles County. The Palisades Fire ignited on January 7 at 10:30 a.m. in the Santa Monica Mountains, southeast of Palisades Drive in the Los Angeles City portion of Pacific Palisades. The Eaton Fire started later that same day in the Eaton Canyon area of the San Gabriel Mountains in Altadena at 6:18 p.m. In addition to the Eaton and Palisades Fires, three other fires started in the Los Angeles County region between January 7 and January 8, 2025: the Hurst Fire in Sylmar, the Lidia Fire in Acton, and the Sunset Fire in Hollywood Hills. The fires necessitated the allocation of resources, the issuance of evacuation warnings and orders, and the use of emergency alerts and notification systems. Additionally, as the response to these fires continued, the Kenneth Fire started in West Hills on January 9, 2025. The Hughes Fire began in Castaic on January 22, 2025, requiring LACoFD resources while containment efforts for the Eaton and Palisades Fires were still ongoing; both fires were fully contained on January 31.

The Governor proclaimed a state of emergency for Los Angeles and Ventura counties on January 7, citing the Eaton and Palisades Fires, windstorm conditions, high winds, low humidity, dry conditions, threats to structures and critical infrastructure, and damaging wind gusts forecasted at 50 to 80 miles per hour. On January 8, 2025, the President of the United States approved a major disaster declaration for California for wildfires and straight-line winds beginning January 7, making federal assistance available to affected individuals in Los Angeles County, including assistance for temporary housing, home repairs, uninsured property losses, and other recovery programs.

Figure 16: Photos from the Eaton and Palisades Fires

INCIDENT SUMMARY

Eaton and Palisades Fires

January 7 – 31, 2025

	EATON FIRE	PALISADES FIRE	TOGETHER Eaton & Palisades Fires
STARTED	6:18 p.m. Jan. 7, 2025	10:30 a.m. Jan. 7, 2025	–
CONTAINED	Jan. 31, 2025	Jan. 31, 2025	Jan. 31, 2025
ACRES BURNED	14,021 acres	23,448 acres	37,469 acres
STRUCTURES DESTROYED	9,414 structures	6,837 structures	16,251 structures
STRUCTURES DAMAGED	1,074 structures	973 structures	2,047 structures
CONFIRMED FATALITIES	19 confirmed fatalities	12 confirmed fatalities	31 confirmed fatalities

Figure 17: Summary of the January 2025 Eaton and Palisades Fires; Source: County of Los Angeles. Fact Sheet: Key Facts About the Eaton and Palisades Fires

The scale of the disaster produced immediate and sustained recovery needs. Los Angeles County-published economic impact figures estimate $5.2 billion to $10.1 billion in economic output losses, approximately 6,800 businesses impacted, approximately 47,000 workers impacted, $2.2 billion to $4.2 billion in labor income losses, and $900 million to $1.6 billion in tax revenue losses.[23] These figures are included to frame the magnitude of displacement, property loss, infrastructure damage, environmental concern, and resident need that shaped the recovery mission. During the initial response, first responders prioritized life safety, evacuation, fire suppression, emergency public information, and access control. As conditions stabilized in some areas, the County and its partners had to begin recovery operations while hazards, closures, utility restoration, debris conditions, shelter needs, and public health concerns were still evolving. This transition was not a clean handoff from response to recovery. Multiple recovery missions began concurrently, including resident reentry, road access, sheltering and temporary

[2] *County of Los Angeles. Fact Sheet: Key Facts About the Eaton and Palisades Fires*. Last referenced September 4, 2026.

[3] *Los Angeles County Economic Development Corporation, Institute for Applied Economics, in partnership with the Los Angeles County Department of Economic Opportunity. Los Angeles Wildfires: Economic Update #1, September 2025.* Last referenced September 4, 2026.

lodging, public health guidance, debris removal planning, donations and volunteer coordination, utility coordination, public information, document replacement, and recovery center operations.

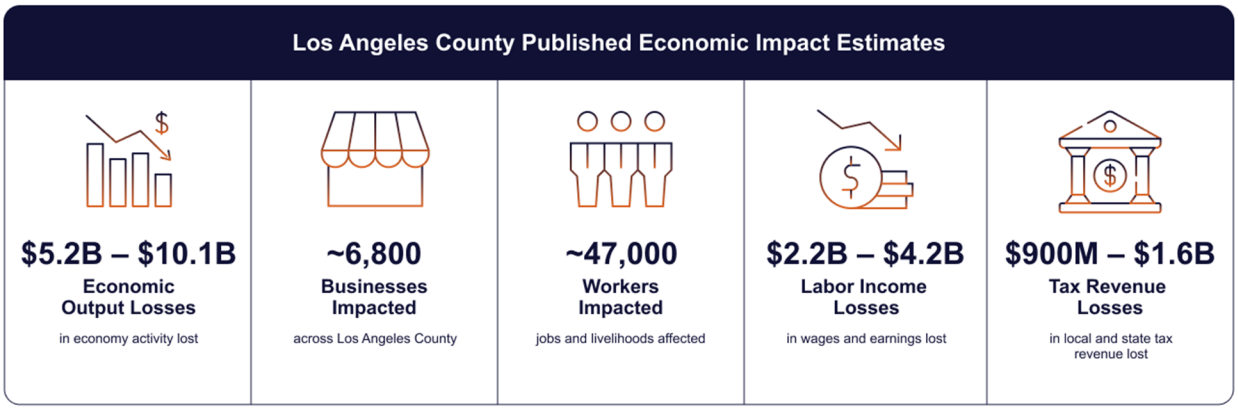


Figure 18: Economic Impact of the January 2025 Eaton and Palisades Fires

County Emergency Support Function Structure

The County organizes emergency responsibilities through eighteen LAC-ESFs defined in the County of Los Angeles Operational Area Emergency Operations Plan (OAEOP). Each LAC-ESF designates a primary department and a set of supporting departments, spanning transportation, communications, mass care, public health and medical, logistics, initial recovery, public information, personnel and volunteers, and donations management. Thirty-eight County departments carry an assignment under at least one function. The complete matrix of primary and support designations appears in *Appendix 6*.

The LAC-ESF structure establishes which department leads each function on paper. Several findings in this review concern the distance between that designation and operational practice, including how responsibilities were exercised during recovery, whether primary departments had defined decision authority, and whether functions with no designated primary were coordinated at all.

Communities and Jurisdictional Context

The recovery environment encompassed incorporated cities, the City of Los Angeles, and unincorporated County communities. The Eaton Fire affected unincorporated communities of Altadena and Kinneloa Mesa, as well as the cities of Arcadia, Pasadena, Sierra Madre, and other surrounding foothill communities. The Palisades Fire affected the Pacific Palisades neighborhood of the City of Los Angeles, the unincorporated communities of Sunset Mesa and Topanga Canyon, the City of Malibu, and other nearby coastal and Santa Monica Mountains communities. These areas differed significantly in geography, governance, wildfire experience, infrastructure, road access, housing stock, and community support networks.

Jurisdictional responsibilities varied by location and recovery phase. In unincorporated communities, County departments held direct responsibilities for emergency management coordination, public safety, public health, recovery services, and resident assistance. Within incorporated jurisdictions, including the cities of Los Angeles, Pasadena, Malibu, Arcadia, and Sierra Madre, municipal governments and local public safety agencies retained primary responsibility for many local operations, while the County attempted to provide regional coordination, specialized services, and other forms of support. Recovery activities also required sustained coordination with state agencies and partners, including the California Governor's Office of Emergency Services (Cal OES), CalRecycle, the California Department of Transportation (Caltrans), and other entities supporting debris removal, transportation, environmental, public health, and recovery functions. Federal agencies, utilities, nonprofit organizations, and CBOs also contributed resources, technical assistance, and resident-facing support.

Residents did not always clearly understand or experience the distinctions among County, municipal, state, and federal responsibilities. From the public's perspective, repopulation and recovery needs were practical and immediate, yet information addressing those needs was not always clear, consistent, or easy to obtain. Residents needed to know when they could return, whether conditions were safe, what documentation was required to access services and assistance, where to obtain help, how debris removal would occur, how to replace critical documents, what programs were available, and which agency or organization could provide authoritative answers.

The physical geography of the impacted areas also added complexity. Foothill, canyon, coastal, and wildland-urban interface communities each had unique impacts and constrained road networks, limited access points, infrastructure vulnerabilities, and burn-area hazards. These conditions affected recovery and repopulation by shaping road reopening, checkpoint operations, utility restoration, debris removal, environmental testing, and public health messaging.

The demographic profile of impacted communities also shaped repopulation and recovery needs. Older adults, people with disabilities, medically fragile residents, people without reliable transportation, people with limited digital access, people experiencing homelessness, residents with language access needs, and people connected to County case-carrying systems, each required different types of support. Some residents were able to navigate web-based information, insurance, Federal Emergency Management Agency (FEMA) registration, document uploads, and recovery center services independently. Others required direct outreach, transportation support, replacement documents, durable medical equipment (DME), medication continuity, accessible sheltering, case management, or help reconnecting to food, health, and social services.

Recovery and Repopulation Conditions

> **IN THE COMMUNITY'S WORDS**
>
> *"The evacuation and repopulation process was chaotic and deeply stressful… residents had to make decisions with incomplete or conflicting information… there was little on-site guidance about safety, documentation, or next steps. Los Angeles County could improve this process by providing more consistent and centralized communication, clearer timelines and criteria for… reentry, and on-the-ground support teams."*
>
> — Public survey respondent

Repopulation was not simply the reopening of neighborhoods after evacuation orders were lifted. Reentry required coordination across law enforcement, fire, public works, public health, utilities, debris management, environmental health, cities, state and federal partners, and elected offices. Agencies had to consider their ability to respond to emergency calls for service in fire-affected areas, road safety, utility status, hazardous debris, ash exposure, damaged structures, water and air quality concerns, law enforcement access control, and the timing and clarity of public messaging.

Public health considerations remained central throughout recovery and repopulation. On January 10, 2025, DPH declared a local health emergency due to the fires and windstorm conditions, citing degraded air quality, health and safety risks, resident displacement, healthcare facility evacuations, and disruption of vital health services and resources. DPH and the Health Officer subsequently issued orders and guidance to reduce exposure risks, including prohibiting power air blowers that could stir ash and particulate matter into the air, and recommending that residents limit smoke and ash exposure, stay indoors when appropriate, maintain clean indoor air, and use properly fitted N95 or P100 respirators when outdoors in smoky or ash-impacted conditions.

In addition, on January 15, 2025, DPH prohibited cleanup or removal of fire debris in critical fire areas until an approved government agency completed hazardous materials inspections. On January 23, DPH revised the power air blower order to apply within the Palisades and Eaton wildfire perimeters. Together, these actions established public health precautions for residents, workers, cleanup contractors, and public agencies operating in and around the burn areas.

Debris removal became a critical dependency for repopulation, recovery, and rebuilding. On January 12, 2025, OEM requested debris removal support. That same day, Governor Gavin Newsom issued an executive order directing expedited debris removal and other measures intended to reduce post-fire hazards. The Governor's Office subsequently announced that California, through Cal OES, was coordinating with the federal government to pre-position debris-removal resources and begin work as soon as affected areas were safe to enter.

IN THE COMMUNITY'S WORDS

"The debris removal crew was kind and compassionate; they were timely and communicative."

— Public survey respondent

Under the federally supported debris-removal program, FEMA, working with Cal OES, issued mission assignments to federal agencies with specialized cleanup capabilities. The U.S. Environmental Protection Agency (EPA) was assigned to lead Phase 1, which focused on identifying and removing household hazardous materials. FEMA subsequently assigned the U.S. Army Corps of Engineers (USACE) to lead Phase 2 removal of remaining fire ash, structural debris, hazardous trees, contaminated soil, and other eligible materials from participating properties.

The County served as the principal local administrator for the consolidated program, including providing residents with program information, receiving ROE forms, verifying eligibility and ownership, coordinating property access, and transmitting eligible properties for federal cleanup. On January 28, 2025, the County made ROE forms available to residents seeking to participate in the government-sponsored program. Property owners could opt in for federally funded Phase 2 debris removal conducted by USACE or opt out and retain an approved private contractor at their own expense. The government-sponsored program included property assessment, asbestos removal, hazardous tree removal, ash and soil removal, structural demolition, vehicle removal, erosion control, environmental monitoring, and potential foundation removal.

Debris operations moved at significant scale. By February 25, 2025, the Governor's Office reported that more than 9,000 properties had been cleared of household hazardous materials, with EPA, the California Department of Toxic Substances Control, and Department of Defense teams completing Phase 1 hazardous waste removal by February 27, 2025.[4] County-published recovery statistics report that the EPA removed more than 300 tons of household hazardous waste and USACE removed more than 2.6 million tons of fire debris. On May 20, 2025, USACE reported that more than 5,000 properties across the Eaton and Palisades burn areas had been cleared of ash and fire debris and received final sign-off, with an additional 2,500 properties cleared and in the final sign-off process. Los Angeles County later reported that USACE completed Phase 2 debris cleanup in September 2025.[5]

4 *U.S. Environmental Protection Agency. EPA Completes Household Hazardous Materials Cleanup in Response to Los Angeles Wildfires*, February 26, 2025. Last referenced September 8, 2026.

5 *U.S. Army Corps of Engineers, with FEMA and Cal OES. More Than 5,000 Properties Complete in Wildfire Debris Removal Effort*, May 20, 2025. Last referenced September 8, 2026.

Resident-Facing Services and Support

DRCs became key public-facing locations where residents could access government agencies, nonprofit partners, recovery information, document replacement resources, benefit programs, debris information, and case support.

> **IN THE COMMUNITY'S WORDS**
>
> *"There were so many organizations, groups, and individuals that jumped in to help, which made it difficult to sort through the noise. It was certainly heartwarming, although attention fades quickly over time."*
>
> — Public survey respondent

The County supported FEMA and the State in opening DRCs to the public on January 14, 2025. The centers initially opened with limited hours, which were quickly expanded to 9:00 a.m.-8:00 p.m. to support public access. The initial locations were UCLA Research Park West at 10850 West Pico Boulevard in the City of Los Angeles and Pasadena City College Community Education Center at 3035 East Foothill Boulevard in the City of Pasadena. County departments available at the centers included Los Angeles County Aging & Disabilities, Assessor, Animal Care & Control, Child Support Services, DCFS, Department of Consumer and Business Affairs (DCBA), Economic Opportunity, Fire, Chief Executive Office (CEO) Homeless Initiative now known as Homeless Services and Housing (HSH), Medical Examiner, Department of Mental Health (DMH), Military and Veterans Affairs, DPH, Department of Public Social Services (DPSS), Department of Public Works (DPW), Regional Planning, Registrar-Recorder/County Clerk, Treasurer and Tax Collector, as well as team members from SD3 and SD5.

Figure 19: County Resources During the Fire

On January 27, 2025, a new Altadena Disaster Recovery Center opened at 540 West Woodbury Road. The County announced that the Pasadena and Altadena locations would operate together through the end of January, with Pasadena services shifting to Altadena beginning February 1. The then-current DRC locations had their last day of service on May 31, 2025.

On June 2, County services continued at four OSPCs:

- 1828 Sawtelle Boulevard in the City of Los Angeles
- 27001 Agoura Road in Calabasas
- 464 West Woodbury Road in Altadena
- Altadena Community Center at 730 East Altadena Drive

All locations operated Monday through Friday from 9:00 a.m. to 5:00 p.m.

The centers helped consolidate services, but they also reflected the complexity residents faced. Survivors had to verify identity, residence, ownership, or eligibility at multiple points in the recovery process, and documentation requirements varied across programs. FEMA assistance, ROE, replacement records, insurance support, County assistance, relief grants, rebuilding support, and nonprofit programs each had their own rules, timelines, and documentation needs. For residents who had lost homes, documents, transportation, internet access, or stable housing, navigating multiple systems became part of the recovery burden.

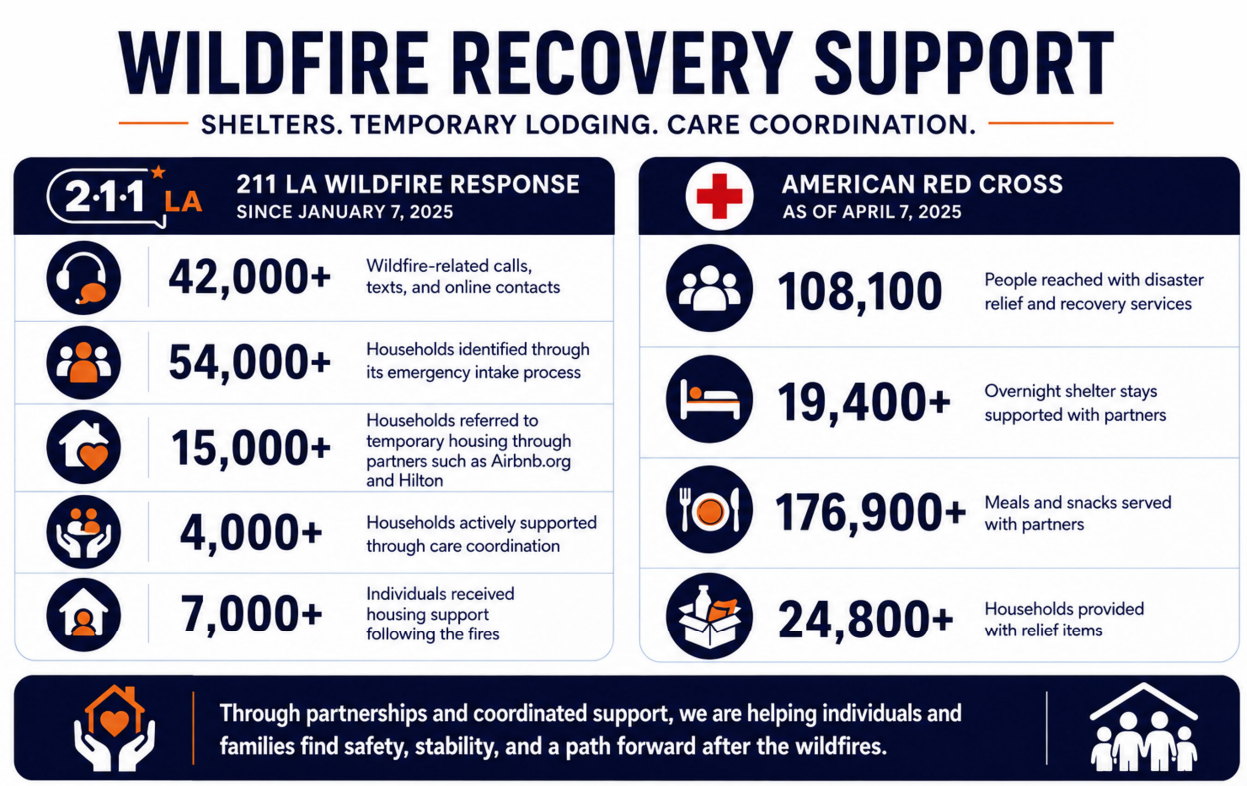


Figure 20: January 2025 Eaton and Palisades fires Recovery Support

Shelters, temporary lodging services, and care coordination were also a major part of the resident-facing recovery support system. 211 Los Angeles (211LA; a non-profit provider) reported more than 42,000 wildfire-related calls, texts, and online contacts since January 7, 2025; more than 54,000 households identified through its emergency intake process; nearly 15,000

households referred to temporary housing through partners such as Airbnb.org and Hilton; nearly 4,000 households were actively supported through care coordination; and more than 7,000 individuals received housing support following the fires.[6] The American Red Cross (Red Cross) reported that, as of April 7, 2025, it had reached an estimated 108,100 people with disaster relief and recovery services; supported more than 19,400 overnight shelter stays with partners; served approximately 176,900 meals and snacks with partners; and provided more than 24,800 households with relief items.[7]

Financial assistance programs also became part of the recovery landscape. On January 24, the County Department of Economic Opportunity (DEO) and the City of Los Angeles Economic and Workforce Development Department announced the LA Region Small Business and Worker Relief Funds. Developed as a public-private partnership, the programs provided direct cash assistance to wildfire-affected small businesses, nonprofit organizations, and workers. Eligible businesses and nonprofits could receive grants ranging from $2,000 to $25,000, while eligible workers could receive $2,000. DEO initially committed $1 million in existing grant funding and worked with the County's Center for Strategic Partnerships, Southern California Grantmakers, AidKit, and community partners to raise funds, administer applications, and distribute awards.

The Board of Supervisors established the Los Angeles County Fire Recovery Fund on January 28, creating the basis for the LA County Household Relief Grant. Administered by the DCBA in partnership with The Center by Lendistry, a nonprofit grant and relief-program administrator, the program opened for applications on February 26. It offered grants ranging from $6,000 to $18,000, based on household size and composition, for unmet needs not covered by insurance or other assistance. The County allocated $32.2 million in American Rescue Plan Act (ARPA)-enabled funding to support the program.

Figure 21: Fire response discussion at the EOC

The Board of Supervisors also took a series of policy and funding actions to stabilize housing, support displaced residents and renters, and address economic disruption during the recovery period. These actions included establishing countywide eviction protections for wildfire-impacted households, including protections applicable across incorporated cities, and establishing the LA Emergency Rent Relief Program by motion in February 2025, with funding

[6] *211 LA After Action Report for the January 2025 Eaton and Palisades Wildfires.* Last referenced September 8, 2026.

[7] *American Red Cross. California Wildfires 2025 One-Year Report*, January 2026. Last referenced September 8, 2026.

identified through later Board actions to help residents facing displacement-related housing instability. The Board also created eviction protections for residents who temporarily housed additional people or pets because of the fires, even when those arrangements exceeded lease occupancy or pet restrictions. In addition, the Board took multiple actions to curb post-disaster price gouging in housing, hotels, and motels, including a February 14, 2025, motion to increase penalties and provide additional support to the DCBA for investigation and enforcement, followed by a March 4, 2025, motion to extend housing price-gouging protections that were otherwise set to expire under the State emergency order.

The County's recovery assistance landscape also included district-level economic stabilization efforts, including the Malibu-Topanga Business Interruption Fund, led by Los Angeles County Third District Supervisor Lindsey Horvath and the DEO. This fund provided emergency financial relief to small businesses impacted by severe 2025 winter storms and wildfires. The program targeted brick-and-mortar storefronts in the Malibu (90265) and Topanga (90290) zip codes that suffered at least a 10% year-over-year revenue loss due to closures on the Pacific Coast Highway and Topanga Canyon Boulevard. Eligible businesses with fewer than 100 employees and under $6 million in annual gross revenue were able to apply for grants ranging from $10,000 to $20,000 during the application window that ran from July 23 to August 22, 2025. Additionally, SD5, led by Fifth District Supervisor Kathryn Barger, and in conjunction with the DEO and Los Angeles County Development Authority (LACDA), led an effort to deploy an emergency capital loan fund for standing and operating businesses impacted by the Eaton Fire. Specifically, it was a $1M fund for low-interest loans to standing businesses in Altadena.

Community Emergency Response Team (CERT) volunteers represented an important element of the County's broader preparedness and community resilience efforts during the January 2025 fires. Existing CERT programs and relationships helped reinforce community readiness by providing residents with prior training in disaster preparedness, emergency communications, situational awareness, and self-sufficiency. While CERT volunteers did not replace professional first responders or serve as part of the County's VDM system, their presence in many communities contributed to neighborhood-level resilience, allowing trained residents to support one another, share reliable information, and assist with preparedness and recovery activities consistent with their training and local program guidance.

Functional Support Needs in Residential and Congregate Care Settings

The January 2025 Eaton and Palisades Fires tested a broad AFN environment that extended beyond residents able to self-evacuate, self-shelter, register for assistance, and return home independently. This operating environment included older adults, children, people in

institutionalized settings, people with limited English proficiency, people from diverse cultural communities, and transportation-disadvantaged residents.

These conditions created sheltering, evacuation, and recovery requirements that differed from those of the general displaced population. Affected residents included people experiencing homelessness, individuals living independently with medical equipment or other functional supports, and people who depended on caregivers, accessible transportation, medication continuity, specialty beds, oxygen, DME, personal assistance services (PAS), or communication assistance. For people experiencing homelessness, HSH worked with contracted providers to relocate clients to alternate facilities, transition individuals requiring higher levels of care, and create additional hospital capacity during the incident. However, interviews and community feedback indicate that not all those experiencing homelessness were aware of these resources or how to access assistance, highlighting the continued need for clearer outreach and referral pathways during future disasters.

Maintaining continuity for these populations required agencies to identify impacted individuals, conduct wellness checks, support evacuation from homes and unsheltered settings, connect residents to appropriate services, and restore or replace essential medical and functional supports. Aging & Disabilities provided an important continuity mechanism by checking on existing clients and helping connect them with needed assistance. These efforts demonstrated the value of maintaining current client information and established outreach channels before an incident, particularly for residents who may not be reached through general public messaging or who may be unable to navigate assistance systems independently.

The congregate care environment was especially complex because it was not a single system. SNFs, assisted living and residential care facilities for the elderly, adult residential and community care settings, children's residential facilities, short-term residential therapeutic programs, and other group or supportive living arrangements operate under different licensing, regulatory, health care, social services, and provider responsibility structures. During the fires, this patchwork complicated operational coordination. Incident-generated needs extended across a broader spectrum of residential care facilities, only a subset of which fell under direct County responsibility. Some facilities were not under County licensing authority, but still required specialized transportation, placement support, or coordination with health-sector resources.

This created a gap in planning and responsibility that made coordination more difficult during the incident. Los Angeles County Emergency Medical Services (EMS) focused on medical transportation and licensed medical facilities, while residential care and other non-acute congregate settings supported residents who needed assistance but did not require acute or sub-acute medical care. In those settings, providers often remained responsible for identifying relocation destinations, even as multiple providers sought the same receiving beds and some preexisting relocation agreements were themselves affected by the fires. As a result, residents with the greatest need for assistance often faced the most complex path to safety and support,

particularly when they had limited ability to self-advocate, arrange transportation, replace equipment, maintain medication continuity, or independently identify an appropriate receiving location.

Custodial, Justice-Involved, and Child Welfare Populations

Certain residents and County-connected populations required support beyond the evacuation and sheltering model. Individuals in custody, youth in juvenile halls and camps, justice-involved individuals in step-down or supportive housing, and children under County care could not be treated as members of the general displaced population. Their evacuation, sheltering, placement, communications, and service continuity depended on custodial agencies, County departments, courts, contracted providers, and CBOs.

For youth in Probation facilities, the operating environment was defined by secure care obligations. Probation's emergency planning framework requires the Department to maintain non-deferrable responsibilities during emergencies, including enforcement of court orders, continued operation of detention and residential treatment programs, continued incarceration of youth, required staffing, living space, meals, clothing, parent or guardian communication, health care, continued access to education and educational programming, and personal care items.

During the January 2025 Fires, Probation operated in a heightened posture. The Hurst Fire ignited near the Barry J. Nidorf Secure Youth Treatment Facility in Sylmar, placing the facility within the evacuation warning zone and prompting action by Probation's Emergency Management Unit due to potential evacuation and sheltering needs.

Although Campus Kilpatrick was not affected by the January 2025 Fires, its prior evacuation during the 2018 Woolsey Fire remains a relevant planning context for Probation's juvenile facility evacuation posture. During the January 2025 Fires, Probation prepared transportation resources and receiving-site options while the Department Operations Center (DOC) monitored multiple fires for potential facility impacts. The Office of Diversion and Reentry (ODR) also supported the response by coordinating placement and continuity of care for justice-involved individuals housed in community-based settings who could be affected by the fires.

Adults in County jails faced a similarly constrained operating environment. Large-scale jail evacuation would require secured buses, armed deputies, receiving-site capacity, and potentially mutual aid transportation. A major movement of people in custody could require substantial time to execute. This created an issue distinct from the general population: individuals in custody could not choose whether, when, or how to evacuate. Their safety depended entirely on custodial decision-making, secure transport capacity, receiving-facility options, and timely communication with families, legal representatives, oversight entities, and the public.

Justice-involved populations outside secure custody also presented a different continuity challenge. The Justice, Care and Opportunities Department's (JCOD) Developing Opportunities

and Offering Reentry Solutions (D.O.O.R.S) program, Reentry Interim Housing program, and related supportive service pathways serve individuals whose housing, supervision, treatment, reentry supports, or youth development services may be connected to County contracts or community-based providers. For this population, the primary operational challenge was not secure evacuation. It was continuity of housing, care management, behavioral health support, transportation, reporting requirements, and provider communication when community conditions, shelter capacity, hotels, and service locations were disrupted.

Children under DCFS care presented a separate case-carrying population with legal, placement, and continuity needs. During the fires, DCFS used Geographic Information System (GIS) mapping and case-based tracking to identify children in affected areas, conduct follow-up, monitor conditions through OEM, and activate Disaster Service Workers (DSW) and shelter support as needed. For resource parents affected by the fires, DCFS social workers were instructed to contact assigned families, confirm safety, follow up weekly, and connect families to Airbnb or hotel vouchers, relative support services, kinship support, clothing, furniture, and County wildfire resources. DCFS identified 370 children with open cases in the Eaton and Palisades Fire areas.

Across these populations, the fires created unique challenges in agency, choice, and access to assistance. General population residents could often self-evacuate, select temporary lodging, or seek help at DRCs. Individuals in custody, people experiencing homelessness, children in DCFS care, youth in congregate care, and justice-involved individuals in supportive or step-down housing depended on agency decisions, provider readiness, caseworker contact, secure or specialized transportation, and receiving-site capacity.

Information and Coordination Environment

The information environment was distributed across many official and unofficial channels. Residents sought updates from County and city websites, a daily County newsletter, department pages, daily press conferences, emergency and recovery webpages, 211LA, DRCs, public meetings, social media, elected offices, community organizations, nonprofit partners, and third-party sources. For many residents, the central issue was not which agency owned a decision; it was whether they could find clear, current, and actionable answers.

The County's recovery website, DRCs, 211LA, department-specific resources, and public information updates helped provide recovery information. However, the breadth of the recovery mission meant that information had to be gathered, verified, translated, and updated across many domains and translated into plain-language guidance for residents.

Once functional, the CJIC performed substantial and valuable work to organize, translate, and disseminate recovery information across a complex, multi-agency operating environment. CJIC teams developed a centralized information section and produced multilingual public service

announcements, explainer videos, frequently asked questions (FAQs), graphics, and translated materials that made technical guidance more accessible to affected communities.

CJIC personnel also staffed public information functions at DRCs and deployed Public Information Officers (PIOs) to Incident Command Posts (ICPs) to gather field information, coordinate media and communications support, and relay available updates to the CJIC. Although these deployments provided an important connection to incident operations, the embedded communicators reported unclear roles, limited orientation to the incident command structure, difficulty identifying information authorities, and inconsistent integration with other County representatives at the ICPs. CJIC personnel also supported community briefings, coordinated media inquiries, and amplified department and partner updates through County websites and social media channels. Collectively, these efforts provided the County with a scalable communications capability and helped translate rapidly evolving operational information into practical, public-facing guidance.

Figure 22: FEMA – Disaster Recovery Center

This translation challenge was especially important during repopulation and debris removal. Residents needed to understand what areas were open, what hazards remained, what documents were required, whether they could access property, what the status was on utility restoration, how debris removal worked, what health precautions applied, and where to obtain help. Public health guidance, debris removal procedures, insurance requirements, FEMA processes, and County service pathways each used different terminology, processes, and timelines. As a result, recovery communication was not only a public information function; it was a core part of service delivery.

Community organizations, nonprofit partners, faith-based groups, philanthropic organizations, elected offices, and partner agencies helped bridge information and service gaps. These partners were especially important for residents who did not have reliable digital access, were literacy or technology challenged, were displaced outside the immediate area, needed language or disability access, or required individualized navigation. Their role underscored that recovery required both formal government systems and trusted community-based channels.

LA-RICS System Use in Los Angeles County

LA-RICS is a regional public safety communications system that provides operable and interoperable radio communications for public safety agencies in Los Angeles County. LA-RICS is a wide-area public safety radio network operated under a joint powers agreement and available

to regional organizations with a direct public safety responsibility or operational nexus. The system integrates digital voice radio with analog conventional radio systems, allowing subscribing and partner agencies to communicate across shared channels, patches, and regional interoperability resources. For fire operations, LACoFD uses LA-RICS-supported analog voice conventional channels and very high frequency (VHF) command channels. The Los Angeles County Sheriff's Department (LASD) uses legacy analog dispatch for some dispatch functions and LA-RICS digital trunked voice capabilities for tactical and specialized communications.

During the January 2025 Eaton and Palisades Fires, LA-RICS supported communications for fire suppression, evacuation coordination, law enforcement operations, perimeter control, mutual aid, and recovery-related field operations. During the Eaton Fire, LACoFD implemented an incident communications approach for foothill operations, including early use of common command channels to support coordination among responding agencies. LASD personnel used LA-RICS and LA-RICS-enabled tactical channels to communicate among field units, ICPs, and emergency operations functions during evacuation and incident management operations. LA-RICS interoperability channels were also assigned to National Guard units and Cal OES response teams, and partner agencies used LA-RICS talk groups when their home systems had technical limitations or when personnel were operating on loaned radios. On January 8, 2025, the highest-impact day for system use, the land mobile radio (LMR) system handled 51,600 minutes of talk time, a 46% increase, while maintaining 100% availability during the analyzed wildfire period. LA-RICS served as a key operational communications backbone during the fires, while the scale, speed, and multi-jurisdictional nature of the incidents placed significant demands on channel management, user familiarity, interoperability practices, and agency coordination.

Disaster Service Workers

Several findings in this report describe surge staffing demands that exceeded what any single department could meet on its own, including shelter operations, call center capacity, recovery center support, and field outreach. Under California Government Code section 3100, all County employees serve as Disaster Service Workers (DSWs), and that workforce is one of the County's most significant and least expensive readiness assets.

Where employees are pre-identified by relevant skill, including language capability, specialized licensure or certification, supervision and management experience, and equipment operation, then assigned to defined disaster roles and trained on those roles on a recurring basis, they arrive ready to perform rather than ready to be oriented. Because DSW status follows the employee rather than their position in the County, capability developed through recurring training remains available to the County as staff move between departments.

The County has reported completing a countywide inventory of employee skill sets for DSW service, which provides a foundation for this work. Establishing a countywide DSW training standard, including a recurring training cadence and role-specific task qualifications, would

allow the County to meet several of the staffing needs identified across the focus areas that follow by building depth within its existing workforce.

Role of SD3 and SD5 in Recovery and Repopulation

Los Angeles County Supervisorial District offices sit at the intersection of policy direction, resident services, public communication, and operational escalation. The Board of Supervisors exercises executive, legislative, and governmental authority for the County, including authority over the County budget, ordinances, public health and safety, and certain emergency actions. During the Eaton and Palisades Fires, SD3 and SD5 did not serve as operational command agencies. Instead, they served as key resident-facing channels by elevating community concerns, amplifying official information, supporting public meetings, and helping residents navigate recovery services.

The Board also used formal motions and funding mechanisms to establish recovery priorities and direct County action, including:

- the January 14, 2025 ratification of the local emergency, curfew, and public health emergency declarations and direction to expedite economic and worker relief;
- the January 14, 2025 Expediting Economic and Worker Relief Efforts in Response to Los Angeles County Fires Through an Equity Lens;
- the January 21, 2025 actions establishing rental protections, addressing short-term rentals, and seeking additional state and federal assistance;
- the January 21, 2025 motion seeking State and Federal Assistance for the Los Angeles County Wildfires;
- the January 28, 2025 Los Angeles County Fire Recovery Fund motion, establishing a $32.2 million fund to provide direct cash aid to homeowners, renters, business owners, workers, and other impacted community members, which subsequently funded the Household Relief Grant Program;
- the January 28, 2025 motion directing an independent After-Action Review of the County's emergency alert, notification, and evacuation systems;
- the January 28, 2025 actions addressing water supply and resiliency of Waterworks District 29 infrastructure;
- the February 11, 2025 support for state legislation concerning dwelling units for persons at risk of homelessness;
- the February 11, 2025 support for state legislation concerning motels, hotels, and short-term lodging in Los Angeles County following wildfires;
- the February 18, 2025 actions addressing housing for wildfire-impacted workers and a skilled and trained workforce for fire recovery;

- the February 18, 2025 motion for Los Angeles County Early Care and Education Child Care Windstorm and Wildfire Recovery Efforts;
- the March 18, 2025 direction concerning analysis of the January 2025 Windstorm and Critical Fire Events and establishment of the Recovery and Repopulation After-Action Review;
- the March 25, 2025 hearing on the 2025 Defensible Space Clearance/Weed Abatement Referees' Hearing Report; and
- the March 25, 2025 reports regarding January 2025 Windstorm and Critical Fire Events bi-weekly emergency contracts.

The Board's role was valuable, but also operationally demanding. Because residents and community partners often turned to Supervisorial District offices when recovery information was unclear, delayed, or spread across multiple sources, the offices became both a bridge to the public and an additional escalation channel for departments and partner agencies. This underscores the need for centralized, consistently updated recovery information pathways that allow elected offices to support residents without becoming the default mechanism for synthesizing and routing operational information during a major disaster.

Supervisorial District 3 Office

The SD3 Office served as a resident-facing coordination and communication hub for impacted communities in the Palisades, Malibu, Topanga, Sunset Mesa, and Santa Monica Mountains areas. The office leveraged established community relationships, email distribution lists, social media, press conferences, recurring topic-based recovery webinars, community meetings, direct coordination with cities, and communication with County departments to gather, synthesize, and share timely information with residents and partners throughout response and recovery. These outreach efforts provided residents with regular updates on topics such as reentry, debris removal, rebuilding, insurance, public health, schools, and available recovery resources.

During response, repopulation, and recovery, SD3 staff coordinated with the LACoFD, CEO, OEM, DPW, LASD, city partners, state and federal agencies, and community organizations to identify resident concerns and elevate operational issues. As repopulation began, the office helped surface and work through complex access and reentry issues involving access passes in the unincorporated County area affected by the Palisades Fire, checkpoints, road closures, school and business access, public transportation needs, Pacific Coast Highway access constraints, debris truck movement, looting concerns, and weather-related impacts. SD3 also advocated with County leadership and state and federal partners to accelerate coordinated debris removal efforts and resolve emerging recovery challenges.

During recovery, SD3 staff continued supporting resident navigation through DRCs and district office channels, helping residents understand housing resources, 211LA referrals, debris removal options, ROE and opt-in/opt-out decisions, insurance questions, public-facing FAQs, and other

recovery services. The office also supported outreach for County relief initiatives, including wildfire-related rental assistance and housing stabilization programs, while continuing to gather resident feedback and elevate community concerns to County leadership to inform ongoing recovery operations.

Supervisorial District 5 Office

SD5 served a comparable resident-facing coordination and communication role for Eaton Fire-impacted communities, particularly for Altadena and surrounding foothill areas. Similarly, the office used established community relationships, email distribution lists, social media, press conferences, weekly town halls, both virtual and in-person, stakeholder briefings, community meetings, direct coordination with local, state, and federal leaders, and communication with County departments to gather, synthesize, and share information with residents and partners.

During response and recovery, SD5 staff worked with OEM, LASD, LACoFD, DPW, DPH, city partners, state and federal partners, nonprofit organizations, community leaders, and service providers to elevate operational issues affecting Eaton Fire survivors. The office established and operated an in-house call center, staffed by DSWs and SD5 staff, to help identify and address recurring resident concerns, route time-sensitive questions to the appropriate departments, and support coordination on issues that required cross-agency resolution, including reentry, debris removal, public health guidance, sheltering and temporary housing, donations, senior services, and residents requiring AFN support.

As repopulation began, the office helped surface and work through access and reentry issues involving LASD and National Guard checkpoint practices, property access, sheltering questions, debris removal, soil testing, public health concerns, utility restoration, and resident confusion about when and how they could return to their homes.

During recovery, SD5 staff also supported resident navigation through DRCs, public meetings, community briefings, and district office channels, helping residents understand ROE forms, USACE debris removal, FEMA application questions, PPE distribution, shelter transitions, senior services, donations, unhoused resident support, and other recovery services.

Strategic Themes

Several themes run through this operating environment and recur in the findings that follow. Recovery and repopulation required clear governance and role ownership, because many functions crossed departmental, jurisdictional, and program boundaries. Resident-facing services needed to be easier to navigate, particularly where separate programs each required their own documentation, eligibility review, and agency contact. Repopulation and public health decisions required operational, infrastructure, environmental health, and communications perspectives to be integrated early, and required shared clarity about which agency held decision authority at each phase. Support for people at higher risk depended heavily on whether those residents were

already known to a case-carrying system or could be reached through trusted community partners. Public communication needed to translate complex operational decisions into plain-language instructions residents could act on.

These themes appear across multiple critical focus areas rather than in any single one. They are addressed in the findings and recommendations that follow, where the evidence most directly supports action.

Findings and Recommendations

Introduction

The following section presents the review's principal findings and recommendations by critical focus area. Recovery and repopulation efforts involved overlapping decisions, agencies, jurisdictions, service delivery systems, and public communications. Organizing the analysis by focus areas allows readers to understand how specific systems performed, where gaps emerged, and which recommendations align with the agencies and processes best positioned to act.

Each critical focus area can be read as a standalone analysis and as part of the broader Countywide recovery and repopulation system. When issues span multiple focus areas, they are addressed where the evidence most directly supports action.

Within each focus area, content is organized into findings and recommendations. Findings state the issue, strength, or area for enhancement, explain its operational significance, and synthesize the supporting evidence. Recommendations identify the corrective and sustainment actions needed.

These findings do not assign blame or evaluate individual performance. They identify system conditions observed during the January 2025 fires and subsequent recovery and repopulation operations.

Critical Focus Area #1 Communications

Introduction

This focus area assesses how recovery and repopulation information was coordinated, approved, translated, updated, and shared across County functions, to people at high risk, and through interoperable public safety communications channels. The section addresses CJIC scaling and publication authority, resident-facing repopulation guidance, access pass and road-status communications, LA-RICS performance and field usability, custody-related information pathways, DPH authority and approval pathways for health-related communications, and communications to AFN populations and related service providers.

Strengths and Best Practices

The County entered the incident with several successful communications capabilities that provided an important foundation for recovery and repopulation operations. Countywide Communications conducted pre-incident coordination and rapidly increased activity as conditions escalated. The CJIC established recurring daily updates, convened meetings, supported public-facing websites, and amplified information through County and individual departmental social media pages. Some stakeholders identified the emergency and recovery

websites and specific LASD points of contact as helpful information pathways, indicating that several communications products and relationships provided value even where the broader system experienced friction.

> **IN THE COMMUNITY'S WORDS**
>
> *"I felt proud seeing the press conferences outside the Pasadena Convention Center – they gave me confidence that things were well in hand."*
>
> — Public survey respondent

The County's rapid adaptation of *recovery.lacounty.gov*, the County's public-facing recovery website, established a centralized information source during the early recovery period. The County used a preexisting COVID-19-era website framework and repurposed it during the Eaton and Palisades Fires rather than building a new platform from scratch. The site was operational by January 12, 2025, allowing the County to consolidate recovery information for residents, departments, and partner agencies under compressed timelines. Despite limited staffing, resources, and pre-established guidance, the personnel responsible for operating the site developed and maintained a functional public-facing recovery hub during an extremely active and evolving incident.

Probation's commitment to future use of GovDelivery also provides a scalable mechanism for future communication with parents, caregivers, legal representatives, and other stakeholders when people in custody are sheltered in place, relocated, or otherwise affected by an emergency.

The LA-RICS Authority's LMR system and infrastructure were also a significant operational strength. LA-RICS remained available with increased regional load and supported interoperable tactical and mutual-aid communications during simultaneous large fires at opposite ends of Los Angeles County. Multiple stakeholders described materially improved coverage over this radio system compared to prior large fire incidents, particularly in the Eaton and Palisades Fires footprints. This preserved an interoperable radio backbone for LACoFD, LASD, National Guard, Cal OES, and other partners during a period of high operational demand. Beyond supporting first responders during the incidents, LA-RICS remained resilient in providing interoperable communications to users during repopulation efforts, including LASD's efforts to enforce traffic control points and closures.

Relationships

County communications benefited from several existing relationship-based pathways, but those pathways were unevenly formalized across the broader incident information system. LASD-related public safety communication benefited from identifiable points of contact and relatively direct information flow to affected Supervisorial Districts. Probation also documented internal emergency communication procedures, including use of the Probation DOC, PIO coordination,

the Countywide Incident Reporting System, the Online Automated Resource Request System, email, telephone, text, and other backup methods.

Communications for older adults, people with disabilities, and AFN populations also relied heavily on established relationships and liaison pathways. Routine OEM updates and existing coordination relationships helped Aging & Disabilities maintain situational awareness, including daily OEM data updates that later transitioned to a weekly cadence.

State Functional Assessment Service Teams (FAST) were requested for the Eaton and Palisades Fires and deployed within 24 hours, where they supplemented Red Cross intake by helping assess whether shelter residents could safely remain in the shelter environment. Disability stakeholders described FAST support as helpful in meeting functional needs and strengthening shelter operations.

These examples show that trusted relationships and known points of contact were important strengths during both the onset of the incident and the recovery and repopulation period. They helped move information, elevate concerns, and connect specialized issues to the agencies best positioned to respond. However, reliance on relationships also created unevenness where contacts, escalation paths, or notification expectations were not documented in advance. Future communications planning should preserve these relationship-based strengths while formalizing them into clear notification triggers, liaison roles, escalation pathways, and public-facing messaging expectations for custody-related and AFN issues.

Resources

The County used several communications resources that should be sustained and further strengthened. Once established, the CJIC produced daily updates, held regular coordination meetings, supported public-facing websites, and amplified recovery information through social media. Public-facing emergency and recovery websites provided a centralized place for residents and partners to find information, even though the broader approval and publication model remained fragmented. Communicators across County departments also used available tools, including map screenshots and web updates, to help residents and partner agencies understand changing access, road, and reopening conditions when official formats were difficult to translate quickly.

Other specialized resources also supported communications needs. DPH issued advisories, held town halls, built dashboards, conducted surveys, and responded to public questions as health-related communications needs emerged. Those resources were valuable, but the incident did not consistently provide clear authority and approval pathways for DPH representatives participating in communications discussions. Probation’s planned use of GovDelivery, custody-related public information points of contact, and AFN-related outreach tools provide additional resource areas to refine, test, and institutionalize.

Stakeholder interviews identified LA-RICS as the most effective technical communications resource for first responder operations. This LMR system remained available under major load, supported interoperable public safety communications, and provided practical value for multiple responder and mutual aid partners. Its performance during the incident provides a sustainment point for hardened-site infrastructure, redundant power and backhaul, severe weather readiness, and continued joint post-incident use.

Key Challenges

The findings that follow address several recurring communications challenges. Formal CJIC scaling, liaison staffing, public-information intake, and call-center functions did not fully match the pace of incident growth during the first 24 to 72 hours of the Eaton and Palisades Fires. The CJIC established useful products and amplification pathways, but it did not consistently operate as a final cross-agency publication authority. This contributed to approval delays, product-by-product inconsistency, and fragmented public pathways to information.

Repopulation communications presented a separate challenge. Zone codes, Genasys outputs, access-pass formats, checkpoint practices, and reopening messages were not consistently translated into plain-language resident instructions. Board offices and communicators reported high levels of uncertainty and complaints related to access passes, checkpoint enforcement, reopening status, and road information.

LASD and Probation relied primarily on public-facing channels and internal logs rather than direct pre-movement family notification during custody-related fire impacts. Multiple DPH participants reported being brought into some health-related communications after decisions had already occurred, and participants did not consistently perceive that they had clear authority or approval capability to finalize health-related guidance on behalf of the department. Communications to older adults, people with disabilities, people with health-related needs, people experiencing homelessness, and related service providers relied on incomplete datasets, manual calling, and ad hoc access arrangements rather than an integrated operational picture.

Technical communications challenges were concentrated less in LA-RICS performance and availability and more in field usability. Some users reported high voice traffic driven by radio-discipline issues among users, suspected third-party jamming, minor nomenclature and training gaps, and outdated or incomplete programming across some agencies.

What Residents Reported

Residents did not experience County communications as a single, reliable source, and the gap was not evenly distributed across the two burn areas. Across all 1,500 respondents, only 3% described road-closure updates as very accurate, while 26% reported that they were never aware of road closures or never received closure updates at all. The largest single group described the updates as a mixture of accurate and inaccurate (31%).

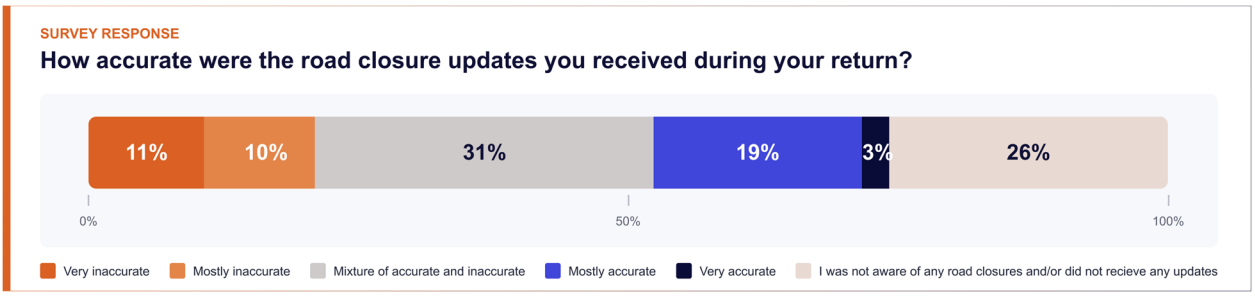


Figure 23: Stacked chart on road closure update accuracy for survey participants.

Respondents in the Eaton Fire footprint were more than five times as likely as respondents in the Palisades Fire footprint to report no awareness of road closures or no closure updates: 34% against 6%. Only 14% of respondents in the Eaton Fire footprint described road-closure updates as mostly accurate.

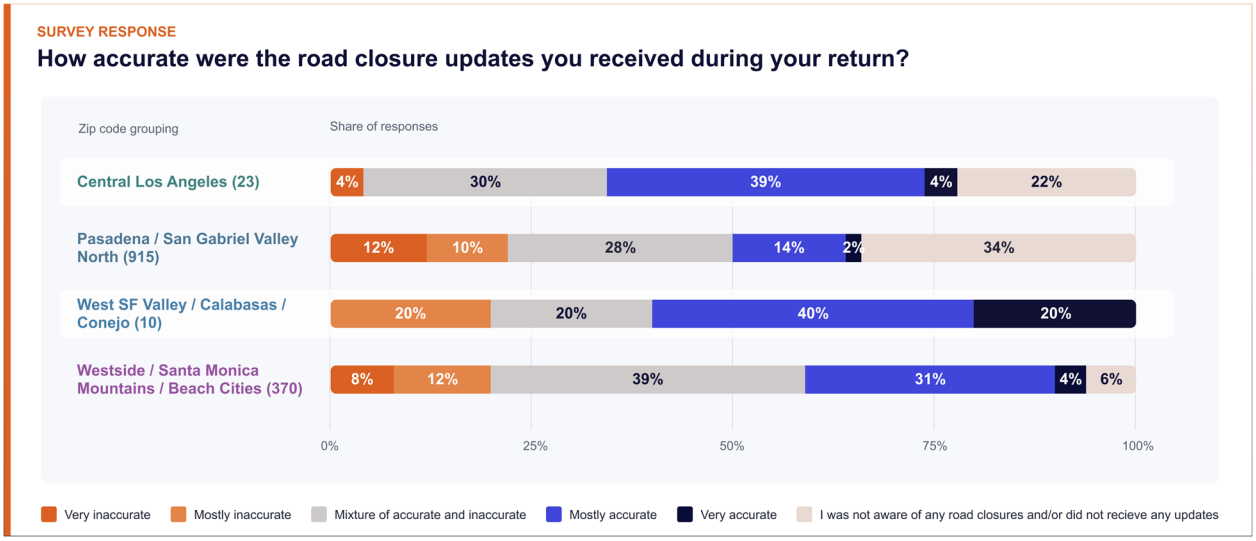


Figure 24: Stacked chart on road closure update accuracy for survey participants by zip code grouping.

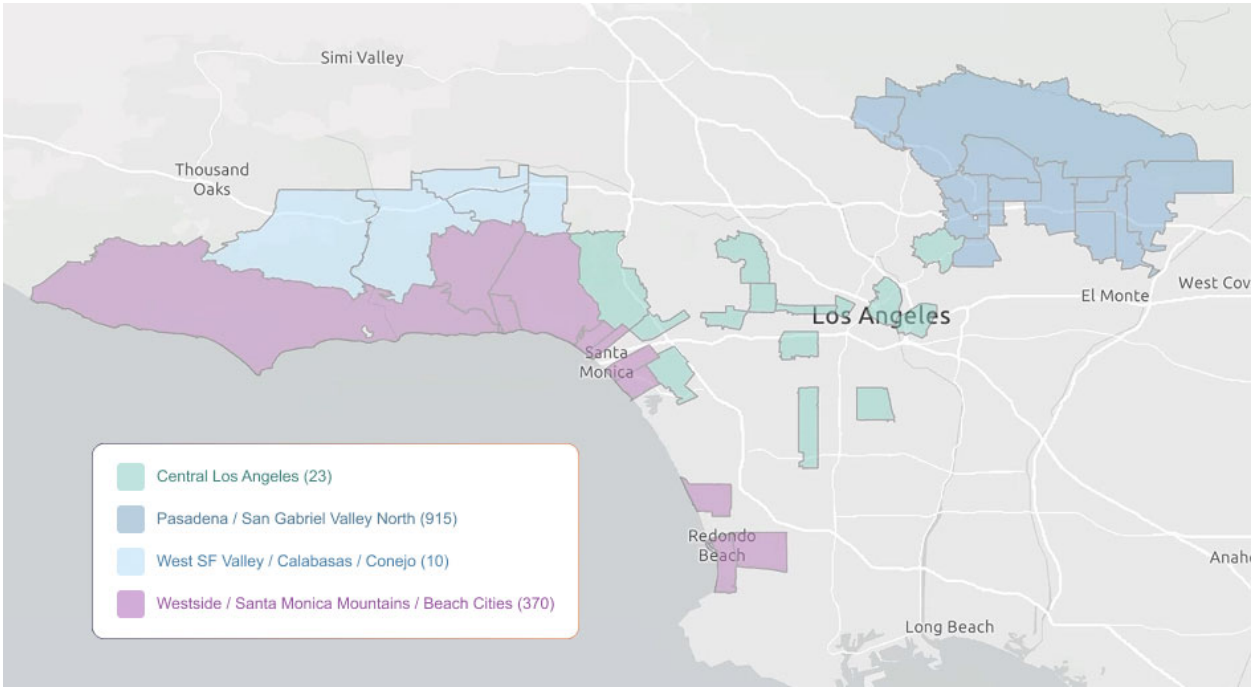


Figure 25: Map of zip code groupings referenced in previous chart.

Road ownership and control during the incident were divided among DPW, Caltrans, the City of Los Angeles, LASD, Los Angeles Police Department (LAPD), California Highway Patrol, and the National Guard, and the two footprints involved different mixes of those authorities. The survey does not establish the cause of the gap between them. Both results are consistent with COM-F1 and COM-F2: the County produced accurate information, but the pathway from operational decision to resident-usable instruction did not work equally well in both fire areas.

Woolsey AAR Connection

Several recommendations from the *AAR of the Woolsey Fire Incident* addressed JIC, PIO, repopulation messaging, and interoperable communications gaps which resurfaced during the January 2025 fires. The following Woolsey recommendations connect to specific findings and recommendations in this report:

- *Rec #65: Create a PIO decision flow process to pre-notice all affected agencies and announce repopulation decisions with phased timeframes* connects to COM-F2, COM-R2, REP-F1, and REP-R1, which address CJIC publication governance, resident-ready repopulation instructions, access-pass and checkpoint communications, and the formal Repopulation Plan.

The following Woolsey recommendations were reported as implemented prior to January 2025 and were tested operationally during this incident; they remain relevant because they connect to current findings and sustainment recommendations:

- *Rec #5: Review radio frequency coverage (LA-RICS implementation, January 2024)* connects to COM-F3 and COM-R3, which identify LA-RICS as an operational strength and recommend sustaining infrastructure practices while expanding adoption and field usability.
- *Rec #34: Shorten approval tempo of evacuation alerts* connects to COM-F1, COM-F2, COM-R1, and COM-R2, which address CJIC scaling, publication authority, approval governance, and standard incident communications cadence.
- *Rec #38: Countywide PIO/JIC policies* connects to COM-F1, COM-F2, COM-R1, and COM-R2, which address formal CJIC scaling procedures, recovery website integration, publication authority, and product governance.
- *Rec #44: Qualified PIO staff roster with language support* connects to COM-F1, COM-R1, COM-F2, and COM-R2, which address surge communicator roles, liaison staffing, language-access support, and approval workflows for public information products.

The following related Woolsey communications recommendations were addressed in the County's *AAR of Alert Notification Systems and Evacuation Policies for the Eaton and Palisades Fires* and are referenced here only where they intersect with recovery and repopulation communications: #35, #36, #37, #39, #40, #42, #43, #45, #46, #47, #48, and #54. Where relevant, their recovery-period implications are reflected in COM-F1, COM-F2, COM-F3, COM-R1, COM-R2, and COM-R3.

Priority Recommendations and Actions

Finding COM-F1: CJIC scaling, integration, and publication authority did not keep pace with recovery needs.

The CJIC provided important communications support as the incident moved into recovery, but early scaling, liaison staffing, information intake, and integration of department-owned content did not fully keep pace with recovery and repopulation communications needs. The CJIC also did not consistently hold final publication authority for cross-departmental recovery information, which limited its ability to serve as a single release point during a fast-moving recovery environment.

Due to staffing limitations, OEM staff with communications skills did not establish a CJIC until January 9, with support from CEO Countywide Communications. The purpose of the CJIC is to coordinate and disseminate accurate, consistent, and timely messages to the public, stakeholders, and media, before, during, and after an emergency or coordinated event when the County Emergency Operations Center (EOC) is activated.

As early as January 2, the County began sharing consistent, real-time updates with the public through its social media channels and website. Between January 2 and January 9, before OEM established an official CJIC, the County shared 122 preparedness and emergency messages on its

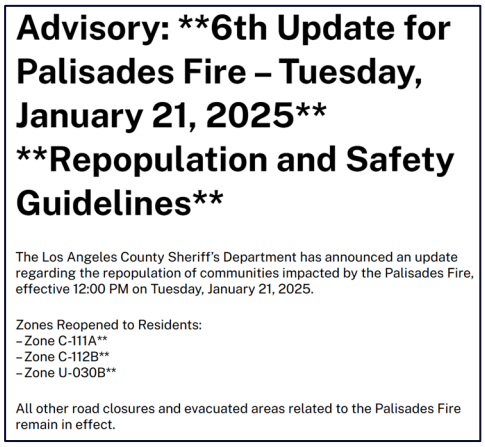
@CountyofLA social media channels, and the website received more than three million public views. Establishing an official, empowered CJIC earlier would have strengthened communications support for the emergency response and could have played a critical role in providing coordinated, accurate, and consistent real-time updates to the public.

Department-owned recovery information remained scattered across separate websites rather than consolidated through one single point of entry. Board offices absorbed the overflow, fielding complaints on public health information, resident access passes, checkpoint enforcement, and reopening status that a unified information pathway should have answered.

Once established, the CJIC created daily updates, held daily press conferences and meetings, used websites and social amplification, and *recovery.lacounty.gov* became an important public-facing source of recovery information. Even after the CJIC was established, some department-owned recovery information remained siloed on separate department websites or social media channels, rather than being consistently mirrored, summarized, or linked through the central County recovery website.

> **IN THE COMMUNITY'S WORDS**
>
> *"I had to rely on Nextdoor to gain information"*
>
> — Public survey respondent

The scaling gap was compounded by a second structural limitation in how communications products were approved and released.



Advisory: **6th Update for Palisades Fire – Tuesday, January 21, 2025**
Repopulation and Safety Guidelines**

The Los Angeles County Sheriff's Department has announced an update regarding the repopulation of communities impacted by the Palisades Fire, effective 12:00 PM on Tuesday, January 21, 2025.

Zones Reopened to Residents:
- Zone C-111A**
- Zone C-112B**
- Zone U-030B**

All other road closures and evacuated areas related to the Palisades Fire remain in effect.

Figure 26: LASD repopulation advisory listing reopened zones by code without neighborhood names.

The CJIC correctly served as the primary coordinator and amplifier of department, agency, and subject-matter expert content for cross-agency public information. The bottleneck occurred where departments and external partners retained final approval authority over their own content and subject matter, which slowed, changed, or prevented release of some CJIC-developed products.

Board offices and field communicators also had to repackage, clarify, or translate information, including evacuation zones, repopulation status, and recovery resources, into formats that residents could more readily understand and use.

During an emergency declaration, County departments are empowered with subject-matter control, but interdepartmental communication was not consistently prioritized, and information was often held within individual departments rather than shared outward. This reduced the CJIC's ability to

function as a single release point for timely, unified public information. The issue is therefore one of governance rather than execution: the County had a communications coordination structure in place, but it was not consistently given the authority, approval pathways, or escalation mechanisms needed to produce unified messaging.

Recommendation COM-R1: Formalize CJIC scaling procedures, publication authority, and recovery website integration.

CEO Countywide Communications should formalize CJIC scaling procedures and central recovery website integration requirements for major incidents. This includes defining activation triggers, liaison staffing, information intake, surge communicator roles, and briefing cadences with Board offices and field PIOs, and updating workflows that align CJIC output with the recovery website. OEM and relevant County Communications staff should support this effort.

The protocol should specify when the CJIC serves as the final publisher for cross-agency public information, what information remains owned and approved by individual departments, who approves each product type, and what review timelines apply. It should also identify fallback approvers and escalation procedures for delayed, conflicting, or time-sensitive products. The process should preserve department subject-matter review while giving the CJIC clear authority to consolidate, format, and release approved cross-agency recovery information through unified public-facing channels.

The protocol should also formalize a standing coordination process with major social media platforms so County content can be distributed quickly, and misinformation can be corrected before it spreads.

The same protocol should designate *recovery.lacounty.gov* as the County's central public-facing recovery information pathway and require department-owned recovery content, including public health advisories, dashboards, FAQs, road and access information, and repopulation guidance, to be posted, mirrored, summarized, or clearly linked through the central site and managed by each department's PIO teams.

This recommendation aligns with the previous *AAR of Alert Notification Systems and Evacuation Policies for the Eaton and Palisades Fires*, which identified fragmented messaging associated with not establishing a CJIC ahead of the event or at the onset and recommended a consistent, formalized model.

Finding COM-F2: Repopulation decisions were not translated into resident-ready instructions.

Repopulation decisions were not consistently translated into clear, resident-ready instructions for access, checkpoints, road status, reopening, and health-protective guidance.

The operational effect was a gap between how decisions were made and how residents experienced them. Department communicators described using map screenshots as workarounds because official zone codes and formatting were difficult to translate into plain-language public guidance.

Road status communications were especially difficult because road ownership and control were divided across multiple entities, including DPW, Caltrans, the City of Los Angeles, LASD, LAPD, California Highway Patrol, and the National Guard. DPW coordinated road-closure information through the CJIC, but stakeholders still reported that road and zone reopening information was not always actionable for residents. This suggests the issue was less about whether operational coordination occurred and more about whether decisions were converted into clear, timely, resident-facing instructions.

Recommendation COM-R2: Standardize resident-facing repopulation and checkpoint communications.

LASD, OEM, CEO Countywide Communications, DPH, and operational partners should standardize resident-facing repopulation and checkpoint communications before future reentry operations.

LASD, OEM, CEO Countywide Communications, and County operational partners involved with or managing checkpoints and/or reentry should create standardized resident-facing repopulation templates and checkpoint guidance that translate zone codes and official notifications into plain-language instructions on access, remaining hazards, required documentation, access-pass formats, consistent information for contractors, and field enforcement expectations.

Finding COM-F3: LA-RICS performed effectively and provided an incident interoperable communications backbone.

LA-RICS performed well under extraordinary operating conditions and provided an effective interoperable communications backbone for County and mutual aid partners.

LA-RICS, an LMR radio system, remained available during a period of extreme regional demand and supported tactical and mutual-aid communications across multiple response partners. Systems-level operational documentation evidenced strong system availability, increased traffic without capacity failure, and improved coverage compared with prior large-fire incidents, particularly within both the Eaton and Palisades Fires' footprints.

The primary improvement opportunities were concentrated in field use rather than core system performance. Some users identified high voice traffic, Palisades coverage gaps, suspected improper interference or jamming by third parties, radio-discipline issues, inconsistent channel naming, and minor training gaps. These issues indicate that the LA-RICS Authority and the County should continue to promote the adoption and use of LA-RICS among mutual aid partners

and municipalities across the region, while addressing practical barriers that limit usability for some field personnel.

Recommendation COM-R3: Sustain LA-RICS infrastructure practices and support expanded adoption.

The LA-RICS Authority, LASD, LACoFD, OEM, and subscriber and user agencies should sustain the infrastructure practices that supported system availability during the January 2025 Eaton and Palisades Fires and work towards expanding LA-RICS adoption among County departments, municipal, and mutual-aid partners that respond to or operate in the region. This should include using LA-RICS for day-to-day operations, during emergencies, and/or for mutual aid. Sustaining infrastructure practices should include ongoing severe-weather readiness checks, validation of radio programming and interoperability talk group access, standardized channel naming, and clear surge channel assignment procedures.

Subscriber agencies should also expand recurring training and exercises on talk group selection, radio discipline, high-traffic operations, mutual aid use, interference reporting, suspected jamming procedures, and tactical channel management. These actions would preserve a demonstrated strength while improving consistency and field usability during future high-tempo incidents.

The *AAR of Alert Notification Systems and Evacuation Policies for the Eaton and Palisades Fires* recommended consistent implementation, training, and use of LA-RICS as a core emergency communications capability. This review extends that objective to secondary responders, recommending that LA-RICS adoption expand beyond primary law enforcement and fire users to include public works, animal control, transit operators, and other agencies supporting evacuation and repopulation, where field coordination is most likely to break down.

Finding COM-F4: Custody communications lacked a predictable family notification pathway.

Custody-related communications did not provide a predictable direct-notification pathway for families, caregivers, and Board of Supervisors stakeholders during custody-related fire impacts.

The communications approach was operationally understandable given the size and security requirements of the custody environment, but it left residual uncertainty. LASD described a robust public information package and unified internal messaging, while Probation acknowledged earlier communication plan weaknesses, delayed website messaging, and reliance on after-the-fact calls.

Even with those efforts, Board offices reported high call volume from advocates and family members, and some respondents described the information-delivery process as unclear and frightening for families and people in custody. The issue is not whether public-facing information existed, but whether custody-related communications provided predictable, scalable,

and understandable information pathways for families, guardians, caregivers, oversight stakeholders, and County leadership.

Recommendation COM-R4: Establish scalable custody-related emergency communications protocols.

LASD Custody Operations and Probation should independently establish scalable custody-related emergency communications protocols.

LASD Custody Operations and Probation should each adopt and maintain separate multi-language documented wildfire and public-emergency communications protocols for people in custody and youth in Probation care, respectively. Each department's protocol should define what information will be communicated publicly, what conditions trigger direct family or guardian notification, how security constraints affect timing and content, and which public information point of contact will be designated early in an event.

The protocols should also address use of scalable notification tools, including GovDelivery or comparable platforms, for timely and consistent updates to families, guardians, caregivers, and other approved stakeholders. Where direct notification databases are maintained, LASD and Probation should independently define how those tools will be utilized, how they will be tested, who will approve messages, and how updates will be coordinated with County public information channels during future emergencies.

LASD and Probation should maintain and routinely test family and guardian contact databases and notification templates for protective actions such as shelter-in-place, movement, visitation changes, and facility status. Facility leadership should also establish a repeatable schedule for briefing individuals in custody on facility status, protective actions, and visitation impacts, and should clearly document when those communications should occur.

Critical Focus Area #2: Volunteer and Donations Management

Introduction

This focus area assesses the County's VDM posture following the January 2025 Eaton and Palisades Fires, including the County's role in coordinating donation offers, routing physical goods, directing unaffiliated volunteer interest, supporting public-facing donor and volunteer information, and establishing financial donation pathways. The section focuses on the appropriate County role in VDM and the systems needed to make that role repeatable in future large-scale incidents.

Strengths and Best Practices

The County and its partners established several important VDM capabilities during the incident. The Internal Services Department (ISD) performed substantial routing work under pressure,

including centralizing donation inquiries, developing tracking tools, categorizing offers, and helping direct donors away from unmanaged physical goods intake. This work provided an important operational bridge during the incident and helped reduce the likelihood that County facilities would become default intake, storage, or distribution points for unsolicited goods.

The CEO's Policy Implementation and Alignment Branch (CEO PIAB) and the CEO's Center for Strategic Partnerships (CEO/CSP) also supported a significant financial-donation capability once the necessary systems were established. The County created pathways for large and small donors, developed account and subaccount structures to track donor intent, allowed donors to restrict contributions to the Eaton Fire or Palisades Fire, and developed receipt and refund language. Even without external paid advertising, the small-donation credit-card pathway received more than $88,000 from donors who found it on the County's website after launch.

Relationships

Existing relationships with nonprofit organizations, Voluntary Organizations Active in Disaster (VOAD) partners, philanthropic partners, 211LA, Los Angeles Works (LA Works), fiscal sponsorship partners, and CBOs supported County VDM. These relationships helped the County route donor interest, connect with philanthropic funders, identify nonprofit partners, and direct some needs toward organizations better positioned than County government to manage physical goods and spontaneous volunteers. 211LA also secured and distributed Hilton and Airbnb housing vouchers serving 15,000 households.

The nonprofit and philanthropic ecosystem also provided direct financial and material support to impacted communities. Community Organized Relief Effort (CORE) was identified as providing $2.4 million in direct cash aid and distributing more than 44,000 hygiene kits and N95 masks. GoFundMe was identified as distributing $1,000 cash-aid grants to 500 impacted individuals and families. These examples reinforce that the County does not need to directly operate every VDM function to support effective disaster giving and volunteerism.

Resources

The response used several managed or affiliated resources, including the ISD donation routing task force, 211LA, LA Works, DSWs, nonprofit partners, fiscal sponsorship mechanisms, public donation webpages, merchant identification setup, account and subaccount structures, donor-receipt processes, and partner-operated direct assistance pathways. These resources were strongest where they had an institutional home, an existing relationship, or a defined operating pathway.

The financial donation system was a particularly important resource once established. The available information identifies a public contact website established on January 21, 2025, merchant identification set up on February 10, 2025, and a live donation hyperlink added on February 11, 2025. The CEO established two donor pathways: a large-donor pathway supported through CEO/CSP and a smaller-donor pathway through the public website and credit-card

process. CEO PIAB supported the cash donation work, while CEO/CSP mobilized philanthropic resources and supported funder engagement.

Key Challenges

The main challenge was not the absence of goodwill, partner capacity, or County effort. It was the lack of a formal countywide VDM model that clearly defined what the County should own and what should be assigned to pre-identified partners. In practice, ISD and other County actors had to fill gaps, route offers, respond to Board office and public inquiries, and build tools while donation and volunteer interest was already converging.

> **IN THE COMMUNITY'S WORDS**
>
> *"Lines were long, wasn't sure where to drop off."*
>
> — Public survey respondent

Physical goods and unaffiliated volunteers created the clearest role-boundary challenge. The County is not well positioned to operate physical donation intake, storage, sorting, warehousing, distribution, screening, training, supervision, or liability management for spontaneous volunteers. Those functions are better assigned to nonprofit, VOAD, and managed partner systems. The County's appropriate role is to coordinate, route, message, and govern cash donations, not to directly run physical donations or unaffiliated volunteer operations.

The County's financial donation system was ultimately a strength, but it was not activation-ready. The County had to build merchant identification, account controls, donor language, fund design, and public routing tools during the incident. As a result, the County missed part of the early giving window.

Figure 27: Public Communication during the January 2025 Eaton and Palisades Fires

What Residents Reported

Residents who tried to help ran into an information problem rather than a generosity problem. Among the 243 respondents who attempted to donate goods or volunteer, the most frequently reported obstacle was unclear or contradictory information about where and how to give (107 respondents), ahead of donation centers being full or refusing items (80) and not knowing where to go (73). Roughly half of these respondents found it difficult to locate a centralized source of donation information, compared with one in five who found it easy.

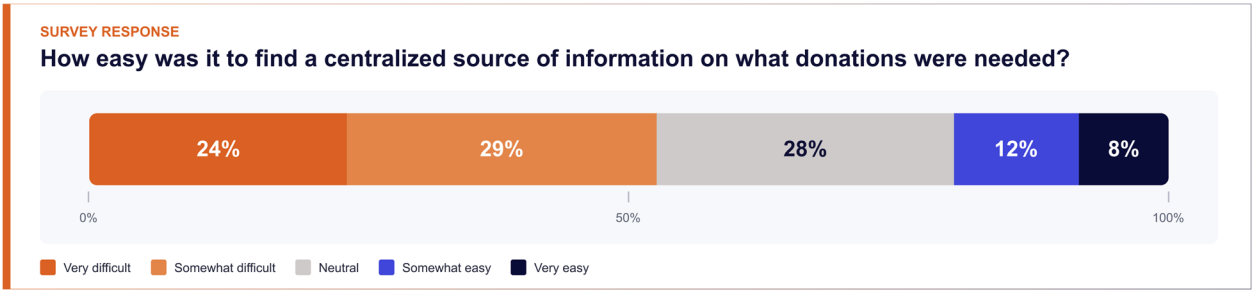


Figure 28: Stacked bar chart on ease of finding centralized donation information by survey participants

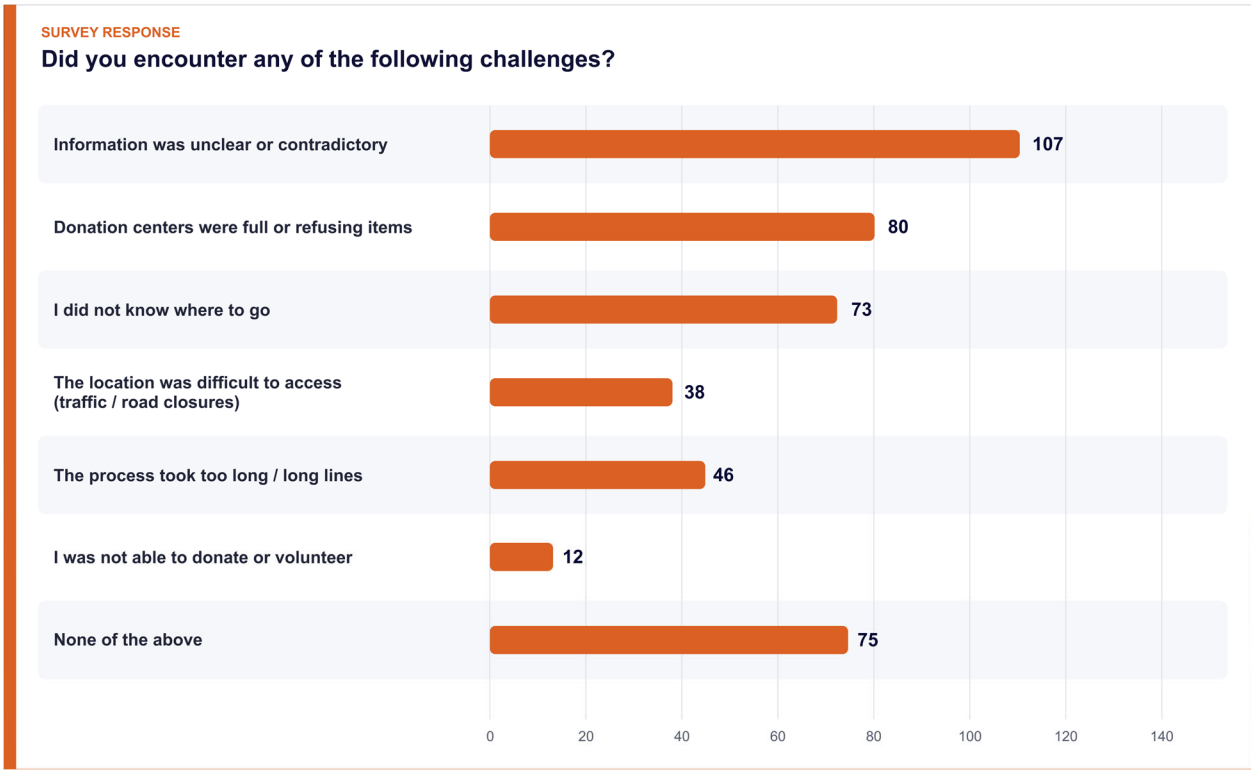


Figure 29: Bar chart on challenges with donation activities by survey participants

The mix of giving ran opposite to the County's stated intent. Of the same 243 respondents, 128 donated physical goods, 97 volunteered, and 72 gave money. County staff worked during the incident to steer donors away from unmanaged intake of physical goods and toward cash, and the survey suggests that message did not reach most people who wanted to give (VDM-F1).

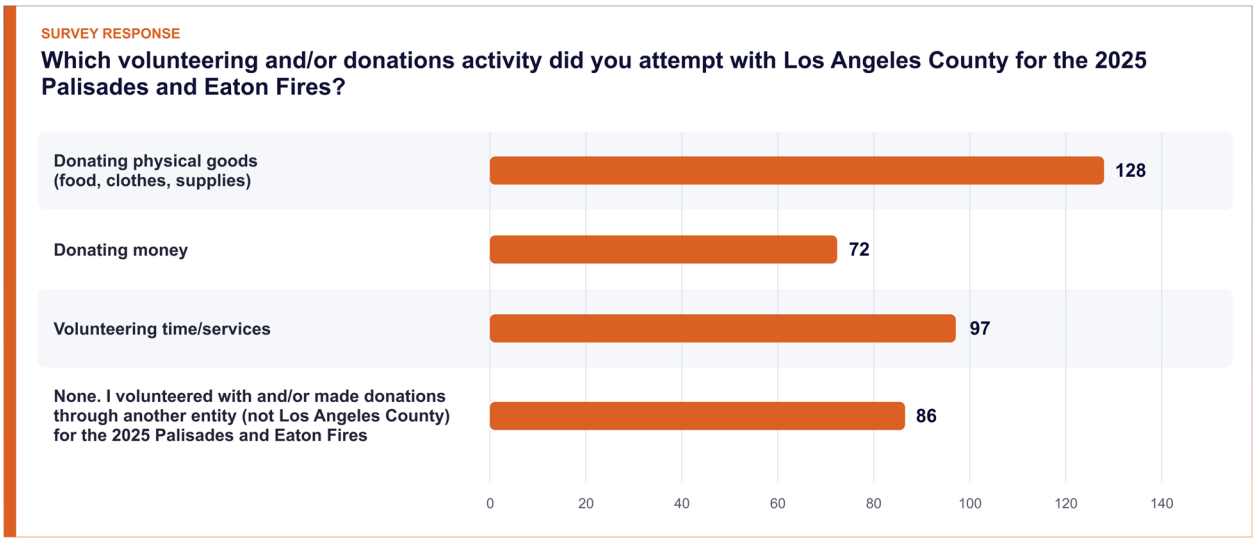


Figure 30: Bar chart on types of donation activities conducted by survey participants

Respondents rated the volunteer pathway least organized of the three. Financial donation and donation drop-off sites drew majority favorable or neutral ratings, while volunteer check-in and assignment drew the highest not-applicable share (41%) and the weakest organization ratings. This is the pattern the County's partner-dependent structure would predict in the absence of a dedicated Voluntary Agency Liaison (VAL) and documented partner pathways (VDM-F1).

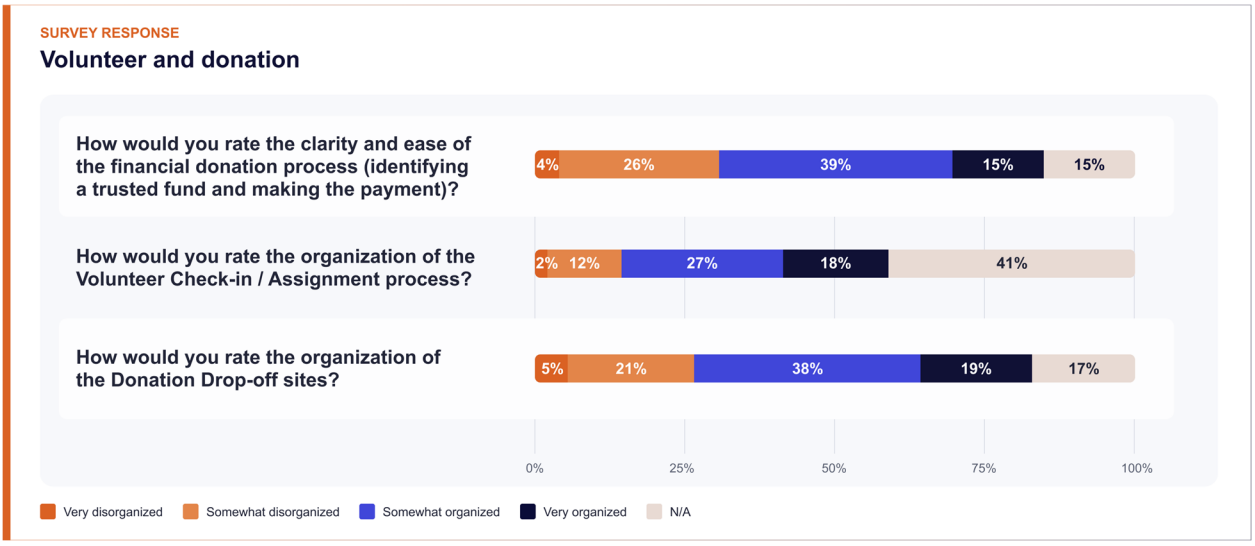


Figure 31: Stacked bar chart on organization of donation activities by survey participants

These responses cover the full giving period rather than the January window specifically. They therefore describe the donation experience after the County's cash donation link went live on February 11, and do not measure the effect of the gap identified in VDM-F2.

Woolsey AAR Connection

One recommendation from the *AAR of the Woolsey Fire Incident* addressed VDM gaps which resurfaced during the January 2025 fires. The following Woolsey recommendation connects to specific findings and recommendations in this report:

- *Rec #67: Develop a program to better manage and distribute spontaneous volunteer and donation efforts, including coordination with the Occupant Support Team* connects to VDM-F1, VDM-F2, VDM-R1, and VDM-R2. VDM-F1 and VDM-R1, addressing the absence of a formal countywide volunteer and donations management model. VDM-F2 and VDM-R2 address over-reliance on individual relationships rather than institutionalized partner pathways. Together, these findings and recommendations update and operationalize Rec #67 for catastrophic, multi-jurisdictional incidents.

Priority Recommendations and Actions

Finding VDM-F1: No formal countywide volunteer and donations management model existed, and partner coordination depended on individual relationships.

> **IN THE COMMUNITY'S WORDS**
>
> *"Was and am unaware of Los Angeles County's Volunteer and Donation Management System – did not know one existed."*
>
> — Public survey respondent

Los Angeles County stood up VDM functions during the incident but did not have a formal countywide model defining roles, operating boundaries, partner responsibilities, and activation procedures. The County's partner ecosystem carried significant operational load, but too much of that system depended on individual relationships rather than institutionalized partner pathways. As a result, departments and Board offices relied on improvised routing processes during a period of high operational demand.

Within days of the fires, OEM began developing a donations management plan, ISD assumed responsibility for physical donations, and public messaging directed residents away from unsolicited goods. ISD also established an exchange-style marketplace and served as an interim coordination hub by centralizing inquiries, tracking offers, matching donations to needs, and routing donors to organizations able to use donated resources. These actions demonstrated adaptability but also highlighted the absence of a standing countywide system.

The County should not serve as the operational receiver, warehouse, sorter, or distributor of unsolicited physical goods, nor should it directly manage spontaneous or unaffiliated volunteers. These functions require facilities, inventory controls, screening, supervision, liability

management, and community distribution capacity that are better provided by qualified nonprofit, VOAD, community-based, and private-sector partners.

Existing County-managed capabilities, including the DSW program, CERT, and affiliated volunteer organizations, are distinct from this function. The County's appropriate role is to establish policy, activate and coordinate the system, provide public information, maintain routing pathways, and oversee accountability.

The County's partner ecosystem was a major strength. Nonprofit, VOAD, philanthropic, 211LA, LA Works, fiscal sponsorship, and managed volunteer partners supported functions that County government should not directly operate at scale.

Notably, the response lacked an established VAL function within the EOC. The VOAD liaison role was assigned to an individual rather than a defined EOC position, and donations coordination similarly relied on personal contacts and incident-specific improvisation. This model is vulnerable when key individuals are unavailable or overloaded.

This is especially important because the recommended VDM model assigns major operational functions to partners. If physical-goods handling, spontaneous volunteer management, fiscal sponsorship, donor routing, and community-based distribution are external partner-led, the County must maintain those relationships as an operational capability rather than as an informal network.

Figure 32: Distribution of donated supplies to the community

Recommendation VDM-R1: Formalize a countywide VDM model and establish a dedicated EOC VAL.

The CEO should formalize a countywide VDM model in which the County sets policy, activates the system, provides public information, coordinates partners, and governs cash donations, while qualified external organizations manage spontaneous volunteers and unsolicited physical goods.

The CEO is identified as the lead for LAC-ESF #17 and has the organizational authority to establish the countywide structure, assign departmental responsibilities, and execute the agreements and contracts needed to operationalize external partners.

The CEO, in partnership with OEM, should pre-identify nonprofit, VOAD, community, and private-sector partners and establish pre-incident operational agreements, memoranda of understanding, and service contracts defining roles, activation, capacity, liability, reporting, and accountability. The County can also apply this approach to organizations it already works with by reviewing and updating existing contracts and agreements to incorporate post-disaster support provisions.

Because the model assigns major operational functions to external partners, OEM should establish a dedicated VAL function within the EOC/OEM structure rather than assigning the liaison role to an individual on an incident-specific basis. The VAL should:

- Maintain the County's operational relationships with key VDM partners, including Emergency Network Los Angeles (ENLA)/VOAD, nonprofit and community organizations, managed volunteer organizations, 211LA, LA Works, philanthropic partners, and fiscal sponsorship partners during preparedness and incident response.
- In partnership with the CEO, maintain documented operating expectations for key VDM functions provided by external partners, including physical-goods intake and distribution, spontaneous volunteer referral, managed volunteer deployment, donor routing, fiscal sponsorship, and direct assistance pathways.

These agreements or operating protocols should identify:

- Each partner's role
- Activation and backup contacts
- Service limitations
- Geographic reach
- The information the County needs to appropriately route donors and volunteers

The County should maintain a recurring partner engagement cycle between disasters that includes scheduled contact validation, tabletop or functional exercises, review of public-facing routing language, confirmation of fiscal sponsorship pathways, and updates to partner capabilities. This process should reduce dependence on individual relationships and ensure continuity when County or partner personnel change.

This model follows the basic approach used by Colorado, where the state plan designates nonprofit partners to lead operational VDM while the state retains the coordinating role. Colorado identifies separate partner teams for spontaneous volunteer coordination and unsolicited donation management and maintains a standing network of volunteer organizations that can be activated rather than creating the capability during the disaster.

California’s own Volunteer and Donation Management Planning Guidance similarly emphasizes leveraging nonprofit, community-based, faith-based, and private-sector resources during disasters.

The objective is to institutionalize the County’s existing partner network and make it an established, scalable operating capability rather than requiring County staff to build the system during each disaster.

Figure 33: Emergency response coordination at the EOC

> **IN THE COMMUNITY'S WORDS**
>
> *"Collaboration with local independent organizations would have been useful to have a network of resources where everyone had fairly consistent information."*
>
> — Public survey respondent

Finding VDM-F2: The cash donation system was not activation-ready when giving interest peaked.

The County's cash donation system became a useful financial support pathway after launch, but it was not activation-ready during the early period when public giving interest was highest.

The County's financial donation work became one of the stronger parts of the financial response after the necessary mechanisms were established. CEO PIAB spearheaded the County's cash donation work, and CEO/CSP helped mobilize philanthropic resources and support large-donor engagement. The County created pathways for large and small donors, used designated accounts and subaccounts to track donor intent, allowed donors to restrict contributions to either the Eaton Fire or Palisades Fire, and developed receipt and refund language. These financial control and donor-confidence measures should be sustained.

> **IN THE COMMUNITY'S WORDS**
>
> *"The Household Relief Grant program was exceptional. Can there be another round as fire survivors are desperate for additional assistance!"*
>
> — Public survey respondent

The challenge was timing. Public interest in giving arrived immediately, but the County's financial donation pathway was not ready when it activated. During this incident, the County established the public contact website on January 21, 2025, set up the merchant identification on February 10, 2025, and added the live donation hyperlink on February 11, 2025.

The late launch reduced the County's ability to capture the earliest giving window, although the available information does not quantify the amount missed.

Recommendation VDM-R2: Maintain an activation-ready cash donation package.

The Los Angeles County CEO should maintain the County's cash donation activation package, and direct ISD to maintain the public-facing donation platform and supporting technical infrastructure.

The CEO should establish and sustain a ready-to-activate cash donation package that includes merchant services, accounting structures, donor-intent controls, approved donor

communications, receipt and refund language, donor-routing protocols, and activation authorities.

The County should also predefine donation pathways for both large and small donors. Large donations should be routed through the CEO/CSP and appropriate fiscal sponsorship mechanisms, while small donations should be supported through a standing credit-card donation process that can be activated immediately.

ISD should maintain a turnkey donation webpage, payment processing capability, and related technical dependencies to enable immediate activation during an incident. The designated donations management lead should ensure public messaging aligns with the County's donation strategy by prioritizing cash contributions and discouraging unsolicited goods unless a validated partner need exists.

Critical Focus Area #3: Recovery

Introduction

This focus area examines how the County organized and delivered post-fire recovery services after the Eaton and Palisades Fires. This section focuses on the County's recovery governance model, including the activation and operation of nine Recovery Task Forces and OEM's recovery planning, roles, responsibilities, training, and coordination with external partners.

The findings also examine core recovery operations that directly affected residents' ability to begin rebuilding and stabilizing their lives, including debris removal, watershed debris management, ROE processing, DRC coordination, OSPCs, and accessing post-disaster benefit programs. Across these areas, the review highlights both significant operational accomplishments and opportunities to strengthen recovery readiness through codified plans, pre-positioned contracts, clearer decision authority, dedicated DRC coordination roles, improved data-sharing practices, and a more integrated resident intake platform that reduces duplicative steps for residents seeking assistance.

Figure 34: Public forum on wildfire response and recovery updates

Strengths and Best Practices

The debris removal process was a true strength for the County in recovery. The speed of the process came from front-end mobilization. Debris governance was stood up before the fires were fully contained, daily coordination began early, roughly 4,000 ROEs were collected in the first few days, and the County also built a local opt-out track aligned with federal standards. USACE had a contingency, on-call contract for debris removal with an experienced contractor that had recently completed debris removal in the wake of the Maui Fires. This competent, responsive contract vehicle, with ample capacity to handle a large-scale disaster, served as the backstop and foundation for all debris removal operations and activities. Debris teams described the operating goal as feeding USACE fast enough not to become the chokepoint, using prior Franklin Fire mass-debris documentation as an immediate playbook and benefiting from Phase 1 and Phase 2 debris removal overlap rather than waiting for perfect sequence. As a result, the County moved large ROE volume into the system early, rapidly pushed debris removal assignments to USACE contractors, and preserved a pathway for opt-out properties instead of forcing all cases into a single federal lane, clearing debris quicker than any previous emergency of this scale.

> **IN THE COMMUNITY'S WORDS**
>
> *"The debris application process was generally understandable and transparent… contractors were very respectful and contacted us in advance."*
>
> — Public survey respondent

A best practice noted by County stakeholders was using GIS products as operational decision tools, not just dashboards, across both land debris and watershed work. Debris teams described

GIS dashboards as the shared source of truth on status, and they benefited from GIS coordinators across different agencies directly coordinating data sharing. Watershed leads used fire, storm, water-quality, and mudflow/hydrology mapping to set priorities and warn neighborhoods. Mapping supported faster prioritization of flood-risk hotspots, clearer public outreach on mudflow danger, and cleaner synchronization among debris actors working on overlapping footprints.

A second strength of the recovery efforts was the layout and functionality of the DRCs. Once site-selection and startup issues were worked through, the DRC model functioned as an integrated service hub rather than a simple information desk, with co-located government, utility, and non-governmental organization (NGO) partners handling benefits, documents, and rebuilding questions in one place. The one-stop model embedded permitting departments alongside FEMA, utilities, and other agencies for ease of accessing information and beginning the recovery process. The layout and operations of the DRC should be noted as a best practice as residents could resolve multiple needs in a single trip path, such as ID replacement, housing/rebuild/zoning/planning questions, utility contacts, and referrals across NGOs/CBOs, which reduced fragmentation even when cases still required follow-up.

Third, the speed of the initial permitting for rebuilding was a strength noted by County officials and residents. The March 3 Board Report identifies the "Permitting Departments" as Regional Planning, DPH, LACoFD, and DPW, and states that the Board directed those departments to support streamlined coordination, plan review, and permit issuance for reconstruction of damaged or destroyed structures. For Palisades Fire survivors, One-Stop workshops began the week of February 17, 2025, at the Calabasas field office, with hour-long appointments held Monday, Wednesday, Friday, and Saturday for applicants to meet with the Permitting Departments about rebuild questions. For Eaton Fire survivors, a temporary Altadena OSPC opened inside the Altadena DRC on February 10, 2025, and relocated to a permanent location at 464 West Woodbury Road on March 3, 2025. DPW and Regional Planning coordinated closely at the centers, and due to the precedent set by Regional Planning during the Woolsey Fire to review the residents' claims in the GIS system and approve their request if there were permits or paid taxes on the home claimed by the resident, the initial process moved quicker for many than what was expected.

Figure 35: Effectiveness of DRC Staff

Relationships

Relationships were strongest during the recovery process between County departments and agencies. The task force structure created usable working relationships across departments and jurisdictions that did not routinely operate together, and multiple sources describe relationship-building itself as a recovery asset. After some initial ambiguity and unclear roles, task forces created connections that did not exist before and brought together disparate people from several County departments, cities, and state/federal agencies. The model gave the County a forum to move issues forward that cut across jurisdictions and issue areas without waiting for normal departmental channels.

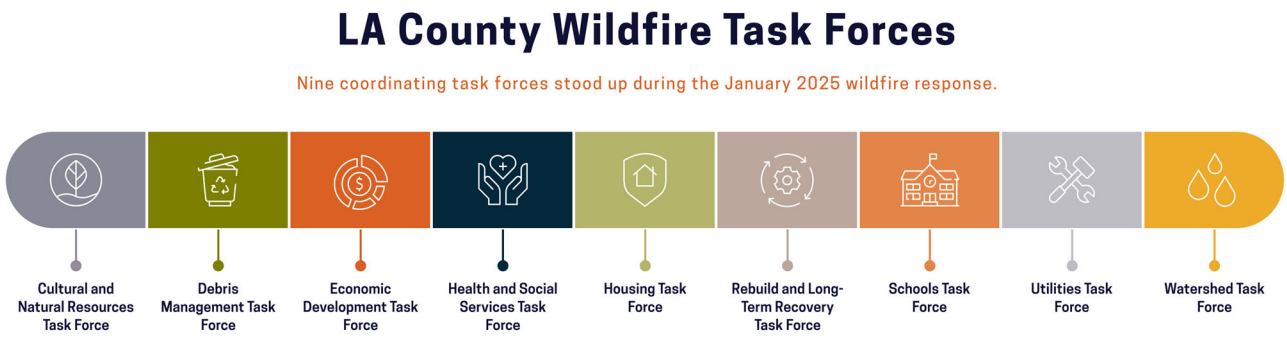


Figure 36: LA County Wildfire Task Forces

While the task force model fostered some relationships, the County and City of Los Angeles struggled to stay on the same page. They were operating in overlapping recovery and public-information environments, but information sharing did not consistently move through established channels. The breakdown was not only a communications problem, but also a decision-making and coordination problem. As a result, County and elected-office staff often filled coordination gaps through ad hoc troubleshooting rather than through a standing embedded coordination structure. This meant that information quality depended heavily on individual relationships, informal text chains, and staff's ability to synthesize large amounts of information quickly. That structure delayed consistent public messaging and increased the likelihood that residents, businesses, and partner agencies would receive incomplete or conflicting information about access, services, and recovery resources.

Resources

The County's recovery resource base consisted of a mix of internal structures, co-located service sites, and technology platforms for data-sharing. Within the first week, the task force structure established daily touchpoints. The DRC system itself served as a major resource platform with DRC tables for County agencies, FEMA, document replacement, NGOs/CBOs, and Red Cross case management. On the technology front, the Utilities and Debris task forces used GIS mapping for data storage and decision-making, and the recovery website and CJIC newsletters served as the central catalog and distribution channel to the public for available assistance programs.

Key Challenges

A central challenge during recovery was that the County did not have an updated Recovery Plan or framework to serve as a single source of truth for recovery roles, decision authority, task force activation, training expectations, and external partner coordination. Some recovery functions relied on institutional knowledge from prior wildfire responses, but gaps remained in role clarity, coordination mechanisms, and decision authority. Task force leads did not receive structured training on their roles, some groups lacked clear missions or rosters, and certain Recovery Task Forces faced delays because the right decision-makers, approval chains, or responsible entities were not clearly identified at the outset.

The County also faced major process and capacity challenges with debris removal, DRC operations, and resident access to benefits. DPW and the Debris Management Task Force operated under extreme pressure without a formal debris management plan, requiring staff to build tools, manage ROE processing, navigate ownership-verification issues, adjust to changing federal rules, and compensate for contracts that were not scaled to the magnitude of the event. DRCs also lacked a single dedicated, trained coordinator for setup, logistics, layout, and problem resolution, which pushed County staff into ad hoc support roles. Impacted residents had to verify identity, residence, ownership, or eligibility across multiple programs with different documentation requirements, leading to duplicative trips, retelling of lived experiences, and frustration during an already disruptive recovery period.

What Residents Reported

Residents rated debris removal the County's strongest recovery service and benefit access among its weakest, and the two results describe the same underlying structure. Debris removal was one process with one point of engagement, and residents rated it well. Recovery services were many programs with many points of engagement, and residents rated that experience less favorably. The difference is not in the quality of the work but in how many times a displaced resident had to start over, which is the resident-side case for the single benefit platform recommended in RCV-R4.

Figure 37: Debris Removal Survey Result

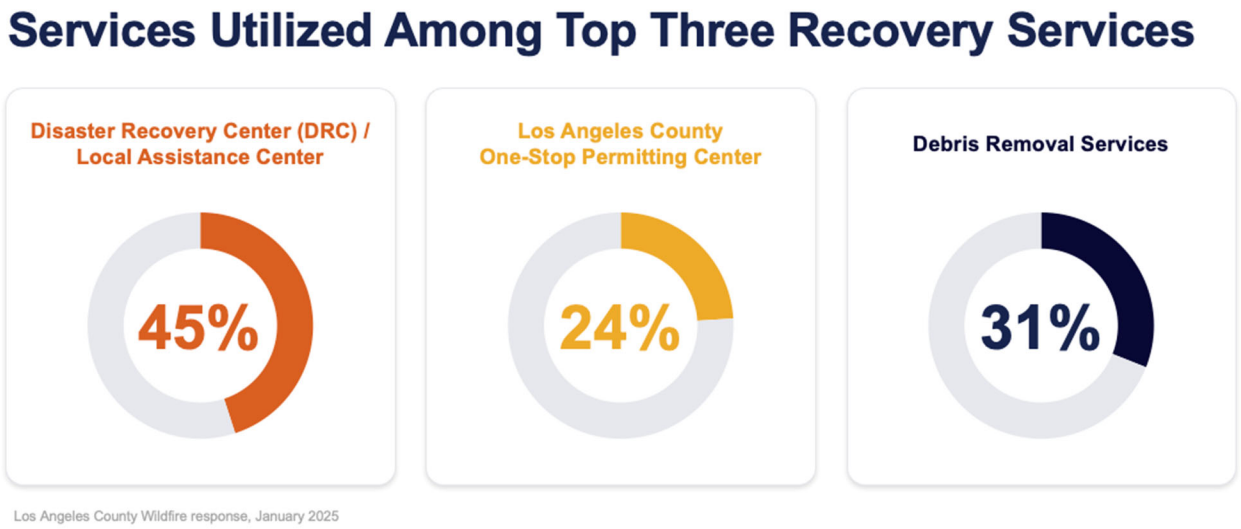


Figure 38: Utilized Recovery Services Survey Responses

Woolsey AAR Connection

Recovery-focused findings and recommendations represent the largest overlap between the *AAR of the Woolsey Fire Incident* and this AAR, some of which directly relate to what is recommended in this AAR, while others supplement the findings and recommendations below. The following Woolsey recommendations connect to specific findings and recommendations in this report:

- *Rec #70: Pre-designated Disaster Assistance Center sites* connects to RCV-F3 and RCV-R3, which address DRC oversight and formal DRC Coordinator/Supervisor roles.

- *Rec #71: Convene a debris management project team capable of activating PPDR without Cal OES/CalRecycle reliance* connects to RCV-F2 and RCV-R2, which address debris operations and the need to codify PPDR and debris management functions.
- *Rec #72: Secure standing contracts with licensed debris assessment/removal vendors* connects to RCV-F2 and RCV-R2, including the recommendation for pre-positioned debris and watershed debris contracts.
- *Rec #73: Adopt DPH standards/protocols for hazardous debris removal* connects to RCV-F2, RCV-R2, PHA-F1, PHA-F2, PHA-R1, and PHA-R2, which address debris operations, Public Health consultation, and wildfire-specific Public Health roles.
- *Rec #74: Address hazardous debris removal at all scales of emergency* connects to RCV-F2, RCV-R2, PHA-F1, PHA-R1, and PHA-R2, which address scalable debris planning, Public Health role clarity, and PPE readiness for ash/debris exposure.
- *Rec #76: Establish an IMT for PPDR operations with trigger points* connects to RCV-F1, RCV-R1, RCV-F2, and RCV-R2, which address recovery task force activation, recovery planning, and debris management doctrine.
- *Rec #77: Work with FEMA on foundation removal reimbursement* connects to RCV-F4 and RCV-R4, which address resident access to post-disaster benefit programs and a more integrated recovery services platform; FEMA policy varies by event.
- *Rec #78: Standard policy for Damage Inspection Report collection/release* connects to RCV-F1, RCV-R1, REP-F1, and COM-R3, because standardized damage information supports recovery governance, access decisions, and resident-facing repopulation communications.

Rec #69: Damage Assessment annex with common data structure was reported as in progress and remains relevant to RCV-F1 and RCV-R1. The following implemented Woolsey recommendations provided foundational structure that supported the January 2025 recovery effort: #1, #2, #22, #23, #25, #27, and #85. These are not restated as new recommendations here, but they support the recovery governance and planning improvements reflected in RCV-R1.

Priority Recommendations and Actions

Finding RCV-F1: The County lacks an updated Recovery Plan.

Without an updated Recovery Plan, some recovery functions were implemented based on institutional knowledge from previous wildfire responses rather than a codified source of truth. The review noted gaps in role clarity, decision authority, and coordination mechanisms, highlighting the need for an updated Recovery Plan.

As part of the initial recovery efforts, the County established several Recovery Task Forces by January 15. The nine task forces were: Cultural and Natural Resources, Debris Management, Economic Development, Health and Social Services, Housing, Rebuild and Long-Term

Recovery, Schools, Utilities, and Watershed. Some task forces stood up for this event were modeled on prior recovery efforts after the Woolsey, Bridge, and Franklin Fires; however, the County did not have a formal written activation package that clearly identified task force missions, rosters, lead responsibilities, training expectations, or key external partners.

Task force leads also did not receive training on how to lead their task force, with many relying on expertise from their non-emergency County roles. Without structured training, some Task Force leads described confusion after being directed to convene meetings before they understood a clear mission and who belonged in the room. While leads navigated that early ambiguity, meeting time was spent largely determining issue ownership rather than advancing recovery efforts, slowing the impact of the Recovery Task Forces.

Additionally, some Recovery Task Forces initiated efforts without established relationships or clear authority within their domains. For example, at the onset, the Utilities Task Force did not have a definitive roster of utility companies or points of contact. As a result, it took several weeks to consistently engage the appropriate decision-makers. To add to the confusion, the Utilities Task Force had no formal authority. Lacking decision-making authority, external attendees were often field staff, and water utilities were coordinated through a separate task force. These issues limited the task force's ability to resolve restoration and resiliency decisions quickly.

Similarly, the Watershed Task Force faced bottlenecks stemming from unclear roles and responsibilities. These included uncertainty over ownership or responsibility for certain bodies of water, coordination bottlenecks with other city departments, and a process in which city requests were routed through the task force and then through County OEM, creating delays when requests became stuck. It was noted that some work required state authorities, especially for full debris removal processes, and that once those authorities expired, bottlenecks returned. Overall, the task force was effective at clearing large amounts of debris ahead of heavy rainfall and storms in February, but the process was hamstrung by a lack of clarity around responsibilities and a clear approval chain of command for debris-removal decisions.

Recommendation RCV-R1: Update the County Recovery Plan.

OEM should lead the update of the Recovery Plan that codifies many of the County's assumed recovery functions.

In updating this plan, the County should use FEMA's National Disaster Recovery Framework (NDRF)[8] as a model. Specifically, Appendix D, Table 3 in the NDRF outlines characteristics and examples of post-disaster recovery plans.

[8] *FEMA National Disaster Recovery Framework*, May 14, 2025. Last referenced August 20, 2026.

In addition to items described in the NDRF, OEM's updated Recovery Plan should be sure to include:

- **Formalized Task Force Roles and Responsibilities:** OEM should identify Recovery Task Forces that can be activated across most emergencies. Using the Recovery Support Function (RSF) layout in the NDRF as a model, OEM should identify:
  - The Coordinating (or Lead) Department(s)
  - The Mission
  - Strategic Outcomes
  - Responsibilities
  - Key External Partners or Points of Contact
- **Establish a Pre-disaster Recovery Legal and Policy Package**:
  - Identify the ordinances, Board actions, delegated authorities, and other legal mechanisms needed to implement the County's recovery framework.
  - For priority authorities, the County should develop draft board motion language for Board consideration before a major disaster occurs.
- **Training and Continuity of Operations:** For the identified task forces, OEM should:
  - Hold training annually (at minimum) for departments leading the task forces, including written documentation in case of transition in/out of roles within departments.
  - Maintain a regular meeting cadence outside of activation for each, at least quarterly, to build relationships and update points of contact.

Finding RCV-F2: The debris removal process functioned at a rapid pace without pre-positioned contracts or tools.

Without pre-positioned contracts or pre-built tools, debris removal teams had to work under incredibly tight timelines and develop solutions as they moved through the recovery process.

Figure 39: Debris Removal in Altadena

The County faced extreme pressure to clear debris on an expedited timeline. Without a formalized debris management plan in place at the time of the Eaton and Palisades Fires, DPW and the Debris Management Task Force were strained for time and resources as they built tools and secured debris removal contracts during the recovery phase.

The debris removal mission began under significant time pressure and required the County to process a volume and complexity of work that exceeded normal operational assumptions. The Debris Management Task Force coordinated with USACE and FEMA to manage private property debris removal (PPDR). USACE received four different debris removal mission assignments between January 17 and February 1 to support the County. DPW created the initial ROE form within 24 hours, but the first version had limited functionality: applicants could not upload supporting documents, and the signature process did not qualify as a legal signature.

After approximately one week, the County transitioned to a consultant-supported virtual ROE platform developed with Tetra Tech. The updated system allowed applicants to upload required documentation electronically and improved the County's ability to review submissions. Staff then had to digitize approximately 1,000 hard-copy ROEs and review approximately 4,000 electronic submissions to determine which could be approved quickly and which required additional information. Each required review, processing, ownership verification, and triage across residential, commercial, public, and private property categories, yet the primary goal for the County was to process them as quickly as possible so they would not become the chokepoint for the USACE debris removal mission.

IN THE COMMUNITY'S WORDS

"Contact with the Army Corps team was essential… They also provided progress reports and videos of the cleanup process."

— Public survey respondent

Figure 40: Distribution of emergency supplies during wildfire recovery

The property verification process added complexity to ROE review because many properties are held in trusts. DPW made an early internal decision to approve simple trust cases where the trust owner matched the individual signing the ROE, which allowed approximately 200 properties to move forward. More complex trust cases required staff to pull deeds and compare the deeded owner against the ROE signatory. When the names matched, the ROE could proceed, but when they did not, the case required additional review. To keep the overall debris removal process moving, staff initially prioritized properties that could be verified quickly and set aside more complicated ownership cases for later review. As a result, some residents who submitted ROEs early still experienced delays.

While navigating the ROE intake, debris personnel had to balance changing federal rules and the urgency from higher levels of government while still complying with legal requirements for property access. The County initially treated the property owner's ROE as sufficient to access the property through the owner's available access route but later shifted toward obtaining ROEs for each area that crews needed to cross after risk tolerance changed during the operation. Throughout the process, the County also advocated for including additional categories of properties in the PPDR program.

For residents who opted out of PPDR, the Debris Management Task Force successfully developed a local program requiring households who opted out to obtain a permit. The task force developed the entire program in-house, including the necessary criteria and ensuring it mirrored federal standards.

The County had some debris-related preparations from prior fires, including internal mass-debris removal documentation and contracts focused primarily on public right-of-way clearing, but those contracts were too small for the scale of this event. Given the scale of the debris cleanup, USACE took operational control and decided where debris would go in an open-market landfill system. Given the time pressure and effort required, the County successfully cleared debris from

the fires, but without USACE involvement, their debris-removal response would have been extended for a disaster of this magnitude.

The Watershed Task Force handled post-fire watershed risks, particularly sediment, debris flow, water quality, and stormwater impacts. Immediately after the fire, when rain was forecasted, the task force effectively cleared debris basins, placed resources in the field, used K-rail where needed to prevent mud from entering homes, and helped distribute filled sandbags. In the following weeks, the task force used mud flow maps and hydrology maps to identify high-risk flooding pinch points, working with USACE and contractors to clear waterways and reservoirs, namely the Eaton Wash Dam. Like the Debris Management Task Force, the Watershed Task Force was largely successful in their mission to clear waterways but would have greatly benefited from pre-positioned contracts to expedite their efforts.

Recommendation RCV-R2: Codify debris operations in a Disaster Debris Management Plan.

DPW should codify many of the debris removal functions from the response to the Eaton and Palisades Fires into a Disaster Debris Management Plan.

DPW's Disaster Debris Management Plan should include:

- **Roles and Responsibilities by Debris Type:** DPW should establish, in coordination with OEM and other County agencies, which debris type will be handled by which department or task force based on different types of emergencies.
- **Debris Collection and Removal Operations:** DPW should establish the modes of collection that will be used for a disaster, as well as define the activation framework for the Disaster Debris Management Plan.
- **Responsibilities for Identifying and Establishing Temporary Debris Storage and Reduction Sites (TDSRs):** The process for identifying TDSRs involves several steps, including site considerations, regulatory compliance, and prescribed processes. DPW should determine the checklist of considerations needed for possible sites and develop a shortlist of qualified TDSRs. Given the time and considerations involved in identifying and developing TDSRs, it is crucial to include this in debris management preparations.
- **PPDR Management:** DPW should codify many of the practices developed during the fire response, including the virtual ROE form, the process for approving ROEs and handling edge cases (e.g., individuals living in a property with another name on the deed), and the requirements for the opt-out program for those not wishing to participate in PPDR.
    - **For Non-Compliant Properties:** DPW should first document the property and attempt to make contact with the owner. If the non-compliance continues and the debris threatens public health or safety, DPW should escalate through a legally authorized official.

    - **For Ineligible Properties:** DPW should refer them to insurance/private disposal options.
- **External Contracting:** DPW, in coordination with OEM and other County agencies, should identify triggers for external debris management contracting following an emergency.
- **Pre-Positioned Contracts:** When contracting externally, the County should have pre-disaster contracts in place, already negotiated and on standby, especially for debris removal and watershed debris removal. DPW should issue Request for Proposals for contingency services as currently identified in OEM's Master Service Agreement:
    - PPDR management
    - ROE management and collection
    - Call Center Support
    - Case Management
    - Temporary Debris Management Sites
- **Data Collection:** DPW should codify the practice of inputting the latest data in the GIS dashboard for easy sharing among agencies. DPW should also determine the best way to share public data on ROE approvals and debris removal operations.
- **Marine Debris:** DPW should identify the trigger points for waterway debris removal escalating to federal assistance or private contractors, as well as the process for locating the debris and determining legal ownership.
- **Public Communications:** DPW should work with CEO Countywide Communications to establish responsibility and ownership of official channels for communication around debris removal to the public.

A reference for good debris removal practices and case studies is outlined in the National Cooperative Highway Research Program (NCHRP) Report 781: A Debris Management Handbook for State and Local Departments of Transportation and Departments of Public Works.[9]

Finding RCV-F3: DRCs lacked a single point of oversight.

County staff supporting DRCs suffered from not having a dedicated and trained single point of oversight, requiring staff to act in an ad hoc support capacity and handle issues as they arose.

[9] *National Cooperative Highway Research Program (NCHRP) Report 781: A Debris Management Handbook for State and Local Departments of Transportation and Departments of Public Works*, 2014. Last referenced August 20, 2026.

The DRC process required coordination among OEM, Cal OES, FEMA, County departments, city partners, elected offices, facility owners, and support departments, but the available evidence indicates that no single County role had end-to-end responsibility for site selection, setup, logistics, layout, and ongoing problem resolution. Once the formal DRC process began, OEM, Cal OES, and FEMA evaluated roughly 10 to 12 potential locations, with site decisions affected by regulatory requirements, parking, site size, and FEMA final review.

Figure 41: Resident experience with DRC staff

After selecting sites, OEM noted that they assigned a DRC manager at each DRC site, but County staff still had to address basic operational gaps as they emerged. County staff served in ad hoc support functions, including supplying extension cords, buying printers and ink, supporting Wi-Fi and generator needs, moving tables, preparing signage, and helping address layout issues. County DRC staff noted that the DRC at the Pasadena City College Community Education Center required constant logistics management. The Westside DRC also reflected the added challenge of operating in a Los Angeles city facility and serving multiple jurisdictions. County staff described needing to rely on the city for facility control, which reduced the County's ability to manage logistics or provide resources quickly. Space constraints created additional issues, including County departments being crowded into limited areas and more agencies and community groups wanting to be present than the site could accommodate.

These challenges required Board offices and County staff to advocate for space, troubleshoot site operations, and resolve problems based on individual relationships and available authority rather than a formal DRC oversight structure. While many staff acted quickly and effectively to solve problems, the process depended on reactive support rather than a single accountable role to anticipate needs, coordinate setup, manage site conditions, and resolve issues across all DRCs. That fragmentation increased the burden on County support staff and created avoidable friction in the resident-facing service environment.

Recommendation RCV-R3: Formalize DRC Coordinator and DRC Supervisor roles.

OEM should formalize the roles of DRC Coordinator and DRC Supervisor during activation to help streamline the initial DRC setup and its first days of operation.

- **DRC Coordinator:** Modeled after FEMA's Federal Disaster Recovery Coordinator, this individual will have the sole responsibility during the initial response and recovery from a disaster to oversee the site selection, setup, and ongoing needs of a DRC.

The position's full responsibilities can be based on the responsibilities FEMA defines for a Local Disaster Recovery Manager, with the scope of the job being limited to just DRC functionality and operability. OEM should identify the individual(s) filling this position before emergency activation and train them in the responsibilities of their role.

- **DRC Supervisor:** In an emergency where multiple DRCs are activated, like the Eaton and Palisades Fires, this individual will oversee the general operations of all DRCs and act as a bridge between DRC Coordinators at each site to ensure consistent experiences for impacted residents. The individual filling this position should be identified before emergency activation and trained in the role's responsibilities.

Finding RCV-F4: Residents made duplicative trips to access benefit programs.

Impacted residents made duplicative trips to DRCs to access different post-disaster benefit programs and services.

Identity and ownership verification fragmented the impacted resident journey, as residents had to verify identity, residence, ownership, or eligibility at multiple points in the recovery process, but the documentation required varied by program and administering entity. Because each program required different documentation, individuals frequently made duplicative trips to DRCs and OSPCs, frustrating residents.

> **IN THE COMMUNITY'S WORDS**
>
> *"I got conflicting information on whether I needed a permit; I was told I needed testing for asbestos but many of the people at the county disagreed… The process was confusing and frustrating."*
>
> — Public survey respondent

Ownership verification complicated the process for residents applying for recovery services. As discussed in *Finding RCV-F2*, many properties were held in trusts, requiring DPW staff to compare trust documents, deeds, and signatories during the ROE process. DPW used its internal database to pull deeds and compare ownership records against signatures, but mismatched names or complex trusts delayed approval. Staff initially set aside more complicated cases to process easier ones first, which frustrated some residents who submitted early but saw neighbors' debris cleared sooner because their ownership documentation was easier to verify. As the final check in the process, residents were required to provide identification, such as a driver's license or passport, to verify their signature and name.

For zoning entitlements and fee waivers, Regional Planning used internal systems at DRCs and OSPCs to verify whether the applicant was the owner of record as of a specific date, rather than requiring the same identity-verification process needed for debris removal.

FEMA Individual Assistance, Red Cross programs, County-administered assistance, and other benefits each used their own eligibility rules and documentation requirements based on the funding source and program purpose. Residents often had to register separately for each program and provide different documentation each time.

DRCs helped reduce some barriers by providing access to replacement documents such as driver's licenses, passports, and Social Security cards, and by allowing paper options or in-person case management. However, those workarounds did not eliminate the broader fragmentation across programs. Survivors had to navigate multiple intake systems, repeat their story, re-prove eligibility, and make duplicative trips to DRCs or other service locations while they were displaced, managing insurance claims, and trying to understand available recovery benefits.

Recommendation RCV-R4: Develop a one-stop web platform for post-disaster services.

OEM, with support from CEO Countywide Communications and ISD, should develop a web platform that acts as a one-stop source for impacted residents to understand, view, and complete all County post-disaster benefit applications.

We recommend that the one-stop web platform be an easily accessible site where impacted residents can view all possible post-disaster benefits, upload documents deemed critical for receiving post-disaster benefits, and select the post-disaster benefits they would like to access. Some of these resources are already posted on Los Angeles County's recovery website: *recovery.lacounty.gov*. ISD and OEM should design this platform on the recovery website, building upon what already exists.

Acknowledging that benefits programs provided by FEMA, the Red Cross, the State of California, and other non-County entities have their own channels for application, the platform should not include the application processes for non-County benefit programs. Instead, it should describe what non-County benefits are available and link to those programs' application pages or process descriptions.

Critical Focus Area #4: Repopulation

Introduction

This focus area reviews the County's repopulation process following the Eaton and Palisades Fires, focusing on how reentry decisions were made, communicated, and implemented in the field. This section demonstrates that repopulation operations relied on a structured IMT and Unified Command rhythm, but that the process was not always translated into a clearly understood authority framework for all supporting agencies. As a result, this section examines both the internal coordination mechanisms that supported repopulation and the gaps that affected how those decisions were understood and carried out externally.

The section also evaluates resident access systems and checkpoint operations during the repopulation effort, particularly the use of access passes in the County unincorporated area impacted by the Palisades Fire and the lack of consistency in access pass use between the Eaton and Palisades Fires footprints. This section highlights resident confusion, inconsistent checkpoint enforcement, and unclear information about eligibility and issuance of access passes as central issues in the repopulation experience. These challenges point to the need for a more standardized repopulation model that includes a single access credential system, clearer checkpoint guidance, and a codified decision-making framework for future incidents.

Strengths and Best Practices

> **IN THE COMMUNITY'S WORDS**
>
> *"Considering the scale of the destruction, the county did a good job in repopulation."*
>
> — Public survey respondent

A best practice of the repopulation efforts after the Eaton and Palisades Fires was the use of a daily IMT/Unified Command repopulation cycle led by the California Department of Forestry and Fire Protection (CAL FIRE) for the Palisades Fire and California Interagency Incident Management Team 5 (CIIMT5) and CAL FIRE for the Eaton Fire. The repopulation meetings also included LASD, LACoFD, DPW, DPH, utility providers (Utilities), OEM, and other relevant partners. Stakeholders reviewed repopulation conditions together and did not move forward without multi-agency input. This structure gave agencies space to stop or delay openings when a prerequisite was incomplete, align section openings with field realities, and maintain a common operating picture before lifting orders. As a result, reopening decisions were treated as contingent on cross-functional safety inputs, especially from DPW, Utilities, and DPH, rather than on fire containment alone.

Second, the County benefited from a phased, zone-based reopening with controlled checkpoints rather than area-wide release across both the Eaton and Palisades Fires regions. The phased reopening included block-by-block progression, controlled ingress points, and resident verification at checkpoints. Reopening began incrementally to avoid overwhelming traffic and later shifted to a faster access process once conditions stabilized. While the lived experience of residents at checkpoints was certainly a shortcoming, the overall reopening approach was positive. This approach helped keep traffic from surging, preventing people from crossing into still-closed segments, and preserving room for public safety responders and utility crews while still giving residents a path back in.

Figure 42: A couple returns to the site of their home in Altadena

Within the County unincorporated area impacted by the Palisades Fire, the early pass rollout experience was largely negative. Yet it became a strength in the later repopulation efforts following the County's shift toward a standardized, resident-facing access pass and more coordinated resident communication. After the initial confusion caused by multiple different passes, agencies converged to align pass appearance and categories, held weekly coordination meetings, relocated pass distribution to more workable sites, used alternative ID methods when documents were unavailable, and coordinated PIO/CJIC and social messaging.

For the County unincorporated area of Altadena impacted by the Eaton Fire, no access pass system was used, which created an inconsistent resident experience during repopulation. As the use of access passes became a strength later in the repopulation efforts for the Palisades Fire area, it is recommended that the pass be used in all areas within the County.

Relationships

The entire coordination network across County departments, agencies, and jurisdictions was crucial to making repopulation decisions effectively. The County partnered with CAL FIRE, National Guard, Red Cross, and CERTs, including embedded liaison roles at the County EOC, linking CAL FIRE IMTs, OEM, LASD, LACoFD, and Board offices. The embedded liaisons in the EOC acted as a force multiplier, moving decisions forward efficiently.

Resources

GIS mapping tools, clearly defined zone boundaries, staffed control points, and field personnel aided repopulation decisions. Notably, the Damage Inspection (DINS) reports played a key role in repopulation. The DINS reports were available before repopulation and showed which homes were destroyed, partly destroyed, or standing. They informed the decisions and actions of DPW, Utilities, among others in Unified Command and, after an initial period of edits and revisions, provided publicly accessible data to residents on the status of their homes.

Key Challenges

A primary challenge during repopulation was the lack of a single, standardized access pass system at the outset of operations. In the Palisades Fire-impacted areas, multiple agencies implemented separate pass systems with different formats, colors, and eligibility criteria before eventually converging on a unified pass design. This created confusion for residents, contractors, utility providers, insurance adjusters, and others trying to understand whether they were eligible to return, where to obtain passes, and which credentials would be accepted. At checkpoints, the absence of initial standardization created enforcement challenges, especially where multiple agencies were responsible for access control.

A second major challenge was the absence of a codified repopulation decision-making framework. Although decisions were made through daily IMT and Unified Command coordination and often proceeded by consensus, final decision authority was not formally articulated by phase. Stakeholders interpreted the roles of Unified Command, CAL FIRE, OEM, and DPH differently. This ambiguity caused uncertainty for agencies less embedded in the command structure and highlighted the need for a County-approved repopulation decision matrix that defines authority, required agencies, minimum reopening criteria, and decision logs.

> **IN THE COMMUNITY'S WORDS**
>
> *"This was a very problematic experience for an 89-year-old with disabilities – having to wait over an hour on PCH after driving an hour."*
>
> — Public survey respondent

What Residents Reported

Advance notice was the repopulation experience residents rated worst. Of the 1,500 respondents, 62% reported dissatisfaction with the advance notice they received before being allowed to return to their property, compared with 12% who reported satisfaction and 26% who were neutral.

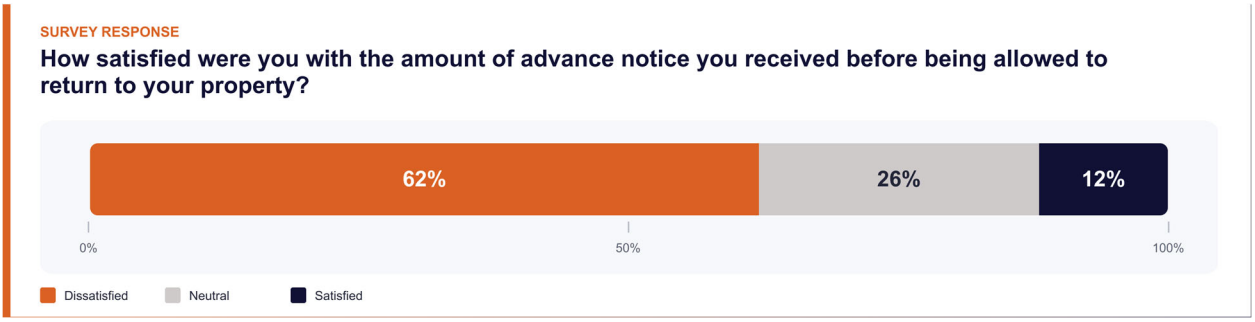


Figure 43: Stacked chart on advanced notice of returning to property for survey participants

Dissatisfaction was consistent across every age group, from 57% among respondents aged 65 and over to 67% among those aged 55 to 64. The absence of meaningful age variation argues that

this was a process and timing problem rather than a digital-access problem, and it points to the same gap identified in REP-F2: the daily Unified Command rhythm functioned internally, but the decision points were not legible to residents or to supporting agencies in advance.

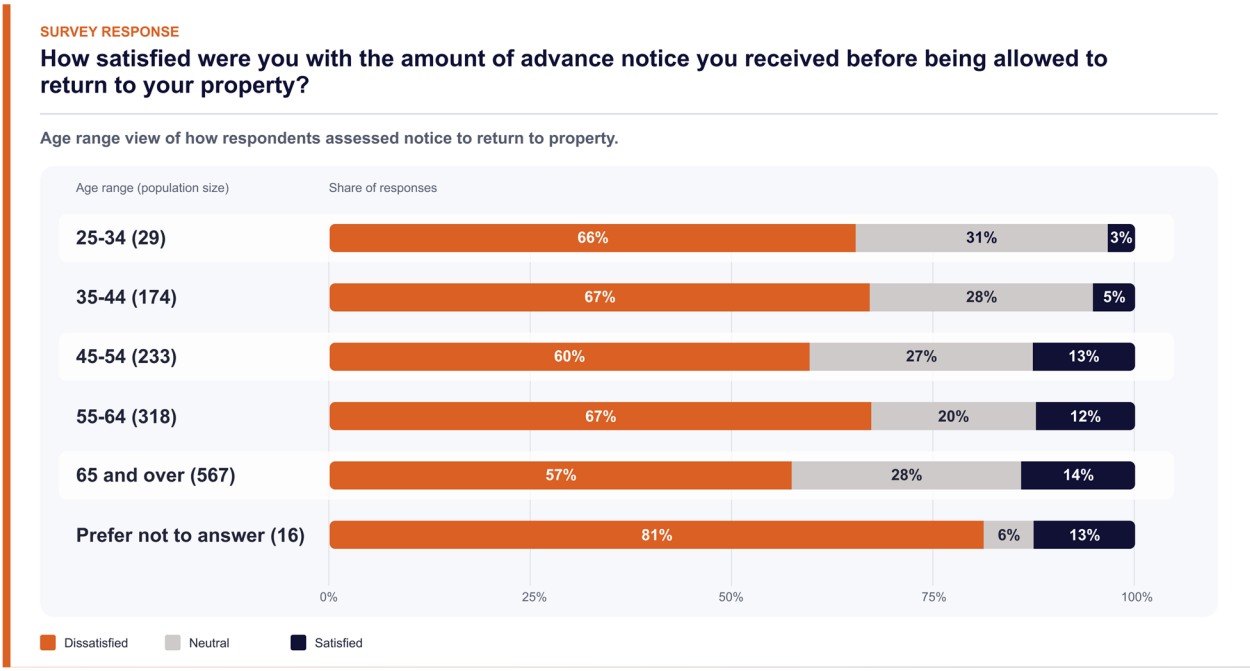


Figure 44: Stacked chart on advanced notice of returning to property for survey participants by age group

Access-pass experience is not reported here as a countywide figure. Multiple entities issued separate passes in the Palisades Fire footprint with different formats, colors, and eligibility criteria before converging on a unified design. The Eaton Fire footprint did not have the same pass system. Because 985 of the 1,500 respondents were in the Eaton Fire footprint and 417 in the Palisades Fire footprint, a combined access-pass percentage would describe a program most respondents never encountered. Where access-pass and checkpoint-credentialing data are reported in this review, it is reported by fire footprint (REP-F1).

Woolsey AAR Connection

Three recommendations from the *AAR of the Woolsey Fire Incident* inform the findings and recommendations in this section:

- *Rec #62: Redesign the repopulation process and establish a decision-making process, including final authority* connects directly to REP-F2 and REP-R1, which address codified repopulation decision authority, required decision participants, approval pathways, and decision logs.
- *Rec #64: Conduct a public repopulation education campaign commensurate with evacuation training* connects to REP-F1, COM-F3, COM-R3, and REP-R1, which address access-pass confusion, checkpoint communications, resident-ready instructions, and the formal Repopulation Plan.

- *Rec #66: Conduct annual repopulation training for all involved agencies* connects to REP-F1, REP-F2, and REP-R1, which call for a formal Repopulation Plan, standardized access credentialing, checkpoint guidance, authority pathways, and training/exercise cycles for participating agencies.

Additionally, *Rec #63: Safe, timely access for evacuees to see property and perform salvage checks* remains a gap. This report partially addresses the issue through REP-F1, COM-F3, COM-R3, and REP-R1, but the recommendation is not fully resolved because the current findings focus on access-pass systems, checkpoint practices, and resident-facing communications rather than a complete salvage-check access policy.

Priority Recommendations and Actions

Finding REP-F1: Access pass systems and checkpoint practices confused residents.

The County's and City of Los Angeles' access pass systems in the areas impacted by the Palisades Fire were confusing for residents until a single pass system emerged, and checkpoint credentialing and information were inconsistent across the areas impacted by the Eaton and Palisades Fires.

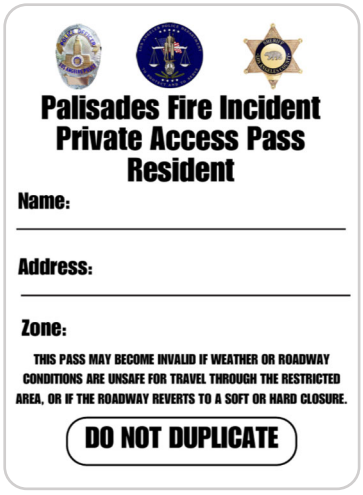


Figure 45: Access Pass

Inconsistent access pass systems and checkpoint enforcement reflect gaps in policy design and operational execution, compounded by communication challenges across jurisdictions. At the onset of the Palisades response, multiple agencies, including City of Los Angeles and County law enforcement, implemented separate access pass systems with differing formats, colors, and criteria. The system evolved iteratively, with agencies eventually converging on a unified pass design after experiencing real-time friction in throughput and verification, and public confusion.

> IN THE COMMUNITY'S WORDS
>
> *"Being expected to drive a long way and wait a long time, to get a piece of paper, which could be easily copied, was irritating. A digital pass applied for online should be available in this day and age."*
>
> — Public survey respondent

Operationally, for both the Eaton and Palisades Fires, the lack of initial standardization created enforcement challenges at checkpoints, particularly where multiple agencies were responsible for access control. Residents reported difficulty understanding eligibility, where to obtain passes, and which credentials were valid, reinforcing that communication mechanisms did not keep pace

with evolving policies. Overall, the issue reflects a lack of pre-incident policy standardization, coupled with real-time operational adaptation and fragmented communication across agencies.

Finding REP-F2: Repopulation decision authority was not clearly understood across all agencies.

Internally, repopulation decisions were made through a structured IMT/Unified Command rhythm, but externally, and sometimes across supporting agencies, it was not always clear who had final decision authority, what role OEM played, or whether DPH had advisory, operational, or clearance authority.

While repopulation decisions followed a structured IMT and Unified Command process, this structure did not translate into a clearly understood or documented authority framework across all participating agencies. Stakeholders consistently described decision-making as occurring through daily meetings, where agencies collectively reached agreement and decisions proceeded only when each party affirmed the proposed action. However, this model of unanimous agreement, while operationally effective, lacked formal articulation of who held ultimate decision authority at each phase.

> **IN THE COMMUNITY'S WORDS**
>
> *"Law enforcement sometimes made it difficult to get into our neighborhood, even with a pass."*
>
> — Public survey respondent

This ambiguity was reinforced by differing interpretations of leadership roles. Some participants described CAL FIRE as facilitating the process, while others emphasized Unified Command as the decision-making body, indicating that authority was distributed but not explicitly defined. Similarly, OEM's role was described as facilitative, managing zones for repopulation and supporting coordination, rather than decision-making, but stakeholders did not consistently understand this distinction. Without a codified framework, participants relied on experience and situational awareness rather than a shared doctrine, which contributed to uncertainty, particularly among agencies less embedded in the command structure.

For example, DPH personnel attended coordination meetings and provided risk communication and safety guidance but did not view their role as clearance authority for reentry and repopulation decisions. However, this distinction was not consistently communicated or understood, leading to differing expectations between DPH and other participating agencies about whether DPH had approval authority in repopulation decisions.

Recommendation REP-R1: Codify informal repopulation decision functions in a formal Repopulation Plan, including a single access credential standard and clear authority, approval, and escalation pathways.

LASD should enhance its current repopulation plans to codify repopulation tactics and processes from its response to the Eaton and Palisades Fires and add decision-making frameworks.

A new Repopulation Plan should include:

- **Repopulation Decision Authority:** LASD, with input from OEM, should establish a County repopulation decision authority framework that defines which agencies and/or entities have decision authority at each repopulation phase: initial reentry, resident access, and sustained return. The framework should be codified in a County-approved repopulation decision matrix that includes the agencies that need to be at the decision-making table, a non-exhaustive checklist of the minimum requirements for reopening at each phase, and decision logs.
- **A Single Access Pass System:** LASD should establish a single County access credential standard for post-disaster repopulation. The standard should specify one pass design, one eligibility matrix, one issuance script, one expiration and revocation process, and one checkpoint guide used by all participating agencies (see *Recommendation COM-R2*).

  LASD should lead training on the standard, with roles defined by function: sworn law enforcement personnel staff checkpoints and verify credentials, while Disaster Service Workers (DSWs) support pass issuance and distribution at intake points under law enforcement oversight.

  Before an incident, LASD and OEM should coordinate with municipal police departments, allied law enforcement agencies, and affected jurisdictions to align on the single access pass and common checkpoint procedures, so credentialing expectations are established in advance rather than negotiated during a response.

  LASD and OEM should also evaluate California's digital ID program as a validation method and consider issuing virtual access passes to residents.

Critical Focus Area #5: Shelter, Housing, and People at Higher Risk

Introduction

During the January 2025 Eaton and Palisades Fires, the County's sheltering, housing, and support systems for people at higher risk exceeded routine emergency shelter operations. While the County benefited from dedicated personnel and agency partnerships, the event exposed several critical areas requiring improvements and enhancements. The event showed that several key sheltering and housing functions would have benefited from updated, scalable frameworks. These included shelter governance, redundant site capacity, additional AFN support, medical

coordination pathways, and shelter-to-housing transition processes that could expand rapidly during a catastrophic, multi-jurisdictional disaster.

This focus area evaluates emergency shelter locations, resource capacity, and partner coordination protocols to help future response efforts to more effectively address AFN considerations for older adults and individuals with disabilities. It also examines evacuation and safe housing strategies for people at higher risk, including justice-involved individuals, youth in custody or care, people in supportive or transitional housing, and individuals experiencing homelessness.

Strengths and Best Practices

The County identified and supported an evacuation sheltering operation to provide a safe location for displaced residents. Three initial evacuation shelter sites were activated during the early phase of the incident: Westwood Recreation Center, El Camino Real Charter High School, and Pasadena Convention Center - an Americans with Disabilities Act (ADA)-compliant shelter. These sites supported immediate evacuation and emergency sheltering needs beginning on January 7, 2025.

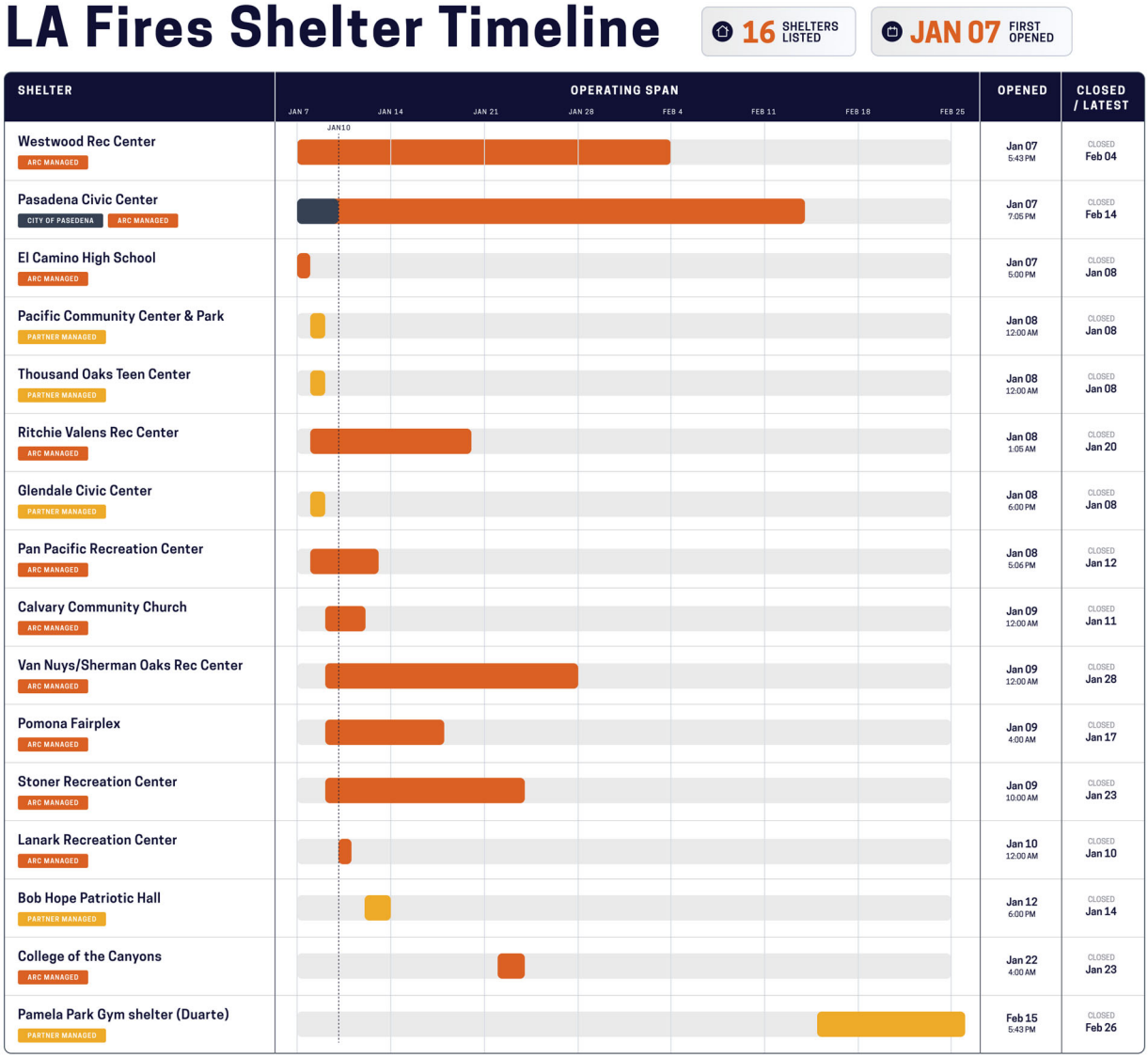


Figure 46: LA Fires Shelter Operations Timeline

The figure above shows the emergency shelters that were opened to house residents displaced by the Eaton and Palisades Fires. As the response transitioned from short-term evacuation sheltering to ongoing recovery support, the County and the Red Cross coordinated the relocation of remaining Eaton Fire evacuees from the Pasadena Civic Auditorium Complex to the Pamela Park Gymnasium in Duarte on February 14–15, 2025.

The County and its partners demonstrated meaningful strengths during the response. DPSS, OEM, Red Cross, DMH, DPH, Department of Health Services (DHS), Aging & Disabilities, 211LA, Los Angeles Homeless Services Authority (LAHSA), CEO-HI now HSH, DCFS, Probation, and community partners mobilized quickly under difficult conditions. The Red Cross opened and operated shelters, DMH surged mental health support into shelters, and State FAST resources supported AFN assessments. DPH supported shelter operations by conducting health

screening, monitoring hygiene and sanitation conditions, providing infection-control guidance, and investigating communicable disease outbreaks in mass-care shelters. Local healthcare partners like Alta Med and Kaiser's mobile medical teams were also on-site to provide medical support.

> **IN THE COMMUNITY'S WORDS**
>
> *"We vegetarians were fed real vegetarian meals at every meal… I liked that the fire chief came and talked to us and a map of the fire progress was updated daily."*
>
> — Public survey respondent

Animal sheltering was also an important component of the response led by Animal Care & Control. Their efforts helped reduce barriers to evacuation for residents who might otherwise have delayed or avoided leaving unsafe areas because of concerns about animal safety.

Animal Care & Control reported activating emergency animal sheltering operations on January 8 within approximately 12 hours of the Eaton Fire's ignition. They opened a shelter at Pierce College Equestrian Center, which housed hundreds of large and small animals. Three large-animal evacuation shelters were open at Pierce College, Antelope Family Fairgrounds, and Castaic Animal Care Center. The Agoura Animal Care Center served as the primary small animal care shelter, and all seven of Animal Care & Control's animal care centers accepted small animals. Several coordinating partner organizations also supported sheltering of approximately 600 evacuated pets.[10] Several short-term housing and recovery operations also functioned well.

Figure 47: Pierce College Evacuation Center for Large Animals

[10] *Los Angeles County Animal Care & Control*. Last referenced August 24, 2026.

Hotel, voucher, and care coordination pathways helped stabilize many residents outside congregate shelter settings, and 211LA-supported care coordination became an important bridge between immediate sheltering and longer-term recovery.

The County implemented several innovative temporary housing options, including permitting recreational vehicles (RVs), manufactured homes, and mobile homes on damaged properties and allowing displaced residents to occupy standalone accessory dwelling units (ADUs) before rebuilding their primary homes. However, these options appeared underutilized, suggesting many survivors were unaware of them or found the temporary housing terminology and eligibility requirements confusing. Future recovery efforts should provide clearer public guidance explaining the full range of temporary housing options, their eligibility criteria, and how each option supports both short- and long-term recovery.[11]

Probation utilized shelter-in-place for one facility, Barry J. Nidorf Juvenile Hall, affected by the Hurst Fire. Facility size and other specific conditions supported that decision. Future incidents should rely on continuously validated, site-specific risk assessments rather than assuming sheltering in place or evacuation is the preferred strategy for all custodial facilities.

Animal sheltering and reunification practices were also successful, and should be incorporated into future shelter planning, including clearer coordination pathways for residents with pets, service animals, large animals, and animals requiring emergency care. These practices should be retained and formalized for future incidents.

Relationships

The County's response was dependent on strong interagency relationships, but the event also showed that relationships alone cannot substitute for clearly assigned authority and operating procedures. DPSS was designated as the County's mass care and shelter lead, while the Red Cross served as the primary shelter partner and cities retained responsibility for sheltering within incorporated areas. In practice, however, shelter sourcing, facility transitions, resource requests, and closure decisions required ad hoc coordination among DPSS, OEM, Red Cross, cities, Board offices, state partners, and service providers.

The Los Angeles County Emergency Centralized Response Center (ECRC), which was established in December 2024 following a September 2024 Board of Supervisors motion, served as a centralized coordinating hub for homeless outreach, interim housing access, and County resources. Working across County departments, LAHSA, outreach teams, and local partners, the ECRC coordinated the evacuation of more than 500 people from 17 interim housing sites located in fire danger zones.[12]

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[11] *LA County Recovers*. Last referenced August 24, 2026.

[12] *Los Angeles County's Emergency Centralized Response Center*. Last referenced August 28, 2026.

The ECRC also supported the identification of alternative shelter placements, distribution of N95 masks and other resources, and outreach to unsheltered individuals remaining in affected areas. The ECRC further maintained coordination with the County EOC to support consistent information-sharing and situational awareness across the homeless services system.

In this way, the relationships and coordination mechanisms established before the fires proved valuable during the response.

Figure 48: Debris cleanup in Altadena

Resources

The County had important resources available, including Red Cross shelter databases, DPSS-trained shelter staff, DSW surge capacity, State FAST support, DMH Emergency Response Team and psychiatric services, DPH and medical partners, 211 call and care coordination capacity, hotel/voucher pathways, and provider-operated transportation for people affected by interruptions in regular transportation services. DCFS providers had evacuation plans, vehicles, and activated internal FAST Teams. Probation had facility plans, transportation arrangements, and internal DOC activation capability.

However, resource visibility was uneven. The County lacked a consistently used real-time picture of shelter availability, AFN resources, medical support capacity, long-term care beds, Short-Term Residential Therapeutic Program (STRTP) relocation options, or justice-involved community housing sites. The gap was not only whether these resources existed somewhere in the system, but whether decision-makers could identify, verify, match, and activate them quickly for the populations that needed them.

Key Challenges

The central challenge was that the County's sheltering, housing transition, and support for people at higher risk framework was not fully operationalized for a catastrophic, multi-fire incident. The scale, speed, and cascading impacts of this event would have challenged any governmental system, but they also revealed areas where County roles, decision processes, and resource visibility need strengthening. Existing plans identified shelter leadership and pre-designated shelter sites. However, key operational elements, including role clarity, escalation thresholds, decision authority, site redundancy, staffing depth, and partner responsibilities, had major gaps and required further development.

> **IN THE COMMUNITY'S WORDS**
>
> *"There was no quiet space for me to process the horrific news that my house was gone. I was so overwhelmed and couldn't process anything."*
>
> — Public survey respondent

This review found limited nearby backup shelter options before the fires began, which further limited the County's options when fire conditions affected planned locations. Staffing capacity was also constrained by reliance on a small group of experienced shelter leaders and trained AFN personnel.

As shelters opened and reached capacity, transitioned, and closed, operational gaps became more visible. Early shelter operations experienced equipment and logistics shortfalls. Many residents noted that shelters had limited medical capacity and that information about shelter locations was not consistently provided. Moreover, shelter demobilization and closure processes were not consistently integrated with housing navigation, case management, transportation, hotel placement, or longer-term recovery services. As a result, some residents faced delays or were at risk of being routed to support pathways that did not fully match their sheltering, housing, medical, or functional needs.

Using surge personnel from outside the region also created challenges in navigating Los Angeles County's complex service-provider landscape. Some personnel lacked familiarity with local referral pathways and community resources, reinforcing the need for stronger orientation materials, local resource directories, and coordination with 211LA and local service providers.

> **IN THE COMMUNITY'S WORDS**
>
> *"The convention center and Red Cross did not have any wheelchairs available. I had my husband's, but I saw other people who needed them without."*
>
> — Public survey respondent

The response also highlighted the need to better integrate the needs of people at higher risk into planning shelter and housing operations. Some older adults, AFN populations, medically fragile residents, residents without transportation, individuals with limited English proficiency or digital access, people experiencing homelessness, justice-involved individuals, youth in care or custody, and other residents requiring specialized support experienced challenges with evacuation, shelter access, housing stability, and recovery. Communities in the Eaton Fire-impacted area also experienced significant housing recovery challenges, underscoring the need for more targeted post-shelter housing strategies. Residents faced deeper recovery challenges, including households with fewer financial reserves, limited or no insurance coverage, or older homes requiring more extensive repair, smoke remediation, debris removal, and rebuilding support.

These conditions made displacement harder to resolve and increased the burden of finding stable housing, especially as Eaton Fire respondents reported high needs for home repair, air purification, debris removal, rent/mortgage help, and replacement of lost belongings.

Shelter and housing decisions directly affected residents' access to safe air, sanitation, DME, medications, behavioral health support, personal care, food and water, medical transportation, animal care, and appropriate placement options.

Some residents noted that communication about shelter locations and availability was inconsistent or insufficient. Survey responses indicate that while some residents were able to actively search for shelter information, others found the information confusing or contradictory, and a notable number reported receiving no information about shelter locations. Similar challenges emerged around short-term housing resources. Airbnb activated thousands of temporary housing vouchers administered through 211LA, providing an important pathway for displaced residents. However, limited centralized coordination and information sharing contributed to confusion about voucher availability, eligibility, and how residents could access assistance.

Future planning should focus on establishing clear coordination mechanisms among all agencies supporting shelter operations, ensuring effective communication and collaboration from shelter activation through demobilization.

What Residents Reported

Forty of the 1,500 respondents reported using a County disaster shelter, and eight reported seeking information about a family member in County custody. They are included because they are directionally consistent with what stakeholders described in interviews and working groups.

Among the 40 shelter users, the most common experience was receiving no information about shelter locations at all: 18 respondents, more than the 7 who found the location clearly communicated in initial alerts and the 9 who found it somewhat clear but had to search actively. Six reported the information was confusing or contradictory. No respondent reported arriving at

a designated shelter that was closed or full. The challenge residents encountered was informational, not capacity-related, which is the distinction SHP-F5 draws.

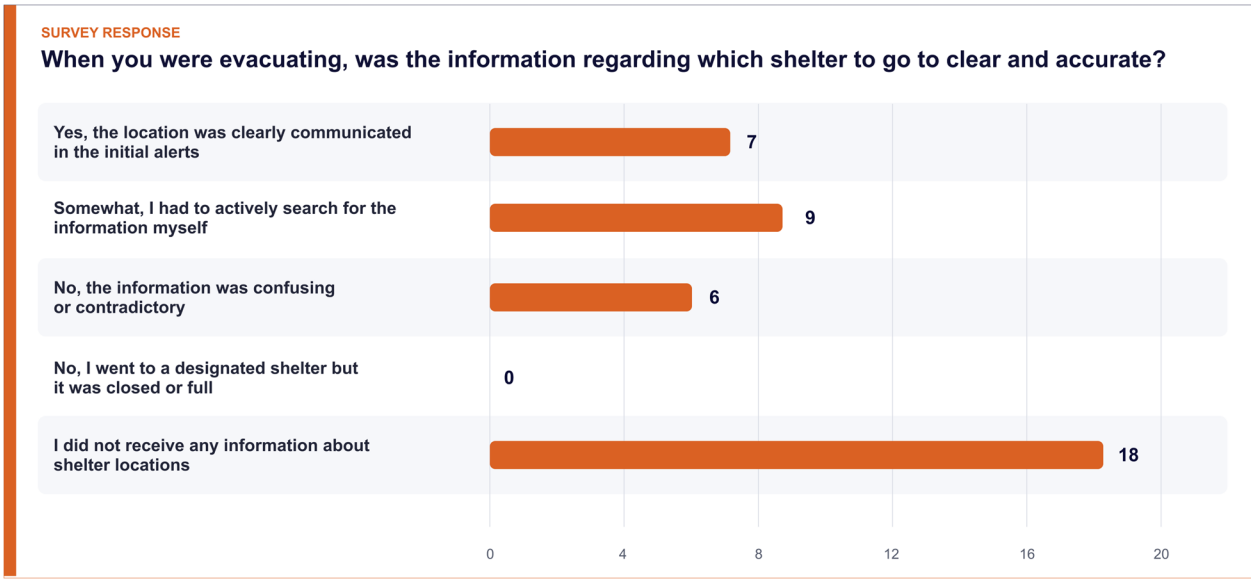

Figure 49: Bar chart on clear sheltering instructions by survey participants

Shelter use concentrated almost entirely in one site. Thirty-six of the 40 used the Pasadena Civic Auditorium, with every other listed shelter drawing one respondent or none. Stays were short: 87% reported staying one to three days.

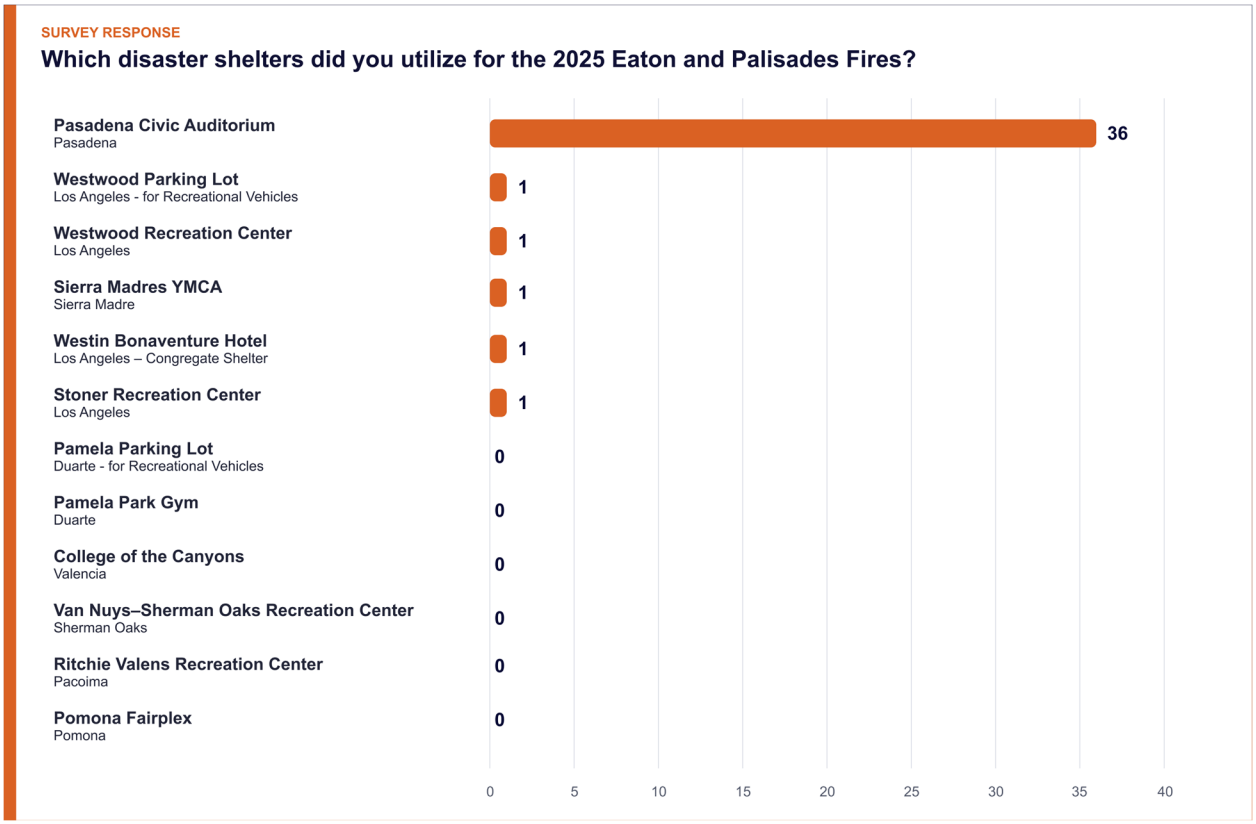

Figure 50: Bar chart on shelters utilized by survey participants

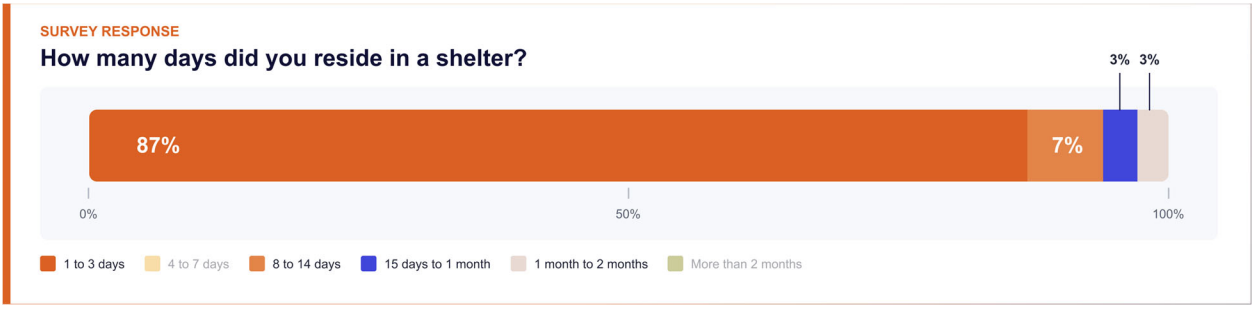

Figure 51: Stacked chart on days resided in shelters by survey participants

On whether shelters met functional needs, responses divided: 38% reported their needs were fully met, 18% partially met, and 13% not met at all, with 33% selecting not applicable. Among those reporting barriers, the most frequent was lack of quiet space or sensory overwhelm (19 respondents), well ahead of lack of medical support or supplies (4), lack of physical accessibility (2), and inadequate information in a primary language (3). Nine respondents reported no barriers.

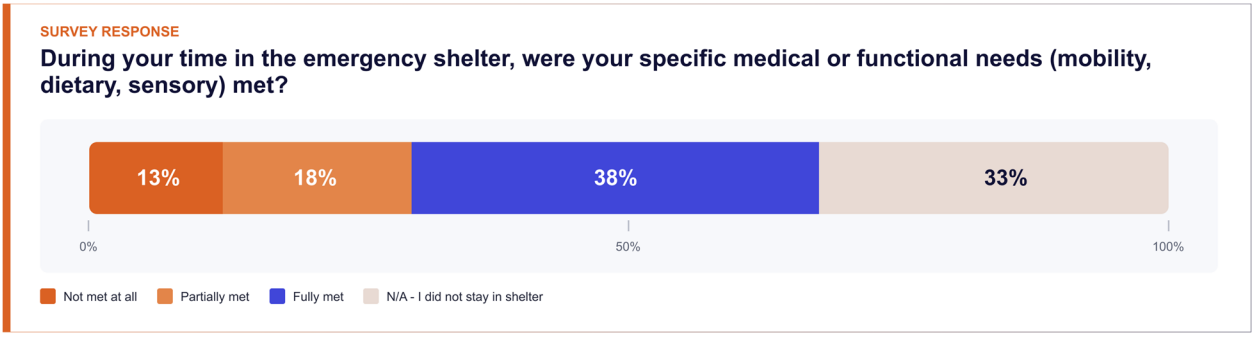

Figure 52: Stacked chart on whether shelters met functional needs for survey participants

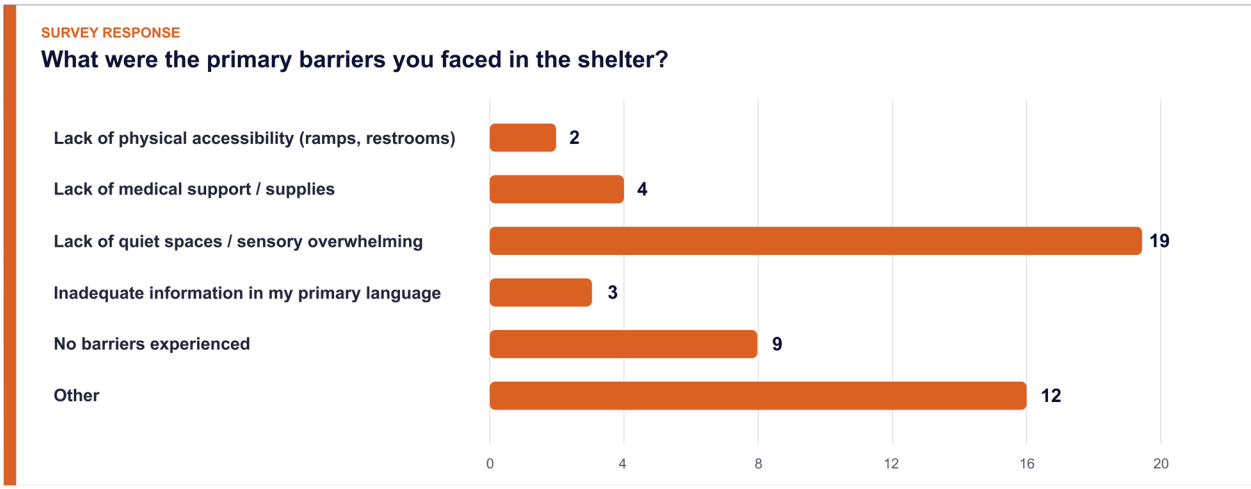

Figure 53: Bar chart on primary barriers faced in shelters by survey participants

Custody-related responses were the sparsest in the survey and the most uniformly negative. Of the eight respondents who sought information about a family member in County custody, six answered the notification item. None reported receiving timely and clear notification. Three received no information at all, two reported that information was delayed, and one received conflicting information from different sources. Eight respondents cannot support a countywide conclusion, but the absence of a single positive response is consistent with the notification gap identified in SHP-F7 and COM-F4.

Figure 54: Bar chart on notification timeliness for family member relocations of survey participants

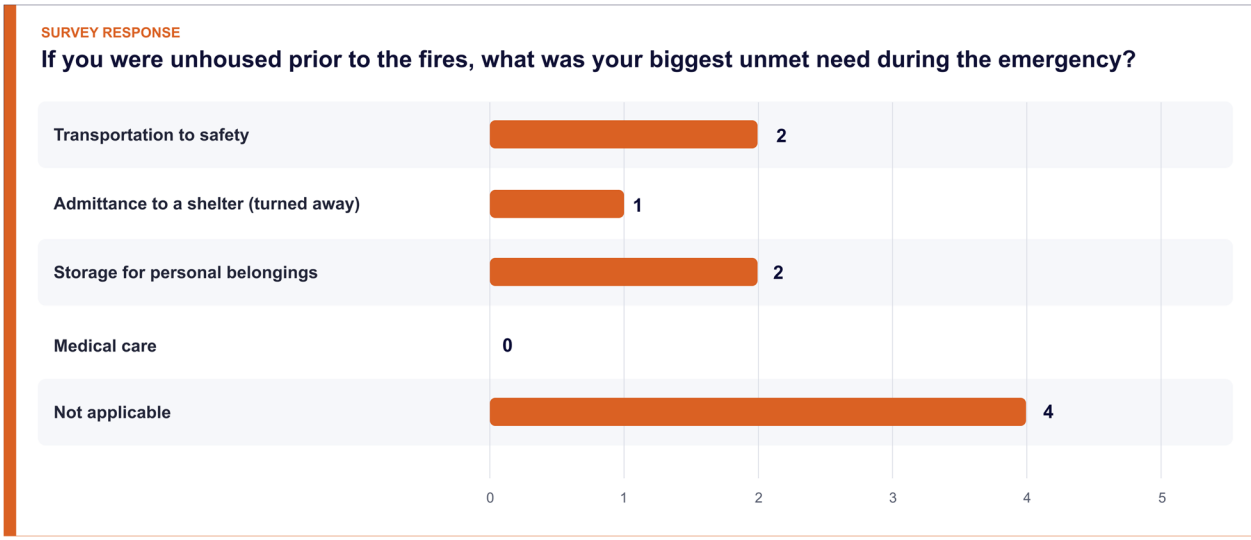

Figure 55: Bar chart on primary barriers faced in shelters by survey participants

Woolsey AAR Connection

The *AAR of the Woolsey Fire Incident* contained limited recommendations specific to shelter, housing, and people at higher risk, but the following recommendations connect to specific findings and recommendations in this report:

- *Rec #60: Update Mass Care plans, procedures, and mutual aid agreements to ensure Red Cross government-liaison personnel are present at the County EOC and DPSS Mass Care and Shelter Branch during Level 2 and Level 1 activations* connects to SHP-F1, SHP-R1, SHP-F4, and SHP-R4, which address shelter governance, site readiness, transition protocols, and multi-agency shelter coordination.
- *Rec #61: Invite DPSS and Red Cross personnel to large-scale exercises including activation of the Mass Care and Shelter Branch* connects to SHP-F1, SHP-R1, SHP-F2,

and SHP-R2, which call for recurring shelter readiness reviews, shelter governance exercises, staffing readiness, and AFN/shelter drills.

Additionally, *Rec #56: Plan for individuals requiring specific notification and evacuation assistance, in coordination with public utilities medical baseline lists* was evaluated in the *AAR of Alert Notification Systems and Evacuation Policies for the Eaton and Palisades Fires* but remains relevant here as context for SHP-F3, SHP-R3, PHA-F5, and PHA-R5, which address AFN sheltering requirements, functional support services, and a year-round AFN preparedness lead.

Priority Recommendations and Actions

The County should update the countywide shelter governance and shelter site selection process that clarifies DPSS, OEM, HSH, EMS, Red Cross, city, state, and support-agency roles. This model should establish escalation and decision rules and build a deeper senior shelter leadership bench/task force for major incidents. The model should also include a tiered, geographically redundant shelter portfolio with proximity population targets, real-time availability checks, and pre-negotiated emergency use agreements with chosen facilities.

The County should investigate establishing a shelter-to-housing transition framework that begins when shelters open, not when they are preparing to close. This framework should embed case managers in shelters early, maintain a shared resident transition tracker, distinguish pre-disaster homelessness from disaster-caused displacement, and connect residents to interim housing, hotels/vouchers, FEMA and disaster assistance, medical and behavioral health support, AFN services, and long-term housing navigation.

For people at higher risk, the County should establish a permanent AFN lead structure and expand FAST and shelter leadership capacity. The County should establish a real-time system to monitor long-term care facility evacuations and available bed capacity.

In addition, the County should build a DCFS child-location and STRTP relocation tracker. Finally, custodial and justice-involved housing plans and policies should include redundant communications and validated relocation plans.

Finding SHP-F1: Shelter governance and site planning gaps limited timely placement.

Shelter governance and site planning gaps limited coordination, decision-making, access, and timely shelter placement near impacted communities.

The County had a formal mass care framework in place, with DPSS identified as the County's Mass Care and Shelter lead and the Red Cross serving as the primary shelter partner. However, the fires exposed a gap between the existing framework and the operational demands of a catastrophic, multi-jurisdictional incident, which would have been a challenge for any governmental agency given the catastrophic nature of the multiple fires breaking out on the same day. Partner organizations generally understood their responsibilities; however, decision

authority, escalation pathways, and operational roles among DPSS, OEM, Red Cross, cities, state partners, and facility-owning departments were not always sufficiently defined to support rapid shelter site identification, activation, and transition decisions at the pace required by the incident.

The fires also highlighted limitations in the County's shelter portfolio and contingency planning. Although pre-identified shelter sites existed, several planned County locations became unavailable or unsuitable because they were too close to the fires, too far for impacted residents to travel, or faced other operational challenges. When primary locations could not be used, the County had few pre-vetted alternatives close to affected communities. As a result, partners often had to identify and evaluate facilities in real time while managing a complex response.

This challenge was not solely a question of shelter capacity, but of shelter location. Effective mass care guidance emphasizes the importance of locating shelters near impacted populations and providing access to transportation, healthcare, social services, and community support networks.

When shelter placement was delayed or located farther from affected neighborhoods, residents with limited transportation options, financial resources, disabilities, medical needs, or fewer social supports faced greater barriers to accessing services. In contrast, residents with personal vehicles, financial means, or alternative lodging options had greater flexibility to adapt.

The early stages of the response highlighted that residents with higher support needs did not always have pre-identified evacuation destinations capable of meeting their needs, underscoring the importance of a more robust and geographically distributed shelter portfolio, updated shelter governance structure, contingency shelter locations, and recurring readiness processes that validate facilities, agreements, staffing assumptions, and decision-making authorities before an emergency occurs.

Lastly, the County's temporary housing planning framework requires further development to clearly define the transition from emergency sheltering to temporary and permanent housing, including roles, responsibilities, and interagency coordination.

Strengthening these capabilities would improve coordination, accelerate shelter activation, reduce reliance on ad hoc decision-making, and support more balanced access to shelter services during future disasters.

Recommendation SHP-R1: Institutionalize a shelter governance and readiness model.

Develop and institutionalize a County shelter governance and readiness model that establishes clear decision authority, strengthens multi-agency coordination, and maintains a scalable, geographically distributed shelter network capable of supporting access during complex incidents.

DPSS, as the County's Mass Care and Shelter lead, should lead the development and updating of a formal shelter governance model that clearly defines roles, responsibilities, decision

authorities, escalation triggers, and approval pathways across DPSS, OEM, Red Cross, cities, state partners, facility-owning departments, and other key stakeholders.[13] DPSS should retain the County Mass Care and Shelter lead role because it mirrors the California ESF (CA-ESF) 6 structure. At the state level, CA-ESF 6 Mass Care and Shelter Annex identifies the California Health and Human Services Agency (CalHHS) as the lead agency for CA-ESF 6, led by the California Department of Social Services (CDSS), and states that CDSS coordinates state mass care and shelter resources in support of local government. The LA County Mass Care and Shelter Annex identifies DPSS as the government lead for Mass Care and Shelter at the Operational Area level and in unincorporated Los Angeles County, with the Red Cross as the primary support agency. However, if the County chooses to re-evaluate DPSS' role as the Mass Care and Shelter lead and designate another department, it should ensure proper staffing to handle the work and still complete a formal shelter governance model with a standing shelter leadership structure. The model should establish a standing shelter leadership structure with designated primary and alternate decision-makers and provide clear procedures for shelter activation, site identification, expansion, transition, and demobilization during large-scale incidents.

The governance model should be supported by a standardized site selection framework that prioritizes proximity to impacted communities and considers transportation access, healthcare availability, AFN, social services, and other community support systems. Consistent with mass care best practices, the County should maintain a geographically distributed portfolio of primary and contingency shelter sites to provide redundancy when planned facilities are unavailable, inaccessible, or compromised. To ensure the shelter sites are accessible, qualified, trained surveyors should validate third-party (i.e., Red Cross) ADA site assessments and maintain a current database of accessible sites to inform which locations are suitable for activation.

In addition, the shelter governance model should include a Temporary Housing Annex to establish a coordinated framework for transitioning survivors from emergency sheltering to temporary and permanent housing. The annex should assign roles and responsibilities for County departments, cities, state, and federal partners. It should also catalog disaster housing resources available through federal programs, County departments, and VOAD partners; and include a housing capability assessment checklist to support coordinated housing operations during future disasters.

To operationalize this framework, the County should implement processes for real-time facility status verification, maintain pre-negotiated emergency-use agreements, and establish procedures for rapidly activating backup facilities without requiring ad hoc legal, governance, or access approvals during an incident. Shelter site information, resource requirements, and operational assumptions should be maintained and routinely updated to support scalable shelter operations.

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[13] *California Emergency Support Function 6 – Mass Care and Shelter: Annex to the California State Emergency Plan*, July 2022. Last referenced August 24, 2026.

DPSS should convene OEM, HSH, Red Cross, 211LA, DMH, DPH, Aging & Disabilities, DCFS, cities, facility-owning departments, and other relevant partners at minimum on a quarterly basis to review shelter availability and readiness, validate staffing and resource assumptions, identify departmental capability gaps, and resolve outstanding operational barriers. These reviews should also confirm the status of primary and contingency shelter locations, validate decision-making authorities and alternates, review escalation procedures, renew emergency-use agreements as necessary, and track corrective actions for identified deficiencies.

DPSS should lead an annual focused shelter readiness assessment to verify that shelter facilities serving high-risk communities remain viable, that contingency sites can be activated rapidly, and that governance, resource, staffing, and access issues have been resolved before an incident occurs. This recurring process should strengthen whole community coordination, improve shelter scalability, and ensure access to shelter services while also supporting the transition to temporary and permanent housing for people who may need additional support during evacuation, sheltering, or recovery.

Finding SHP-F2: Shelter staffing relied on too few experienced leaders and FAST personnel.

The County had an established shelter training baseline, and the Red Cross provided experienced shelter management personnel at shelter sites, with DPSS providing staff, resource coordination, and other support to shelter operations. DMH, State FAST support, and other County and partner resources also augmented operations during the incident. While these resources supported shelter operations during a complex, multi-fire event, the response highlighted the importance of maintaining sufficient surge capacity across supporting functions, including shift coverage, logistics and resource coordination, and AFN support.

FAST capacity was particularly important because shelters received residents with mobility limitations, medical equipment needs, transportation barriers, and other AFN considerations, including long-term care residents. As the County's Mass Care and Shelter lead, DPSS was responsible for coordinating FAST support and requesting additional FAST resources when needed. During this incident, the County relied on State FAST. Although those teams were effective, California FAST guidance indicates they are intended to provide trained, ready-to-deploy personnel who conduct functional assessments, identify and track needed resources, assess needs for PAS, DME, consumable medical supplies (CMS), and medications, develop service plans, and coordinate with shelter management. The County FAST was not activated. Available data indicates that local FAST capacity was insufficient to meet incident demands, resulting in reliance on State FAST resources. During fast-moving incidents, local AFN support must deploy quickly and sustain operations over multiple weeks.

Red Cross, DMH, and DPSS' surge support helped stabilize shelter operations, but future incidents should not depend on a small number of experienced shelter leaders or external FAST support to carry the operational load. DPSS had surge capacity through trained shelter staff and

the broader County DSW system, but the DSW surge was most clearly used to support 211/call-center operations. The County needs a deeper credentialed bench, pre-assigned shift and relief rotations, clear County FAST activation triggers, EOC-linked reporting and resource-ordering processes, and recurring shelter/AFN drills that test mobilization, handoffs, AFN assessment, assistance, accommodations, resource tracking, and continuity of care from the beginning of the event through recovery.

Recommendation SHP-R2: Establish a formal shelter staffing readiness program.

DPSS should establish a formal shelter staffing readiness program that expands the pool of qualified shelter leaders, shift supervisors, logistics/resource coordination staff, and deployable FAST personnel. This will reduce reliance on a small number of experienced staff and ensure sustained 24/7 shelter and AFN operations during large-scale incidents. The program should define the number and types of staff needed for concurrent shelter operations, recruit personnel from DPSS and partner agencies, and implement a structured training and credentialing pathway for shelter management, shift supervision, AFN support, reporting, resource ordering, and care coordination.

DPSS should also maintain current rosters with contact information, role assignments, qualifications, availability, and pre-planned relief rotations; establish activation thresholds for County FAST deployment; and ensure County FAST personnel are trained and ready to conduct functional assessments, identify and track AFN resources, support PAS, DME, CMS, and medication-continuity needs, develop service plans, and coordinate directly with shelter management. Moreover, to increase local FAST capacity, the County should identify and develop a cross-departmental surge workforce by assessing personnel with comparable skills across County departments. Staff such as Community Health Workers and other personnel within DHS, DPH, DMH, other agencies, and community partners could be trained and credentialed to augment FAST operations during disasters, creating a more scalable and resilient countywide capability. Finally, DPSS should validate the staffing model through recurring shelter and AFN exercises that test rapid mobilization, leadership transitions, shift handoffs, EOC reporting, resource requests, and continuity of support over multiple operational periods.

Finding SHP-F3: Shelter and housing options were not consistently equipped for the full range of AFN needs.

Shelter and housing options were not consistently equipped or coordinated to meet the full range of medical, mobility, personal care, and continuity needs among older adults, people experiencing homelessness, and individuals with AFN.

During the Eaton and Palisades Fires, the shelters needed to accommodate older adults, people with disabilities, people from nursing homes, and residents using DME, medications, personal care, and dietary support.

Operationally, shelter staff and partners worked to address these needs through available resources, partner referrals, and case-by-case problem-solving. These efforts helped support many residents, but they also placed significant pressure on DPSS, Red Cross, DPH, DHS/EMS, DMH, Aging & Disabilities, and FAST resources. The incident demonstrated the need for clearer thresholds, stronger coordination pathways, and more scalable support options for AFN residents in sheltering.

An additional concern is for residents who are bedbound or unable to independently manage activities of daily living. These residents may require enhanced shelter support, medically supported sheltering, transfer to a licensed care setting, or other structured continuity-of-care arrangements.

Future planning best practices should assume that residents may not be able to self-navigate digital systems, arrange transportation, manage medical or functional needs independently, or rely on family support during a fast-moving disaster. Additionally, residents and caregivers should take personal responsibility to plan for their unique circumstances.

Recommendation SHP-R3: Strengthen AFN requirements in shelters and establish an AFN Coordinator.

The County should update the OAEOP and its annexes to strengthen its focus on AFN in shelter planning and operations. The County should establish an empowered AFN Coordinator position in the EOC filled by Aging & Disabilities to provide strategic oversight, operational coordination, and accountability for integrating aging, disability, medical, behavioral health, and functional support considerations across all phases of emergency management.

The County should assign and train designated AFN personnel and backups to serve in this EOC role. The AFN Coordinator should report directly to EOC leadership, maintain direct communication with the Operations, Logistics, Planning, and Finance sections, and provide cross-functional technical support throughout the response. The position should not be limited to a single function, such as mass care, but should have the authority and visibility to support AFN integration across all EOC functions and operations.

The OAEOP should clearly define agency roles, authorities, operational triggers, resource coordination procedures, and decision-making processes across County departments, incorporated cities, nongovernmental organizations, healthcare partners, and CBOs, along with the underlying processes, procedures, protocols, policies, training, exercises, and evaluation methods needed to operationalize them**.**

At a minimum, the OAEOP and its annexes should be updated to enhance or address:

- AFN evacuation planning and transportation coordination;
- Accessible alerting, warning, and public information strategies;

- Shelter site selection and accessibility standards;
- Health and Functional Support Services (HFSS) integration within general population shelters;
- DME, CMS, and medication continuity procedures;
- PAS and caregiver support;
- Functional assessment and triage processes;
- Behavioral health support and crisis counseling;
- Accessible non-congregate sheltering options (e.g., hotels, motels) and interim housing strategies;
- Reunification and caregiver continuity planning;
- Data-sharing and information management protocols; and
- Recovery, housing navigation, and long-term support services.

As part of this reevaluation, the County should establish or improve existing minimum medical capabilities for all emergency shelters, including first aid, basic health screening, medication support, DME coordination, and clear clinical escalation procedures.

The County should also look into establishing pre-event agreements with regional hospital systems and healthcare partners to support medical surge operations during disasters. These agreements should define the conditions under which temporary medical surge sites can be established adjacent to large healthcare facilities or when mobile medical clinics should be deployed near shelters so as to provide triage, assessment, and intermediate medical care for individuals whose needs exceed basic shelter capabilities but do not require hospital admission.

Expanding medical surge capacity in this manner would help preserve hospital resources for patients with acute medical needs, reduce delays in care, and minimize the risk of patients being denied or deferred treatment when hospitals are operating at or near capacity.

As part of this framework, the County should develop a regionally coordinated, medically supported shelter capability based on nationally recognized HFSS principles. Consistent with FEMA's *Guidance on Planning for Integration of Functional Needs Support Services in General Population Shelters*[14] and National Mass Care Strategy guidance[15], the objective should not be to create separate medical shelters for most residents with health-related needs, but rather to enhance general population shelters through integrated health service support, medication replacement, DME assistance, behavioral health services, dietary accommodations, personal care support, care coordination, and referral pathways to higher levels of care when necessary. This

[14] *FEMA, Guidance on Planning for Integration of Functional Needs Support Services in General Population Shelters (2010)*. Last referenced August 24, 2026.

[15] *FEMA National Mass Care Strategy, Sheltering Framework*. Last referenced August 24, 2026.

approach allows many residents with stable medical and functional needs to remain safely within community shelter environments while preserving hospital and licensed-care capacity for individuals requiring more intensive services.

This approach has proven valuable in multiple large-scale disasters. Following Hurricane Florence in 2018, researchers evaluated health and functional support services delivered across 19 Red Cross-operated general population shelters. These shelters successfully supported residents with medical and functional needs through medication replacement, diabetes management supplies, DME, behavioral health services, transportation assistance, and specialized dietary accommodations. The study concluded that many health and functional support needs can be effectively addressed within general population shelters when structured assessment processes, support services, and coordination mechanisms are in place, reducing the need for separate medical sheltering operations.[16]

Further establishing pre-disaster coordination mechanisms, including medical support resource inventories, transportation agreements, DME and medical supply caches, Medical Reserve Corps and healthcare volunteer integration, staffing plans, mutual aid procedures, accessible non-congregate sheltering options (e.g. hotels, motels), caregiver support strategies, and programs that help high-risk populations develop and maintain personal emergency plans, will strengthen the County's ability to provide timely, coordinated, and equitable support to AFN populations.

The proposed OAEOP enhancements and sheltering framework (SHP-R1) are also consistent with approaches used by other large jurisdictions facing complex emergency management challenges. San Diego County integrates AFN planning directly into its OAEOP and Medical and Health Services planning structure. San Diego County also incorporates public health coordination, Medical Reserve Corps healthcare volunteers, medical surge planning, shelter medical support, and AFN considerations into its core sheltering model rather than treating disability and aging needs as a separate function.[17] This integrated approach provides a scalable example of how health, medical, and functional support services can be embedded into general population shelter operations while maintaining continuity of care for vulnerable populations.

Given Los Angeles County's size, complexity, and estimated population of more than one million residents with AFN, this capability should be developed as a regional coordination framework supporting both incorporated cities and unincorporated communities. The OAEOP should also clearly define how County departments support local jurisdictions through public health guidance, EMS/Medical and Health Operational Area Coordinator (MHOAC) coordination, transportation coordination, facility status visibility, accessible sheltering

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[16] *Uscher-Pines, L., et al. "Health Care and Supportive Services in General Population Disaster Shelters." Disaster Medicine and Public Health Preparedness (2023)*. Last referenced August 24, 2026.

[17] *San Diego County Operational Area Emergency Operations Plan and Medical and Health Services Annexes*, 2022. Last referenced August 24, 2026.

resources, medical support capabilities, and continuity-of-care planning. Establishing this framework before future disasters would strengthen preparedness, improve continuity of care, reduce avoidable hospital utilization, support more effective evacuations, and provide clearer pathways to assistance for residents who might need acute medical interventions.

Lastly, the County already identifies 211LA through the *Alert LA* County emergency website as a 24/7 resource for people with disabilities and others with AFN. However, the County should proactively promote and integrate this resource into preparedness and response efforts by leveraging long-term care facilities, In-Home Supportive Services (IHSS) through DPSS, DPH programs, and other trusted community and healthcare networks. Targeted outreach through these existing service networks would help ensure individuals with disabilities and AFN are aware of and able to access 211LA for emergency information, referrals, and support before and during disasters.

Finding SHP-F4: Shelter transition and demobilization lacked a formal protocol.

Shelter-to-housing transition and demobilization lacked a formal, multi-agency protocol, delaying placements and increasing the risk of shelter closure outpacing resident recovery needs.

As shelters began closing, many residents described the transition as fragmented and difficult to navigate. Shelter demobilization did not appear to be consistently coordinated with housing navigation, case management, transportation, medical or behavioral health support, AFN supports, or longer-term recovery services. As a result, the move from emergency shelter to interim or longer-term housing often felt abrupt and disconnected rather than planned, documented, and supported.

The planning gap was the absence of a shared shelter transition and closure protocol among DPSS, Red Cross, CEO-HI (now HSH), LAHSA, DMH, DPH, DHS, 211LA, and community providers. National guidance[18] and after-action lessons emphasize that successful shelter transition requires early multi-agency coordination, embedded casework, clear roles, a common case information process, and active matching of each resident to appropriate housing and services before closure.

Plans also did not provide clear, trauma-informed triage criteria to distinguish people experiencing homelessness before the fires from people who became displaced or unhoused because of the disaster. That distinction mattered because different populations may require different funding sources, eligibility pathways, case management models, service providers, and placement options. Without embedded case managers and a shared resident transition tracker, remaining shelter residents were at risk of misclassification, delayed placement, repeated assessments, or routing to an inappropriate support system. This affected people experiencing

[18] *FEMA Pre-Disaster Housing Planning Guide*, April 2024. Last referenced August 24, 2026.

homelessness before the fires, newly displaced fire-impacted residents, older adults, people with disabilities, medically fragile residents, and residents without transportation or family support.

Recommendation SHP-R4: Establish a formal shelter transition and demobilization protocol.

The County should establish and exercise a formal shelter transition and demobilization protocol, jointly led by DPSS and HSH and implemented through a multi-agency Shelter Transition Team.

The protocol should be developed with the Red Cross, DMH, DPH, DHS, 211LA, DCFS, community-based providers, disability and aging partners, transportation providers, and recovery case management partners. At a minimum, it should define agency roles and decision rights; establish closure triggers and transition planning timelines before shelter populations plateau; deploy embedded case managers and housing navigators early; and require a shared resident transition tracker or system of record that captures housing status, eligibility pathway, service needs, AFN considerations, transportation requirements, medical or behavioral health considerations, responsible case owner, next-step placement, and handoff status.

The protocol should include trauma-informed triage criteria to distinguish residents experiencing homelessness before the disaster from those newly displaced by the incident so that each group is routed to the appropriate funding source, case management model, and placement option. FEMA guidance on identifying pre-disaster housing status can help the County establish consistent screening criteria, documentation standards, and referral pathways for making this distinction during future disasters.[19] Before any shelter closes, DPSS as the County's Mass Care and Shelter Lead, should require a documented disposition plan for every remaining resident, including confirmed next-step placement, warm handoff to the receiving provider if appropriate, transportation plan, and a clear process for raising urgent concerns to the right decision-makers where it relates to medically fragile individuals, older adults, people with disabilities, residents with behavioral health needs, and others with multiple access needs.

The County should train and exercise the protocol in advance and apply it consistently across shelter operations, so no resident is discharged to unsheltered homelessness or an unsafe temporary setting when an appropriate placement, service linkage, or process for raising concerns is available.

The Temporary Housing Annex recommended earlier in this report is a valuable addition to this protocol and should be integrated into the shelter transition process. It will provide a coordinated roadmap for moving survivors from emergency sheltering to temporary and permanent housing by clearly defining agency roles, intergovernmental coordination, housing resources, case management, and wraparound support throughout recovery.

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[19] *FEMA: Pre-Disaster Housing Planning Guide*. Last referenced August 28, 2026.

The recovery process should also use the significant resources mobilized following a disaster to help individuals experiencing homelessness transition toward stable housing, where feasible, rather than returning individuals to pre-disaster homelessness. This should include early connections to housing navigation, case management, benefits, and available interim and permanent housing resources as part of the broader recovery effort.

As the newly established department leading the County's homelessness response, HSH should develop and implement a standardized protocol to distinguish individuals experiencing homelessness before a disaster from those newly displaced by the incident. The protocol should establish clear triage criteria and referral pathways that connect fire-displaced residents to appropriate disaster recovery and housing assistance programs outside the homeless services system whenever feasible, preserving limited homelessness resources for those experiencing homelessness prior to the Fires while ensuring equitable access to recovery services.

Lastly, the County should investigate establishing a homeless liaison role in the County EOC filled by HSH, with clearly defined responsibilities during emergency activations, sharing situational awareness regarding impacted homeless services and housing programs, coordinating resource and service needs, and supporting cross-departmental decision-making throughout response and recovery operations.

Finding SHP-F5: Public shelter and housing information was fragmented.

Residents, field staff, Board offices, and partner agencies had to rely on multiple information sources to determine which shelters were open, what services were available, where transportation could be accessed, how hotel or voucher programs worked, and what options existed for pets, service animals, or animal sheltering. The County lacked a single public-facing information architecture that integrated shelter status, housing pathways, transportation, AFN supports, recovery resources, and animal care guidance in one coordinated location.

This fragmentation conflicted with emergency communication best practices, which emphasize timely, accurate, consistent, and coordinated public information during crisis conditions. Residents needed simple, decision-ready answers: where to go, whether a site was accessible, whether pets or service animals could be accommodated, whether transportation was available, whether hotel options existed, and what documentation or eligibility requirements applied. When those answers were spread across multiple agencies, websites, hotlines, press conferences, social media accounts, and field channels, the burden shifted to residents and frontline staff to assemble the system themselves.

The burden was not evenly distributed. Residents with reliable internet access, English proficiency, transportation, time, and strong social networks were better positioned to navigate fragmented information. Older adults, people with disabilities, limited-English-proficient residents, people without digital access, transportation-dependent residents, and pet owners faced higher risk of delay, confusion, or non-evacuation. This is especially important because

evacuation and sheltering guidance recognizes that transportation, sheltering, accessibility, location, service animals, and household pets must be planned as connected components, not separate information streams. A single multilingual shelter-and-housing hotline and digital hub would reduce that burden by providing real-time, location-based information on human shelters, animal shelters, service animal accommodations, pet reunification, hotel/voucher options, transportation, AFN supports, and recovery services.

Recommendation SHP-R5: Establish a single multilingual shelter and housing information system.

Establish a single, multilingual shelter-and-housing information system, anchored by a centralized digital hub and supported by a live hotline, that serves as the County's public source of truth for sheltering, interim housing, transportation, animal services, AFN supports, and recovery resources.

The County should designate a centralized emergency information website as the official public-facing source of truth for shelter and recovery information and pair it with a live hotline like 211LA for residents who cannot easily access, understand, or navigate online resources. The system should be activated at incident onset and maintained through a clearly assigned operational owner responsible for content updates, quality control, and cross-department coordination. At minimum, the County should define who updates shelter status, transportation availability, hotel or voucher information, accessibility accommodations, animal sheltering guidance, pet reunification information, and recovery-service links. It should also establish update intervals, verification standards, and escalation procedures so information remains current during rapidly changing conditions.

Across the United States, 211 systems are routinely integrated into disaster response and recovery operations as centralized public assistance pathways. United Way reports that 211 helps communities during disasters by directing residents to shelters, evacuation information, food, water, housing assistance, transportation resources, and recovery services. During disasters, 211 centers often coordinate with government agencies and can absorb surge call volumes when local systems are overwhelmed.[20]

California jurisdictions have increasingly integrated 211 into emergency information systems. 211Now (serving portions of California) operates dedicated disaster and community distress resource portals that aggregate emergency alerts, disaster resources, power outage information, and recovery services into a centralized public-facing platform.[21]

Virginia's statewide 211 system provides a useful example of a consolidated information hub that combines web, phone, text, chat, and referral services into a single public assistance platform.

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[20] *United Way 211 – Our Impact*. Last referenced August 24, 2026.

[21] *211 Now*. Last referenced August 24, 2026.

Residents can access housing, transportation, disability-related services, healthcare, and emergency assistance through one portal and one phone number.[22]

The County should operate this system using Joint Information System principles: one coordinated public message, distributed consistently through many channels. Emergency alerts, press briefings, social media posts, field communications, call center scripts, Board office materials, partner messaging, and 211 referrals should all direct residents to the same website and phone number. To support this, the County should develop pre-scripted messages, visual templates, multilingual language-access protocols, and plain-language call scripts before the next incident. Departmental PIOs, call takers, field staff, shelter staff, animal-care partners, and recovery partners should be trained on when and how to use them.

The digital hub and hotline should prominently surface the information residents need to make immediate decisions: which shelters are open, exact locations and hours, current capacity when available, accessibility features, transportation pickup points or options, eligibility or documentation requirements, whether pets are accepted, where animal sheltering or pet reunification services are available, and how to access hotel, voucher, or other interim housing programs. Information for residents with disabilities and others with AFN should appear near the top of the page in a highly visible location. 211LA should also be elevated as a primary assistance pathway during emergencies rather than embedded deep within the site.

The County should also treat animal sheltering information as a core evacuation and sheltering function, not a secondary resource. Public messaging should clearly distinguish service animal access, household pet sheltering, co-located or separate animal shelter options, transportation considerations for animals, reunification resources, and documentation expectations. This should be tested before disasters because lessons from prior events show that residents may delay or refuse evacuation when they do not have clear, trusted options for their animals.

Finally, the County should routinely test the hub, hotline, scripts, and partner messaging through exercises, accessibility reviews, multilingual user testing, and AARs. These tests should verify whether residents can quickly answer the practical questions that determine evacuation and sheltering behavior: *Where can I go? How do I get there? Can I bring my animal? Is the site accessible for my mobility, medical, language, or caregiving needs? What should I bring? Who can help me if I cannot evacuate on my own?*

Finding SHP-F6: Relocation tracking for children in care was not standardized.

Evacuation and placement efforts for children in DCFS care generally safeguarded their immediate safety; however, processes for tracking relocations and planning alternate placements were not consistently standardized.

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[22] *211 Virginia*. Last referenced August 24, 2026.

The fires affected a significant number of children and youth under the care of DCFS. DCFS reported 224 children who were impacted by the Eaton Fire, another 41 children who received support in the area, and 105 children with open cases in Palisades, for a total of 370 child-related cases**.** DCFS demonstrated several strengths in their response during the fires. The department conducted safety checks, supported impacted caregivers and families, provided hotel/voucher connections, distributed go-bags and gift cards, tracked school continuity, and worked with providers to identify temporary placements. These actions helped protect children's immediate safety and basic needs during a fast-moving incident. In some cases, DCFS coordinated with the State to approve youth being out of their homes during evacuation and displacement.

DCFS conducted safety checks and supported impacted caregivers and families. In partnership with faith-based organizations (FBOs), the department connected families to hotel vouchers, distributed go-bags and gift cards, and identified families needing grant assistance from FBOs and CBOs. DCFS faith partners also provided food box giveaways and water packages in local communities to support children, youth, families, and caregivers impacted by the fires. The department also tracked school continuity and worked with providers to identify temporary placements.

The main gap was that relocation tracking and alternate placement planning were not standardized across the system. DCFS had emergency procedures and provider plans, but the response relied on rudimentary spreadsheets, provider updates, iTrack (an incident tracking system used by DCFS), incident reporting, and staff-level coordination rather than a live child-location and placement-status dashboard. iTrack served as an incident-reporting mechanism, not a real-time child-location system. That distinction matters because children in County care require continuous accountability for location, caregiver/provider contact, assigned worker, transportation, medical/behavioral health needs, school continuity, visitation, and return-to-placement status.

As the fire spread, one STRTP received fire damage, and three of their providers were impacted; children had to be moved, and staff had to find open STRTP beds or temporary/transitional shelters. One provider moved youth to a hotel after losing its rented location. Evacuations relied largely on provider emergency plans, provider vehicles, daily communication with DCFS, and special incident/iTrack updates. Although youth were kept safe, relocation required real-time problem-solving and ad hoc placement searches rather than a standardized STRTP relocation matrix with pre-identified backup beds, receiving sites, transportation assets, hotel protocols, and continuity-of-care requirements.

DCFS' contracts with the STRTPs mention a Plan of Operation and Program Statement and require services according to that plan, but the master contracts do not include a detailed

emergency operations annex.[23] The contracts are strong on monitoring, records, insurance, audits, corrective action, and 24-hour incident reporting. They allow County monitoring and require records to be available during and after disasters, but they do not clearly require real-time evacuation status reporting, backup lodging agreements, transportation capacity, AFN plans, or disaster drills.

Although DCFS provided assistance to impacted caregivers and families, foster parents, relative caregivers, and biological families with open cases often relied on their own arrangements for evacuation and temporary lodging, including hotels, shelters, family members, and other temporary accommodations.

A more standardized DCFS support pathway could help families develop individual emergency plans before a disaster and quickly access lodging, transportation, financial assistance, essential supplies, and continuity of medical care, behavioral health, education, and other services during emergencies.

These considerations reinforce the importance of establishing standardized relocation and continuity-of-care procedures for children in DCFS care, particularly youth in STRTPs. Planning should address alternate placements, transportation, location tracking, continuity of medications and behavioral health services, education, visitation, and other essential supports. Establishing these procedures in advance would strengthen DCFS and provider readiness and reduce reliance on ad hoc coordination during future emergencies.

Recommendation SHP-R6: Create a real-time dashboard and readiness standards for children in care.

During this incident, child tracking was too manual and not real-time enough. In addition, the evacuation of children appeared to depend heavily on individual provider emergency plans and available transportation arrangements, rather than on a centralized DCFS-led process with standardized expectations. Therefore, a real-time emergency dashboard is needed that pulls from placement data, GIS, iTrack, STRTP reports, and social worker updates. It should show each child's current location, caregiver, evacuation status, hotel/shelter location, transportation status, medical needs, school status, AFN considerations, and unresolved needs.

As DCFS develops the dashboard, it should establish interim requirements to strengthen provider-level disaster preparedness. Specifically, DCFS should require STRTPs and related contracted providers to incorporate measurable disaster-readiness standards into their contracts, including annual emergency drills and tabletop exercises. A relocation playbook also needs to be established with pre-identified alternate STRTP beds, hotel protocols, and transportation assets. This will reduce the ad hoc coordination during a disaster of this scale and speed. Additional

[23] County Provided: *Master Contract for STRTPs b/w LA County and Five Acres – The Boys and Girls Society of Los Angeles*, January 2019. Last referenced August 24, 2026.

Emergency Disaster Services Section (EDSS) staffing and funding would help ensure DCFS and its providers can sustain annual emergency drills and tabletop exercises.

DCFS should partner with HSH to leverage its experience managing contracted provider networks and develop consistent emergency coordination protocols for youth-serving providers across the County.

During active evacuation or displacement, DCFS should require immediate provider notification and updates every 2–4 hours until every child is confirmed safe and stable. The 24-hour standard can remain for routine movement, but not for active disasters. A data tracker that consolidates resident needs and shares them with faith-based partners such as CarePortal would be very beneficial, enabling rapid, prepared support during crisis situations.

DCFS may also consider developing a pre-established evacuation and lodging support protocol for foster parents, relative caregivers, biological families with open cases, and youth in out-of-home care.

An emergency of this scale requires an immediate and flexible funding mechanism to address urgent child, caregiver, and provider needs. DCFS should establish an emergency assistance fund with authority for same-day use during disasters and other large-scale emergencies.

Additionally, DCFS should establish a countywide standard for emergency support go-bags, gift cards, and similar assistance that are issued automatically to all impacted children and families based on defined need, not on whether a Children's Social Worker (CSW) requests them or to which office the family is connected. The standard should also include procedures to support educational continuity by ensuring timely coordination with schools, transportation providers, caregivers, and educational agencies so children can resume attendance as quickly as possible following evacuation or displacement.

For children with disabilities, DCFS should also create a child-specific AFN emergency plan, including medical needs, behavioral health needs, communication, mobility, and medication needs, DME, service animals, continuity of education, and caregiver support needs.

Lastly, the County should establish a standing DCFS liaison role within the County EOC during major incidents with the authority to coordinate child welfare needs in real time, including provider status, child and caregiver relocation, sheltering, and transportation.

Finding SHP-F7: Custody and justice-involved planning and communication need development.

Probation's shelter-in-place and monitoring approach worked for this event because Campus Kilpatrick did not ultimately require evacuation. Probation had a plan to move youth if conditions worsened, had vans and buses ready, and had its DOC open to monitor multiple fires. DMH also indicated that mental health clinicians would be redirected if youth were moved so services could continue. These are important strengths and should be retained.

Figure 56: County agencies coordinating wildfire response and recovery efforts

However, the incident showed that custodial evacuation planning must mature from a preferred-site model to an all-hazards, multi-site, continuously validated contingency model. Best practice for juvenile residential facilities calls for written, exercised, and regularly revised plans developed with emergency management, law enforcement, courts, child welfare, medical, mental health, and other community partners. In a multi-fire incident, backup sites must be checked in real time against fire perimeter, smoke, road access, power, staffing, security, medical capacity, appropriate transportation, and bed availability. During the fires, stakeholders noted that Barry J. Nidorf Juvenile Hall had been identified as a potential receiving facility for evacuated youth. However, because the facility was also located near the Hurst Fire impact area, its suitability as a receiving site became uncertain. This illustrates why primary and secondary receiving locations should not be assumed to remain available during a regional disaster and should instead be validated through real-time GIS analysis and operational assessments before use.

Public and partner communication also require strengthening. Site-level phone calls, emails, and texts may be manageable for a small camp population but are not scalable for larger facilities such as Barry J. Nidorf or Los Padrinos. Correctional emergency guidance emphasizes clear communication channels, information-sharing protocols, and joint exercises so emergency information reaches staff, people in custody, leadership, and partner agencies. Probation's DOC-level communications should therefore include direct, redundant channels to Los Angeles County Office of Education (LACOE), Board Offices, DMH, nursing/medical staff, ISD[24], legal representatives, oversight bodies, and parents/guardians rather than relying on third-hand facility-level communication.

For justice-involved individuals outside secure facilities, the incident also exposed a planning gap. Probation indicated that it does not manage housing placements for individuals in

[24] *ISD – Management Services Manual*, 2008. Last referenced August 24, 2026.

supportive or step-down settings and that its emergency management function did not have a clear understanding of the department's operational relationship with JCOD or Department of Youth Development (DYD). Because these placements may be dispersed across small contractor-operated homes, they may be harder to identify, contact, evacuate, and support than large County-operated facilities.

DCFS used GIS and Child Welfare Services/Case Management System (CWS/CMS) data to identify youth and non-minor dependents in affected areas and shared that information with Probation Child Welfare, which coordinated daily outreach with impacted providers, youth, caregivers, and families to confirm safety and identify relocation or resource needs. Probation leadership and assigned officers coordinated relocation plans, while caregivers provided transportation and ongoing support, with regular updates shared across CDSS, DCFS emergency services, and Probation emergency management teams.

In addition, individuals in custody cannot self-evacuate, choose alternate shelter, independently manage medical or behavioral health continuity, or freely communicate with families and advocates. Justice-involved individuals in community placements may also face supervision restrictions, behavioral health needs, transportation barriers, or program rules that limit independent action. Plans should include protocols for pre-evacuating individuals with complex needs when conditions warrant, allowing sufficient time to coordinate appropriate transportation, staffing, receiving locations, and continuity of care, and reducing the risk of injury or delays associated with late-stage evacuations.

Recommendation SHP-R7: Jointly update shelter plans for custody and justice-involved populations.

Probation, LASD, OEM, DMH, EMS, DPH, LACOE, LACoFD, JCOD, DYD, and relevant housing and contracted-service partners should jointly update wildfire shelter-in-place and evacuation annexes for secure facilities and community-based placements. The annexes should use an all-hazards planning approach, assign Incident Command System (ICS)-aligned lead and support roles, and identify primary, secondary, and contingency receiving sites for each population.

At a minimum, agencies should verify receiving sites during an incident against current wildfire perimeter, smoke, road closure, power, staffing, security, medical, behavioral health, and bed-capacity conditions. Plans should identify transportation assets, embarkation points, temporary refuge options, medication and medical-support requirements, security requirements, and decision thresholds for when to shelter in place, relocate internally, transfer to another County facility, or move to an alternate care or temporary refuge site.

Future plans should also incorporate GIS-based validation of receiving and backup sites; continuity of education coordinated through LACOE; public health decision thresholds established with DPH; continuity of medical, behavioral health, supervision, and security

services; and redundant notification systems for parents, guardians, family members, legal representatives, continuity partners, oversight bodies, and people in custody.

Finally, these annexes should be validated through GIS-based scenario reviews, tabletop exercises, transportation drills, and multi-agency AARs. Updates should be incorporated on a recurring basis, so procedures remain current, coordinated, and executable under multi-fire conditions.

Finding SHP-F8: Justice-involved community housing lacked a countywide coordination model.

Justice-involved adults and youth living in JCOD, DYD-contracted, or community-based step-down and supportive housing were not covered by a clearly defined countywide emergency coordination model.

During the incident, this created unclear ownership for identifying and locating residents, tracking resident status, coordinating evacuation or shelter-in-place decisions, arranging accessible transportation, maintaining supervision requirements, and continuing behavioral health, medical, medication, case management, and court-related services during displacement.

This gap is significant because best practice for emergency management calls for an all-hazards, multiagency coordination structure with clear roles, resource-request pathways, interoperable communications, and shared situational awareness. It also requires advance planning for people with AFN, including individuals who may need transportation support, medical or behavioral health continuity, communication assistance, medication access, or help evacuating safely. Justice-involved individuals in smaller contractor-operated homes or dispersed community placements may be less visible than individuals in County-operated facilities, making them harder to identify, locate, transport, supervise, and support during fast-moving emergencies.

The absence of a countywide protocol increased the risk that these individuals would not be consistently incorporated into emergency notifications, evacuation planning, resident tracking, shelter decisions, continuity-of-care planning, or post-evacuation reunification and supervision processes. This increases the risk that their safety, legal status, supervision, and service needs will not be addressed in a timely or coordinated manner.

Recommendation SHP-R8: Adopt a justice-involved community housing coordination framework.

JCOD, DYD, Probation, OEM, DMH, DPH, EMS, and contracted providers should jointly develop and adopt a *justice-involved community housing emergency coordination protocol* aligned with the National Incident Management System (NIMS)/ICS and County emergency operations procedures. The protocol should define agency ownership, decision rights, activation thresholds, and resource-request pathways for each justice-involved population and placement

type, including County-operated facilities, contractor-operated homes, dispersed community placements, and supportive housing settings.

At a minimum, the protocol should assign a lead coordinating agency and backup lead for each placement type; identify primary and alternate points of contact for each department and provider; establish common incident notification, situation reporting, escalation, and resource-request procedures; and define how provider-level information will flow into the County's emergency coordination structure. It should also require a secure, regularly updated, GIS-enabled inventory of sites and residents, including site access information, current resident census, supervision restrictions, transportation needs, mobility or medical considerations, behavioral health and medication needs, communication needs, service-provider contacts, and potential receiving locations. This inventory should be usable during an incident to support hazard-zone analysis, evacuation prioritization, transportation deployment, resident accountability, and continuity-of-care decisions.

The protocol should require each provider and responsible County department to maintain site-specific emergency plans covering evacuation, shelter-in-place, transportation, reunification or family/caregiver notification where applicable, resident accountability, staffing, communications, and continuity of operations. These plans should specify how residents will be accounted for; how accessible transportation will be requested and prioritized; where residents will relocate if evacuation is required; how supervision and court-related requirements will continue; and how behavioral health services, medication access, medical care, case management, and other essential supports will be maintained during displacement.

To support execution, the County should establish standardized status categories and real-time reporting requirements for resident location, evacuation status, unmet needs, transportation requests, staffing limitations, service disruptions, and receiving-site capacity.

Annually, providers should be encouraged to conduct tabletop and operational exercises that include both dispersed homes and larger supportive housing sites, test transportation and resident-tracking processes, document corrective actions, and assign owners and deadlines so identified gaps are resolved before the next high-risk period.

Lastly, the County should conduct a formal assessment of Less Restricted Placements (LRPs) to evaluate their operational benefits, emergency preparedness challenges, communication requirements, and potential County liability during disasters. Based on this assessment, the County should determine whether LRPs remain a viable placement model and establish clear departmental ownership, contact protocols, and emergency responsibilities for any continued use.

Critical Focus Area #6: Public Health and Access and Functional Needs

Introduction

This fire event required a sustained public health posture that evolved well beyond the initial wildfire response. Although DPH was not the incident lead, they became an essential support agency for health-related decision-making.

Under LAC-ESF #8: Public Health and Medical Services, DPH's role aligned with coordinating and supporting public and environmental health needs during the incident, particularly where wildfire conditions created risks for displaced residents, people with health-related needs, care facilities, response workers, and communities with AFN. LAC-ESF #8 also reinforced DPH's responsibility to translate health risks into operational guidance, support healthcare and shelter systems, assist with exposure reduction, and coordinate public health messaging and recovery priorities within the broader emergency management structure.

Figure 57: Distribution of Public Health Supplies

In practice, DPH supported a wide range of public health activities, including shelter health operations, environmental health guidance, public health orders, exposure reduction, outreach to healthcare providers, PPE guidance and distribution support, DRC operations, and recovery coordination.

DPH's role expanded as the County moved into reentry, repopulation, debris removal, environmental assessment, and long-term recovery. It shifted from providing specific public health support services to helping translate complex health risks into clear, practical guidance for residents, workers, care facilities, and AFN populations.

> **IN THE COMMUNITY'S WORDS**
>
> *"I did get my soil tested through CAPLA… I was interested in whether I could eat the food in my garden as we had high levels of arsenic in our soil. The LA county dept of health was able to finally get me some assurances."*
>
> — Public survey respondent

DPH also supported PPE distribution planning and coordination to help reduce exposure risks for response personnel and affected residents. During the rebuilding phase, DPH continued to

support recovery by assisting with septic system clearance and related environmental health reviews needed to help residents safely move forward with repair and reconstruction.

The County's AFN response relied on a network of agencies and partners, including Aging & Disabilities, DPH, DPSS/IHSS, EMS/MHOAC, 211LA, independent living centers, CBOs, and shelter/recovery partners. The AFN response included Aging & Disabilities using its known networks, Area Agency on Aging clients, Adult Protective Services, a program within Aging & Disabilities, contracted providers, independent living centers, and the emerging Aging and Disability Resource Center (ADRC) structure, to identify and support older adults and people with disabilities, while recognizing that the County did not have a complete universe of all AFN residents. Aging & Disabilities prioritized residents with the greatest social and economic need, coordinated with OEM, DPSS, Parks and Recreation, City of LA Aging partners, contractors, and grantees, and helped connect impacted residents to meals, case management, caregiver support, respite, material aid, clothing, DME, and recovery navigation. The department also had representation in the Unified Coordination Group (UCG) and EOC, which helped keep AFN considerations visible in countywide coordination and supported cross-agency alignment on outreach, sheltering, transportation, and recovery needs.

This section evaluates public health system performance in response and recovery, with particular attention to DPH's role, its LAC-ESF #8 support responsibilities, and its decision authority. The analysis distinguishes between resource constraints and governance gaps, including where DPH had clear authority to act, where it functioned as a technical advisor or coordinating partner, and where broader emergency management structures shaped the timing, scope, and implementation of public health decisions.

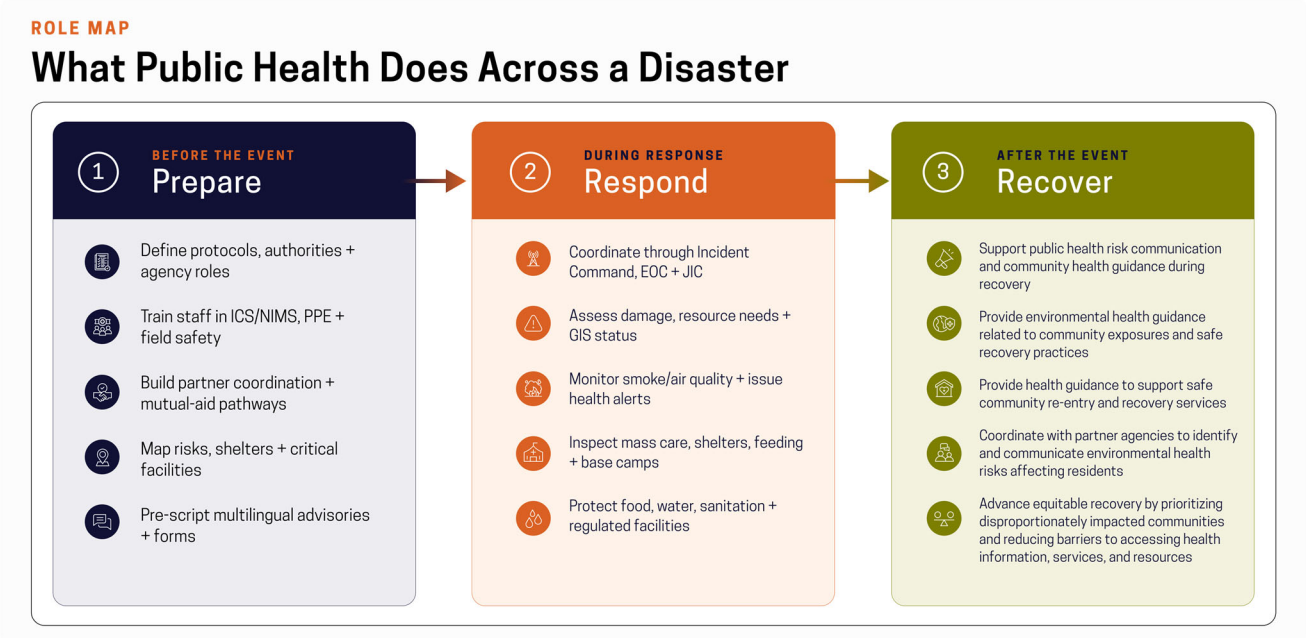

Figure 58: Role of DPH during a Wildfire

Strengths and Best Practices

DPH demonstrated important strengths in areas where its public health authority and technical expertise were clearly applicable. The local health emergency and associated Health Officer actions provided a mechanism to reduce exposure to wildfire ash, debris, and particulate matter during early recovery. Health Officer Orders addressing unsafe fire debris removal and the use of power air blowers in burn areas were practical tools for reducing avoidable exposure risks as residents and workers began returning to affected areas.

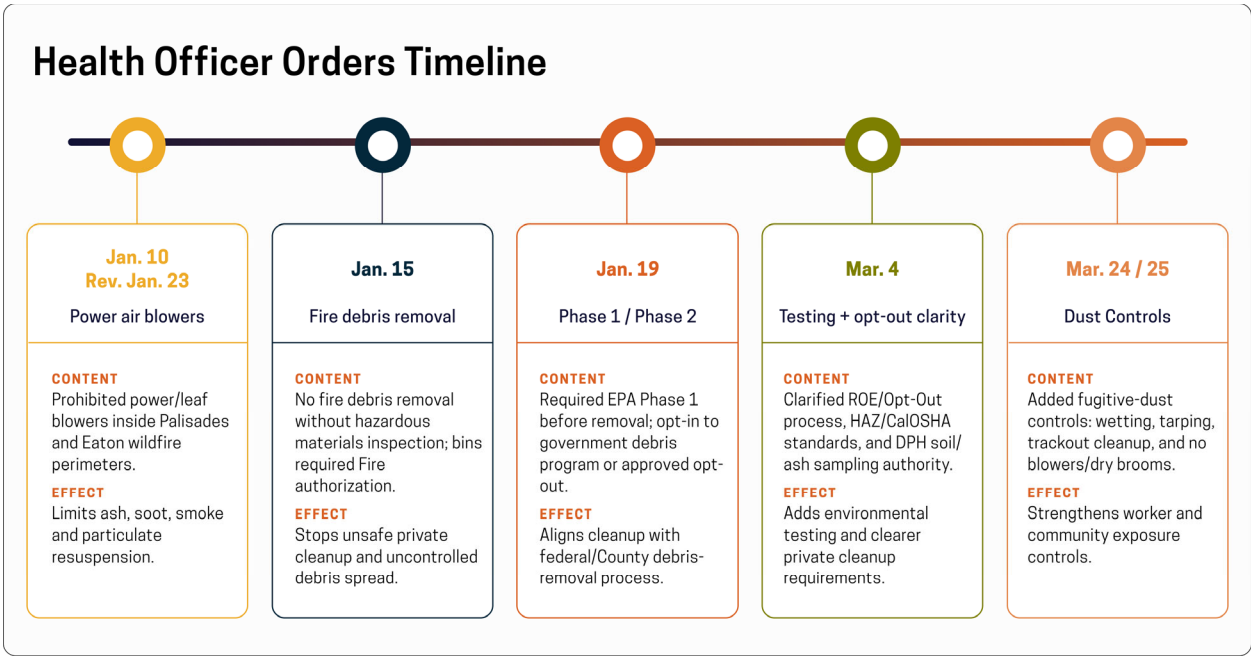

Figure 59: Timeline of Health Officer Orders issued during the January 2025 Wildfires

DPH also adapted quickly to meet urgent health risk mitigation needs. It amplified guidance on smoke, ash, outdoor exposure, cleanup safety, respirator use, and environmental hazards, often in coordination with the South Coast Air Quality Management District (AQMD). Messaging addressed residents returning to burn areas as well as higher-risk groups, including children, older adults, pregnant people, people with respiratory or cardiovascular conditions, outdoor workers, unhoused residents, and displaced shelter populations.

The Health and Social Services Task Force was a major recovery strength. In recovery, DPH helped convene public health, mental health, social services, environmental health, benefits access, schools, childcare, partners working with people at higher risk, CBOs, and other agencies into a shared structure. This provided a mechanism to identify community needs, coordinate partner actions, and elevate emerging issues that crossed departmental boundaries.

DPH's rapid needs assessment also provided a useful model for resident-centered recovery. The assessment helped identify unmet needs in housing, health, mental health, financial, environmental, and essential goods and supported referrals to partners. The later Rapid Needs

Assessment report documented 2,306 responses across Eaton and Palisades Fire-impacted areas and identified widespread displacement, worsening mental health, worsening physical health, health concerns about proximity to burned areas, and confusion about recovery information.

DPH's environmental health coordination evolved into another best practice. The Department helped coordinate public-facing information on soil, water, air, blood lead testing, and related health concerns through dashboards, town halls, partner briefings, and public guidance. These tools improved transparency and created a more credible place for residents to find studies from academic institutions, government agencies, and research organizations. The dashboard was a valuable resource, though it may have had greater impact had it been available earlier in the response, before public uncertainty began to build.

Relationships

Preexisting relationships helped the County move faster than it otherwise could have. DPH, EMS/MHOAC, DHS, DMH, OEM, Aging & Disabilities, DPSS/IHSS, 211LA, AQMD, local jurisdictions, CBOs, healthcare partners, and academic and nonprofit partners all contributed to some part of the response or recovery ecosystem. Relationships developed through COVID-19, emergency preparedness work, the healthcare coalition environment, and existing public health emergency structures helped DPH stand up coordination forums, connect with partner agencies, and manage a broad range of health concerns.

Further, establishing the Health and Social Services Task Force and creating a dedicated Vulnerable Populations Subcommittee strengthened collaboration, coordination, and communication across agencies. These groups provided a structured space for service providers, community partners, and key stakeholders to come together, identify shared priorities, and respond more effectively to the needs of people at higher risk.

At the same time, the event showed that relationships alone cannot substitute for formal role clarity. Several functions depended on real-time problem-solving or informal escalation rather than pre-assigned responsibilities. This was particularly evident in PPE distribution, AFN outreach, environmental testing interpretation, reentry consultation, and long-term care placement coordination.

The opportunity to improve is not to replace relationships with bureaucracy, but to formalize the strongest relationships into standing partner networks, liaison assignments, shared contact lists, joint exercises, data-sharing protocols, and pre-scripted decision pathways.

Resources

DPH and partners used a mix of formal authorities, existing public health systems, leftover COVID-19 supplies, donations, partner distribution channels, recovery centers, provider emergency alerts, dashboards, and community networks. DPH used Health Officer authority to address exposure risks; leftover N95 supplies and donations to support respirator distribution; Los Angeles Health Alert Network (LAHAN) and healthcare-sector messaging to reach providers; the Rapid Needs Assessment to identify recovery needs; and the Health and Social Services Task Force to coordinate recovery actions.[25]

Figure 60: Picture from the Resident Check-in at Malibu Pier

Key Challenges

A central public health challenge was role clarity. Existing County planning materials recognized DPH's mass-care and shelter support role, including prescription assistance when requested, health screening, shelter hygiene and safety inspections, Medical and Health Branch staffing, and outbreak investigation in mass care sites. But those materials did not clearly define DPH's wildfire-specific role across repopulation, reentry, debris removal, PPE distribution, environmental health interpretation, recovery centers, AFN outreach, and long-term recovery. As a result, DPH's role expanded during the incident, but decision approvals and pathways were not always clear.

DPH was present in operational decision forums, but its role in reentry, debris staging, cleanup, environmental testing, and public exposure messaging was not always fully defined. This highlighted opportunities to clarify DPH's role and strengthen how consistently public health input was incorporated.

PPE distribution was a successful adaptive response, but it lacked a fully pre-assigned logistics structure. DPH used leftover N95 supplies, donations, and partner channels to distribute respirators and safety materials to residents, workers, unhoused individuals, shelter populations, and healthcare facilities. That effort helped address urgent needs, but DPH leaders noted that PPE procurement, warehousing, supply chain management, and large-scale logistics are not normally DPH's core functions. The issue was both a capacity issue, because stockpiles and

[25] *ASPR – HHS emPOWER Program*. Last referenced August 24, 2026.

logistics infrastructure were limited, and a coordination issue, because lead responsibility had not been assigned in advance.

Public health messaging existed, but it was not sufficiently operationalized before the fires. DPH and partners issued or amplified guidance on smoke, ash, cleanup, respirator use, and environmental health risks, but the review points to a need for clearer ownership, faster partner integration, pre-scripted multilingual and accessible materials, and plain-language resident-facing explanations. The environmental dashboard became a transparency strength, but future incidents require ready-to-activate tools that combine technical data with clear "*what this means for you"* guidance.

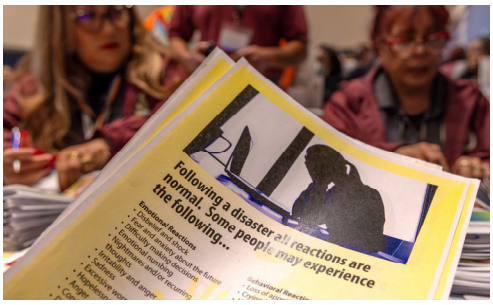

Figure 61: Disaster mental health resources

Coordination with SNFs and other long-term or residential care settings exposed a significant system-level gap. SNFs are required to maintain disaster plans, evacuation procedures, transportation arrangements, relocation records, and drills under Title 22;[26] however, compliance with written requirements did not necessarily translate into operational readiness for a fast-moving regional disaster affecting many facilities and receiving sites at the same time.

The fires also exposed a gap between DPH's Health Facilities Inspection Division's (HFID) regulatory role and the operational coordination needed to evacuate and place residents. HFID supports state-delegated oversight for SNFs and certain healthcare facilities, but HFID does not write facility emergency plans, command evacuations, serve as the first responder, or manage real-time bed placement. EMS/MHOAC supports transport, but stakeholders reported that appropriate placement and bed matching, not transportation alone, were major gaps.

Finally, DPH's staffing bench and long-duration surge capacity were strained. DPH staff had emergency response experience, but the scale, duration, and diversity of public health tasks strained personnel while normal operations continued.

[26] *California Code of Regulations, Article 5, Section 72551 - External Disaster and Mass Casualty Program | California Code of Regulations | Justia*. Last referenced August 24, 2026.

What Residents Reported

Of the 1,500 respondents, 200 identified access and functional needs and were the largest specialized subgroup. Among them, 48% reported that their needs were not met at all during repopulation, 32% reported they were partially met, and 5% reported their needs were fully met.

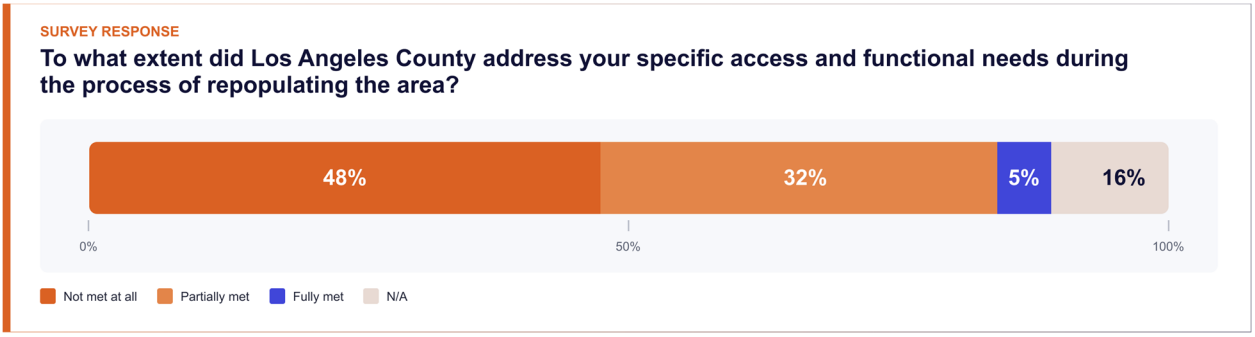

Figure 62: Stacked bar chart on access and functional needs during repopulation by survey participants

This is a large enough base to report with confidence, a plurality of AFN respondents reported total non-delivery rather than partial or delayed support. It is the resident-side measure of the coordination gap described in PHA-F5, where AFN preparedness lacked a permanent lead and a formal emergency liaison role, and it aligns with the shelter barriers reported in critical focus area #5 (SHP-F3).

Woolsey AAR Connection

Two recommendations from the *AAR of the Woolsey Fire Incident* are directly relevant to public health recovery functions evaluated in this section:

- *Rec #73: With DPH, adopt standards, protocols, resources, and timeline expectations for mitigating public health risks associated with post-emergency hazardous debris removal* connects to PHA-F1, PHA-F2, PHA-R1, PHA-R2, RCV-F2, and RCV-R2, which address Public Health role clarity, consultation pathways, and debris management protocols.
- *Rec #74: Ensure hazardous debris removal is addressed at all scales of emergency, in a manner reflective of Public Health Agency requirements* connects to PHA-F1, PHA-R1, PHA-F3, PHA-R2, RCV-F2, and RCV-R2, which address scalable hazardous debris planning, Public Health wildfire roles, and PPE readiness for debris and ash exposure.

Priority Recommendations and Actions

The County should strengthen its public health and AFN response by creating a dedicated AFN coordination function within the EOC and IMT, improving outreach, evacuation, and transportation support for high-risk populations, and standardizing health protections during sheltering and recovery. These actions would improve real-time coordination, ensure individuals requiring AFN support receive timely assistance, and reduce public health risks related to smoke, ash, debris, medical needs, and behavioral health impacts during future emergencies.

DPH personnel were present in coordination meetings and provided risk communication and safety guidance; however, the record reflects the department was not consistently included in reentry decision-making. In some cases, DPH appears to have been part of the discussion, while in others its input was not clearly brought in before key repopulation decisions were finalized. This underscores the need to more clearly define DPH's role and establish a consistent process for incorporating public health expertise into reentry decisions.

Finding PHA-F1: DPH's LAC-ESF #8 responsibilities were not sufficiently operationalized before the incident.

DPH had an established leadership role for public health functions under LAC-ESF #8; however, it had not sufficiently translated its post-incident responsibilities into internal policies, procedures, triggers, and decision-support protocols before the incident. Stakeholders held differing views about DPH's role and performance but broadly agreed that public health considerations were critical to many operational decisions and that expectations for when DPH should lead, advise, review, or escalate were not consistently shared across participating agencies.

The primary gap was therefore not the absence of an established public health role or subject-matter expertise, but DPH's internal operationalization of its LAC-ESF #8 responsibilities for a large-scale incident. Procedures did not consistently define when DPH should initiate or elevate its involvement, how its expertise should inform operational decisions, what consultation should occur before decisions with potential public health consequences, or how DPH should coordinate its input across response and recovery functions.

Some stakeholders reported that DPH had the authority to provide direction but did not always provide clear or timely guidance on issues such as reentry, debris and cleanup, environmental testing, PPE, and public exposure. Other stakeholders emphasized that DPH leadership was actively engaged in the decision-making forums to which it was invited and generally had the appropriate authority to make decisions.

Despite these differing perspectives, the stakeholders broadly agreed that public health considerations were critical to many operational decisions. DPH participated in the Health and Social Services Task Force and Vulnerable Populations Subcommittee, provided health and risk guidance, and exercised Health Officer authorities.

The differing perspectives point to a broader coordination and role-clarity issue rather than solely to DPH's performance. Future planning should more clearly define DPH's consultation triggers, expectations for timely guidance, decision roles, approval authority, and escalation pathways so that Public Health expertise is consistently incorporated into decisions and public messaging with health implications, and so that the department can more consistently execute its LAC-ESF #8 leadership responsibilities during future incidents.

Recommendation PHA-R1: Adopt a Public Health Response and Recovery Role Annex.

OEM should lead, with DPH's Emergency Preparedness and Response Division (EPRD) serving as co-lead, the development and adoption of a Public Health Wildfire Response and Recovery Role Annex to the County OAEOP and related support-agency materials. The annex should move beyond a general statement of support and establish a practical operating framework for use before, during, and after a wildfire incident.

At a minimum, the annex should define DPH's responsibilities in each of the following phases:

- Preparedness
- Active response, including PPE technical guidance, debris and cleanup, and environmental health communications
- Shelter and interim housing support
- Repopulation and reentry, including rapid community health assessment and DRC support
- Long-term recovery

Across all five phases, the annex should address DPH's health-related AFN responsibilities. These are anchored in the skilled nursing and residential healthcare facilities DPH licenses or oversees and extend to health-related needs across the affected population, including medical care, medication continuity, DME, infection control, and the accessibility of health guidance.

To make the annex operational, the County should require key implementation products: a phase-based role matrix, a decision tree for public health consultation and approval, a contact roster for core and surge partners, pre-scripted multilingual public information templates (reentry, air quality, soil testing, debris exposure, PPE use, safe cleanup, behavioral health), a PPE logistics concept, and a rapid-assessment option such as the Centers for Disease Control and Prevention (CDC) Community Assessment for Public Health Emergency Response (CASPER). The County should also designate a standing interagency group to maintain the annex, define DPH's activation process for expanded response, and clarify the transition from response to recovery governance. OEM and DPH should assign named owners, set a completion date, brief County leadership, and incorporate the annex into annual exercises testing consultation triggers, decision authority, and response-to-recovery transitions. Lessons from each exercise or incident should feed a structured after-action process that assigns corrective actions and updates the annex and related materials.

Finding PHA-F2: No PPE stockpile or distribution model existed at the time of the fires.

The County lacked a wildfire-specific PPE readiness capability for repopulation, ash cleanup, or debris-removal operations, including a defined stockpile, standing procurement pathway, donation-management process, or last-mile distribution model. As a result, DPH filled an

operational gap using available COVID-19 era N95s, donated reentry-kit supplies, Local Assistance Center/DRC distribution points, and community partners.

DPH's routine role is public health education, explaining exposure risks and how residents should protect themselves, but wildfire reentry creates a practical logistics requirement as well. Public guidance from CDC and Hawai'i Department of Health shows that residents returning to ash-contaminated areas may need specific PPE, including National Institute for Occupational Safety and Health (NIOSH)-approved N95 respirators, goggles, gloves, protective clothing, and shoe coverings; Maui's 2023 reentry model tied PPE kit distribution to the vehicle-pass process through nonprofit partners.

During the January 2025 fires, PPE distribution depended on improvised supply availability and donations. This created coordination questions around what supplies were appropriate, where they should be stored, how they should be transported, which populations or sites should be prioritized, and who should serve as the gatekeeper for donated PPE. FEMA and California donations management guidance underscore that unsolicited goods can complicate disaster operations unless intake, screening, warehousing, communications, and distribution pathways are established in advance.

> **IN THE COMMUNITY'S WORDS**
>
> *"Maybe more County [personnel] driving around with aid and PPE in the weeks that followed. When people went back to their lots would have been the best way to distribute these materials. Or have a checkpoint set up."*
>
> — Public survey respondent

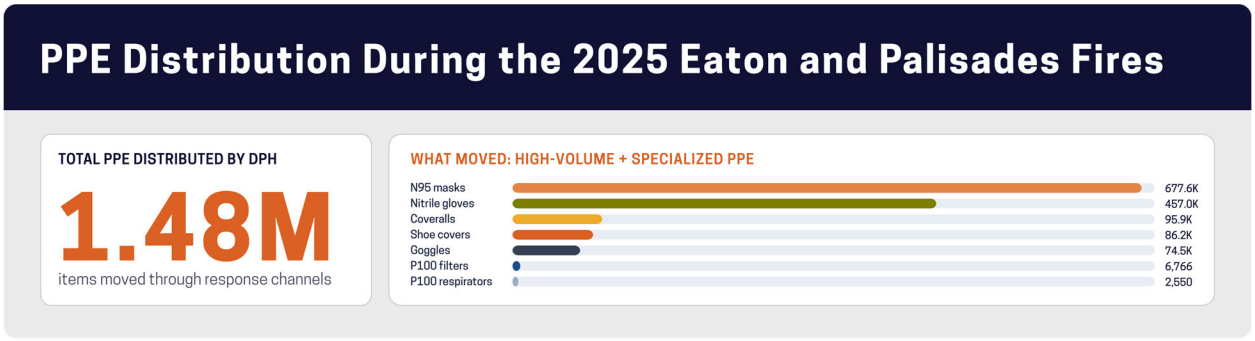

Figure 63: PPE distribution during the January 2025 Eaton and Palisades Fires

Recommendation PHA-R2: Institutionalize a PPE readiness playbook.

The above figure (Figure 63) shows that during the 2025 Eaton and Palisades Fires, DPH distributed approximately 1.48 million PPE items. The scale of distribution underscores the need for a more structured approach to PPE readiness. Before the next emergency, OEM and ISD, in

coordination with CEO Donations Management and DPH EPRD providing public-health technical support, should develop and institutionalize a wildfire PPE readiness playbook that can be activated as soon as repopulation, ash cleanup, or debris removal is anticipated. OEM should lead playbook development and coordination; ISD should manage PPE procurement, pre-positioned warehousing, logistics, and distribution; DPH EPRD should provide public health and PPE technical guidance; and CEO Donations Management should coordinate donated PPE and partner resources.

In addition, the County should ensure that departments responsible for this function have the resources necessary to sustain the capability, including maintaining appropriate PPE inventories.

The playbook should move the County from an improvised, donation-dependent model to a defined operational capability by establishing:

- Activation triggers tied to incident conditions, public reentry decisions, and ash/debris exposure risk;
- A PPE typing matrix that identifies baseline items by use case, such as N95 respirators, goggles, gloves, protective clothing, and shoe coverings;
- A decision framework for when to use a County-held cache, just-in-time purchasing in preparation for an event, emergency procurement, standing vendor agreements, partner-supported distribution, or a hybrid model; and
- Assigned roles for ordering, inventory management, storage, transportation, distribution, donation screening, and public messaging.

Given Los Angeles County's scale, population density, and recurring wildfire risk, the County should establish a baseline planning assumption for the volume and type of PPE likely to be needed during the first operational period of reentry and cleanup. Use that assumption to build a rotating cache, compliant pre-positioned contracts, standing vendor agreements, or a hybrid model. FEMA guidance supports treating disaster commodities as an end-to-end logistics function involving sourcing, acquisition, warehousing, transportation, staging, tracking, and distribution to residents.

At a minimum, the playbook should specify which department maintains inventory data, where supplies are stored, how PPE will be transported to DRC, reentry pass sites, or community distribution points, and how donations will be accepted, screened, stored, and routed so they supplement rather than complicate County operations.

DPH should define health-based prioritization criteria and issue standard guidance on PPE type, intended use, fit/limitations, and public risk communication. ISD/OEM should manage supply-chain planning, warehousing, transportation, and last-mile delivery. CEO, working with VOAD and nonprofit partners, should establish a donations coordination process that identifies approved

intake points, accepted items, screening standards, storage locations, and distribution pathways before an incident occurs.

To operationalize this recommendation, because ISD operates under a fee-for-service model, any countywide PPE logistics responsibility would require a dedicated funding source or Net County Cost (NCC) offset to ensure the capability can be implemented and sustained efficiently.

Moreover, the County should validate the model through an annual wildfire-season readiness review led by ISD with support from OEM, incorporate it into reentry and debris-management plans, and conduct at least one logistics-focused exercise testing ordering, staging, donation intake, transportation, and distribution. The 2023 Maui wildfires provide a practical model: Hawai‘i DOH issued reentry PPE guidance, PPE kits were offered during vehicle-pass distribution, nonprofit partners supported kit distribution, and additional kits were requested as the need continued.

Finding PHA-F3: Public health messaging lacked an operationalized communications playbook.

Public health messaging on smoke, ash, cleanup, and environmental risk improved over time, but the County lacked a fully operationalized wildfire public health communications playbook that could rapidly convert technical risk information into clear, trusted, multilingual protective-action guidance.

DPH issued and amplified public guidance on smoke, unhealthy air, ash, cleanup safety, respirator use, protection of sensitive groups, continuity of care, mental health resources, cleanup precautions, and water safety. This aligned with established wildfire-smoke practice: public health agencies should provide repeated, plain-language guidance on the Air Quality Index (AQI), reducing exposure, clean indoor air, respirator use, ash cleanup, and protections for children, older adults, pregnant people, people with heart or lung conditions, outdoor workers, displaced residents, and other higher-risk groups.

DPH used virtual town halls to provide a direct forum for agency leadership to communicate with residents affected by the wildfires. The sessions allowed County officials and subject-matter experts to share updates and respond to questions about public health risks and ongoing recovery activities.

The challenge was not the absence of messaging but rather that the messaging system was not sufficiently operationalized for the scale, pace, and complexity of the incident. Residents needed clear, repeated answers to practical household questions: whether it was safe to go outside, whether to clean ash themselves, what type of mask to use, how to interpret AQI and local monitoring data, whether to run heating, ventilation, and air conditioning (HVAC systems), how to protect children and older adults, and what to do if their home was standing but surrounded by burned structures. Best practice is to pair technical data with immediate protective actions, not to rely on data publication alone.

The Post-Fire Environmental Data Dashboard became a transparency strength, but it launched after public confusion had already developed and required clearer interpretation. Technical testing results alone did not answer residents' most pressing question: "*What does this mean for me and my household today?*" During wildfire response and recovery, residents need a trusted public-safety dashboard with agency-verified data, plain-language interpretation, protective actions, uncertainty statements, and referral pathways. The dashboard should clearly distinguish County-verified findings from external or emerging studies.

Figure 64: Picture from the Eaton Fire in Altadena

The LAHAN network is an established channel for communicating urgent public health guidance to health care providers; however, during the wildfire response, the January 13 notification appears to have been the only LAHAN message issued. This limited use reduced DPH's ability to provide timely, consistent updates to healthcare providers on evolving concerns such as smoke exposure, ash, debris, cleanup safety, and repopulation-related health risks.

LA Health Services Wildfire Resource page[27] was a useful public-facing resource because it consolidated key assistance links in one location for residents affected by the wildfires. The page connected residents to medical care, mental health support, housing and shelter resources, food assistance, transportation, insurance, financial/legal resources, and returning-home guidance. It was especially helpful to include benefit-related links such as DPSS cash aid, General Relief, CalFresh, FEMA, Small Business Administration (SBA), unemployment benefits, and free legal help, since residents often need practical assistance quickly during disaster recovery.

[27] *Health Services Los Angeles County – Wildfire Resources*. Last referenced August 24, 2026.

Recommendation PHA-R3: Develop and exercise a public health communications playbook.

DPH, in coordination with CEO Countywide Communications, AQMD, OEM, city partners, schools, healthcare providers, CBOs, and AFN-serving organizations, should develop and exercise a *wildfire public health communications playbook* before the next wildfire season.

The playbook should include pre-scripted, multilingual, accessible templates for wildfire smoke, ash, cleanup, HVAC and filtration, clean rooms, respirator use, debris exposure, soil concerns, water concerns, standing-home concerns, reentry safety, worker protection, mental health, and continuity of care. For air quality and AQI interpretation, DPH follows guidance developed by South Coast AQMD; the playbook should emphasize translating this technical guidance into actionable public health messaging that residents can readily understand and use. Templates should be written in plain language and organized around resident questions and protective actions.

AQMD should remain responsible for monitoring air quality and issuing smoke advisories, while DPH should continue translating those findings into public health guidance and amplifying the message through County channels. The County should maintain a clear joint protocol that defines message review, timing, approval, and distribution across routine, urgent, and emergency conditions.

The County should maintain a ready-to-activate environmental health dashboard for wildfires and other hazards. The dashboard should include agency-verified data and public-facing interpretation for air, soil, water, debris, ash, lead, and other post-fire hazards. Each update should include what was tested, what was found, what it means for health, what residents should do now, what remains uncertain, who to contact, and where to get help. The dashboard should be mobile-friendly, accessible, multilingual, and clearly marketed as the central source for DPH environmental health updates.

DPH should designate a lead program owner and interagency working group to maintain the playbook, templates, approval workflow, dashboard content, and partner contact lists. The County should test the system through at least one tabletop exercise and one live communications drill with AQMD, OEM, city partners, schools, healthcare providers, CBOs, and AFN-serving organizations. Performance measures should include the time from air-quality alert to public health guidance release, the number of languages activated, the number of channels used, partner reach, dashboard traffic, and resident/frontline partner feedback.

OEM, DPH, Aging & Disabilities, and DPSS/IHSS partners should also establish earlier targeted notifications for older adults, people with disabilities, people with health-related needs, people who rely on powered medical equipment, people experiencing homelessness, and others who may need more time or assistance to take protective action. The process should include privacy safeguards, activation thresholds, multilingual and accessible messaging, and multiple delivery methods, including phone, text, email, provider alerts, in-home service networks, senior centers, disability service organizations, and CBO outreach.

DPH should increase its use of the LAHAN network during emergencies by issuing more frequent alerts and updates to health care providers. Establishing clear activation triggers, a regular update cadence, standardized message templates, and coordination procedures would strengthen DPH's ability to deliver timely, consistent, and actionable guidance during future response and recovery operations.

Lastly, the County should investigate standardizing and expanding the LA Health Services Wildfire Resources page[28] as an all-hazards public assistance hub that can be activated for future disasters, including wildfires, earthquakes, floods, and other emergencies. The resource should be maintained through a formal process with clear ownership, update cadence, verified links, multilingual access, and coordination across DHS, DPH, DPSS, OEM, DPW, DMH, and other relevant departments. Digital accessibility should be integrated into the design and maintenance of this page so people using screen readers, captions, keyboard navigation, magnification, voice control, alternative input devices, and other assistive technologies can effectively access and use the information. It should also be promoted as a central "*one-stop shop*" where residents can easily find current information on health services, benefits, financial assistance, legal support, shelter, food, transportation, cleanup guidance, and safe return-home resources.

Finding PHA-F4: The Rapid Needs Assessment and the Health and Social Services Task Force proved valuable and should become standing capabilities.

Two coordination capabilities that emerged during recovery proved to be significant strengths, but both were adapted during the incident rather than pre-established: the Rapid Needs Assessment deployed by DPH, and the Health and Social Services Task Force and its subcommittee structure. Each should be institutionalized before the next disaster.

The Rapid Needs Assessment deployed by DPH was a major recovery coordination strength, providing valuable real-time insight into resident needs. It helped identify housing, health, mental health, financial, essential goods, AFN, and information needs, and the results guided partner actions and follow-up. It also provided a structured way to elevate community-identified needs into the Health and Social Services Task Force and related subcommittees. The assessment's electronic distribution allowed for speed; it was also released in multiple languages to maximize accessibility and community reach.

The key lesson is that rapid assessment is most effective when it is pre-built as an operational toolkit with ready survey instruments, field protocols, analysis templates, reporting products, and referral pathways. CDC's CASPER model reinforces the value of preparing rapid needs assessment tools in advance, including guidance for preparation, field collection, analysis, and reporting. The U.S. Department of Housing and Urban Development (HUD) unmet needs assessment guidance also emphasizes that recovery assessments should connect impact data,

[28] *Wildfire Resources - Health Services Los Angeles County*. Last referenced August 24, 2026.

assistance already provided, organizational capacity, and prioritization so recovery programs respond to on-the-ground needs.

Following the same pattern, the Health and Social Services Task Force was an effective structure built during the incident, but it would be stronger if established in advance.

DPH became a major convener through the Task Force and its Vulnerable Populations Subcommittee. The task force helped coordinate public health, behavioral health, social services, environmental health, benefits access, schools, childcare, CBOs, and other partners. This was a significant strength because many recovery needs cut across departmental boundaries and directly aligned with the national recovery principle that health and social services recovery should restore and improve networks that support resilience, independence, behavioral health, well-being, and the whole community.

The task force model created an effective coordination framework through topic-specific subcommittees. This subcommittee structure allowed partners to surface emerging needs, share information, and coordinate response actions.

Recommendation PHA-R4: Institutionalize the Health and Social Services Task Force and maintain a standing Rapid Needs Assessment toolkit.

DPH should establish the Health and Social Services Task Force as a formal, standing recovery coordination structure and should maintain a standing Rapid Needs Assessment toolkit as a ready-to-activate capability that feeds it. Designated co-leads from core health, behavioral health, social services, emergency management, and community-facing agencies should support the Task Force.

Before the next disaster, the DPH should define and document activation thresholds, leadership roles, lead and support responsibilities, subcommittee charters, decision rights, meeting cadence, reporting templates, partner rosters, community engagement protocols, data-sharing processes, issue-tracking procedures, referral pathways, and escalation routes to the broader recovery structure.

The Rapid Needs Assessment Toolkit should include multilingual and accessible survey instruments with phone, paper, electronic, and in-person collection options; disability and AFN-specific questions; translation and interpretation procedures; privacy and data-sharing protocols; standardized analysis dashboards; and pre-established referral pathways to 211LA, DMH, DHS, DPSS, Aging & Disabilities, housing partners, healthcare partners, and CBOs. The County should set activation triggers, maintain current partner contact lists, pre-identify outreach channels for displaced residents and digitally disconnected populations, and define how assessment findings will be converted into taskings for partner agencies. The toolkit should also include procedures for using available AFN-supporting data and partner intelligence, such as the U.S. Department of Health and Human Services (HHS) emPOWER program where appropriate,

to support outreach to at-risk individuals who rely on electricity-dependent medical or assistive equipment and essential health services.

Assessment findings should route into the Task Force and its subcommittees as the standing mechanism for converting community-identified needs into assigned, tracked partner actions, so that the assessment produces accountability rather than only information.

The County should regularly test and update the toolkit through recurring exercises and AARs.

Finding PHA-F5: AFN preparedness lacked a standing year-round lead.

During the fires, multiple agencies supported AFN-related operations, including Aging & Disabilities, DPH, DPSS/IHSS, EMS/MHOAC, LACoFD, LASD, 211LA, healthcare partners, independent living centers, and CBOs. These efforts were valuable, but coordination relied heavily on existing relationships, informal escalation, and real-time problem-solving.

The County had committed partners, but it had not updated its AFN preparedness structure, nor did it have a single year-round lead responsible for partner network maintenance. It also lacked primary and backup contact lists, tabletop exercises, accessible public information pathways, information-sharing procedures, and emergency-time coordination.

The best practice is to identify AFN considerations before, during, and after disasters and integrate them across emergency management systems, rather than treating AFN coordination as an incident-by-incident workaround. AFN planning should also involve AFN stakeholders and service providers, because lived-experience partners help identify operational gaps that emergency managers may otherwise miss.

Here, DPH provided critical public health guidance, but AFN preparedness is much broader than health guidance. It includes disseminating public information by establishing pre-disaster coordination with long-term care facilities, Area Agencies on Aging, IHSS providers, and other disability-serving organizations to disseminate emergency information through trusted community networks, support two-way communication with individuals who may not receive or respond to mass notifications, and identify unmet AFN-related needs during response and recovery.[29]

The information shared should be around evacuation support, accessible transportation, shelter accessibility, DME, backup power, medication continuity and refrigeration, service animals, caregiver continuity, wellness checks, benefits access, and recovery case management. These are the kinds of functional needs identified in the ADA and CDC guidance as requiring advance planning and operational integration.

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[29] *FEMA - Developing and Maintaining Emergency Operations Plans,* May 2025. Last referenced August 24, 2026.

As part of this review, stakeholders discussed whether a voluntary AFN registry could improve the County's ability to identify and support residents who may require additional assistance before, during, and after emergencies. While registries are often viewed as a mechanism for improving visibility into AFN and disability populations, California guidance, national lessons learned, and stakeholder experience indicate that voluntary registries are generally not the preferred approach for supporting AFN populations during large-scale disasters.[30]

Cal OES strongly discourages the use of voluntary disaster registries because of the operational challenges of maintaining accurate information, protecting personal data, ensuring sustained participation, and integrating registry information into emergency operations. Registries are inherently incomplete because participation is voluntary, information can quickly become outdated, and many of the populations most likely to require assistance during disasters may never enroll. Individuals who are socially isolated, have limited English proficiency, experience cognitive or behavioral health challenges, are experiencing homelessness, have recently developed functional needs, or are distrustful of government systems are often among the least likely to participate in registry programs.

Stakeholders further noted that registries can create unrealistic expectations among residents who may believe that enrollment guarantees individualized evacuation support, transportation, wellness checks, or other emergency services during a disaster. In rapidly evolving incidents such as wildfires, responders must make time-sensitive decisions using available resources under highly dynamic conditions. Access constraints, infrastructure impacts, communication disruptions, and competing life-safety priorities limit responders' ability to conduct registry-based outreach or provide individualized support to all registrants. As a result, registries create a false sense of security while providing only limited operational value during fast-moving incidents.

Lessons learned from California wildfires and other large-scale disasters increasingly support a whole-community preparedness model rather than a registry-based approach.[31] Under this model, jurisdictions focus on building capabilities and partnerships that benefit AFN populations regardless of whether individuals have previously identified themselves to government agencies.[32] These capabilities include accessible alert and warning systems, evacuation assistance planning, transportation coordination, shelter accessibility, HFSS integration, DME and medication continuity planning, caregiver and service animal support, accessible public information, and recovery case management.[33] [34]

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[30] *Cal OES Voluntary Disaster Registry Planning Guidance*. Last referenced August 24, 2026.

[31] *FEMA Whole Community*. Last referenced August 24, 2026.

[32] *Cal OES Access & Functional Needs Program*. Last referenced August 24, 2026.

[33] *Access and Functional Needs | ASPR*. Last referenced August 24, 2026.

[34] *Cal OES Evacuation & Transportation Guidance* and *Cal OES Integrated Evacuation Planning Guide*. Last referenced August 24, 2026.

Jurisdictions have also found that trusted service-provider networks frequently maintain more current and operationally relevant information than standalone disaster registries.[35] Organizations such as Aging & Disabilities programs, Independent Living Centers, IHSS providers, Area Agencies on Aging, healthcare systems, disability advocacy organizations, CBOs, and other social service providers maintain ongoing relationships with individuals who may require additional support during emergencies.[36] These relationships often provide more effective pathways for preparedness outreach, information sharing, two-way communication, and identifying unmet needs than a centralized voluntary registry can.

Similarly, responders increasingly rely on community-level and geographic information rather than individual registrant databases during wildfire operations. Facility inventories, long-term care provider information, community vulnerability analyses, transportation planning data, and established partner networks generally provide greater operational value when prioritizing evacuations, identifying resource needs, and supporting populations with AFN during rapidly changing incidents.

Given Los Angeles County's size, population diversity, and the dynamic nature of AFN, this review found that investments in community partnerships, preparedness integration, accessible communications, transportation coordination, information-sharing protocols, service-provider engagement, and year-round AFN preparedness capabilities will yield greater operational benefit than development of a standalone voluntary registry.[37] Accordingly, the County's primary focus should be on enhancing AFN preparedness by strengthening a sustainable, partnership-based AFN preparedness framework that bolsters integration of AFN considerations across planning, response, recovery, evacuation, sheltering, and public information activities rather than relying on a registry-centered model.

Aging & Disabilities is best positioned to lead this year-round preparedness function because of its standing relationships with older adults, disability-serving organizations, independent living centers, CBOs, the Los Angeles Commission for Older Adults and the Los Angeles Commission on Disabilities. The improvement opportunity is not to diminish the work performed during the incident, but to formalize that work into a durable system that includes documented roles, tested partner pathways, current contact rosters, and a clear EOC liaison function.

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[35] *CDC Access and Functional Needs Toolkit* and *Cal OES Access & Functional Needs Program* Last referenced August 24, 2026.

[36] *People With Access and Functional Needs: Disaster Planning | SAMHSA*. Last referenced August 24, 2026.

[37] *Public Comment Opposing Disability Disaster Registries and Advancing Real Solutions – The Partnership for Inclusive Disaster Strategies*. Last referenced August 24, 2026.

Recommendation PHA-R5: Designate a year-round AFN lead and liaison role.

The County should formally designate Aging & Disabilities as the lead agency for year-round AFN preparedness and create a trained AFN Liaison role within the County EOC structure, supported by the dedicated resources needed to sustain this function.

This designation should be documented in County emergency plans, departmental roles and responsibilities, and EOC procedures so AFN coordination is established before an incident occurs. The lead-agency role should reflect recognized best practices: integrate AFN into emergency planning before, during, and after disasters; include AFN representatives and stakeholders in planning for communications, evacuations, and sheltering; and shift from planning *for* AFN communities to planning *with* AFN communities.

As lead agency, Aging & Disabilities, with support from EOC, should maintain a standing AFN preparedness program that includes regular AFN-focused drills and tabletop exercises; a current multiagency partner roster with primary and alternate contacts; documented activation, referrals, and public information protocols.

The program should expand routine pre-incident coordination to include OEM, DPH, DPSS/IHSS, EMS/MHOAC, LACoFD, LASD, 211LA, healthcare partners, independent living centers, transportation providers, utilities, and CBOs. CDC guidance specifically supports building AFN partner lists, defining partner roles, maintaining backup contacts, testing dissemination pathways, addressing gaps, and integrating partners into exercises.

The program should define how the County will identify, track, and coordinate support for key AFN considerations before, during, and after incidents, including evacuation assistance, accessible transportation, shelter accessibility, DME, medication continuity, refrigeration, backup power, caregiver support, service animals, wellness checks, benefits access, and recovery case management.

The AFN Liaison should be a trained, position-specific role with documented duties, activation criteria, and reporting relationships. The role should activate during high-risk weather events, evacuation warnings and orders, shelter operations, repopulation, and recovery transitions. During activations, the liaison should serve as the central coordination point for AFN considerations, synthesize AFN-related situational information, and coordinate outreach to partner agencies and service providers.

They should also identify unmet needs and resource shortfalls, integrate AFN requirements into evacuation, sheltering, transportation, and public information decisions, and provide regular updates to the UCG to inform operational planning and prioritization.

Together, these actions will establish a durable AFN coordination capability that improves preparedness, response, and recovery for future disasters.

Finding PHA-F6: Residential care emergency coordination was fragmented, lacked real-time capacity visibility, and relied on compliance-based facility planning.

Emergency coordination for residential care facilities was fragmented by facility type, licensing authority, and operational responsibility. That fragmentation produced three connected gaps during the fires:

1. No single entity coordinated evacuation and response across facility types;
2. The County lacked reliable real-time visibility into long-term care bed availability, facility status, and usable receiving capacity; and
3. Facility-level evacuation planning requirements were compliance-based and did not account for simultaneous regional evacuations.

DPH HFID supports state-delegated oversight for SNFs and certain healthcare facilities, while many assisted living, independent living, memory care, board-and-care, group home, and other residential care settings fall under different state licensing structures.

HFID can verify, as part of its state-delegated licensing and certification responsibilities, whether an SNF has required emergency plans and drills, but it does not write facility plans, command evacuations, serve as the first responder, or manage real-time placement.

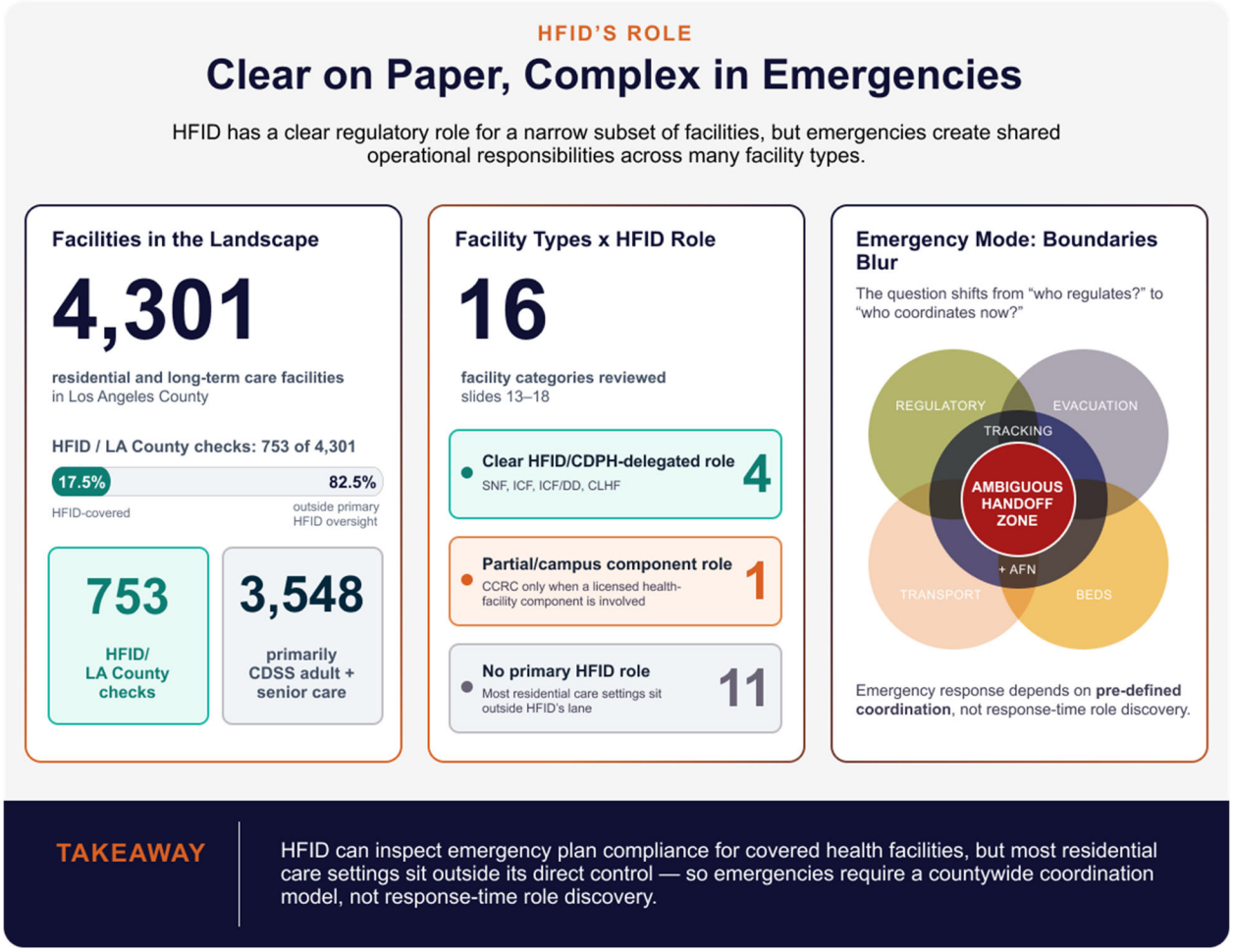

Figure 65: HFID Oversight and Coordination Gaps

The fires demonstrated that regulatory categories did not align neatly with operational needs. Residents in skilled nursing, assisted living, memory care, board-and-care, independent living, group home, and congregate living settings may all require transportation, medication continuity, DME, supervision, accessible communication, placement support, and family reunification. Best practice and regulatory guidance emphasize the need for advance planning, current facility information, coordinated transportation and relocation, resident tracking, and post-relocation follow-up.

Fragmented coordination was compounded by the absence of a reliable common operating picture. EMS/MHOAC stakeholders reported that transportation was not the only, or even the primary, bottleneck. Transportation resources were generally available or could be obtained, including through ambulance strike teams and other mutual aid mechanisms. The more difficult problem was identifying appropriate receiving beds and confirming whether those beds were usable. Consistent with bed-capacity best practice, an "available" long-term care bed should not mean merely vacant; it should mean staffed, equipped, licensed or otherwise authorized, clinically appropriate, and currently able to accept a resident with the relevant acuity, gender or

room configuration, infection control needs, behavioral health needs, oxygen dependency, dementia care needs, mobility limitations, and specialty care requirements.

EMS/MHOAC could have supported movement but lacked sufficient verified visibility into SNF beds, staffing capacity, facility operating status, evacuation posture, or appropriate placement options across the region.

HFID had regulatory knowledge and facility contacts but was not designed or staffed to function as the real-time placement coordination entity during a large regional disaster.

The third gap was at the facility level, in the assumptions underlying required emergency plans. California and federal rules require SNFs and residential care facilities to maintain emergency and disaster plans that address evacuation, transportation, relocation sites, resident transfer information, communications, training, drills, and relocation tracking. These requirements are important and provide a regulatory foundation for facility-level preparedness.

However, written compliance does not necessarily equate to operational readiness for a regional disaster. Many facilities focus on single-facility emergencies, such as a power outage, internal fire, or facility-specific evacuation. For this event, multiple facilities and receiving sites were affected at the same time, transportation routes were constrained, staff were personally impacted, and receiving capacity was uncertain. Plans that appear sufficient for an isolated facility incident are not realistic when many facilities attempt to evacuate, receive residents, request transportation, and secure staffing at the same time.

Recommendation PHA-R6: Establish a residential care emergency coordination program with real-time capacity visibility and a regional planning standard.

The County should establish a countywide residential care emergency preparedness coordination program led jointly by EMS/MHOAC and DPH/HFID, and state licensing partners, including California Department of Public Health (CDPH) and CDSS and supported by OEM, Aging & Disabilities with assistance from the Long-Term Care Ombudsman.

The program should assign County departments for each major residential care sector based on the applicable state licensing authority, designate a lead coordinating entity, establish an interagency governance structure with named points of contact, and adopt shared protocols for notification, escalation, decision support, transportation coordination, medical and health resource requests, placement support, public information, and family assistance. These roles should be clarified before an incident to close information gaps across facility types.

As an initial deliverable, the program should develop and maintain a countywide residential care coordination annex or playbook containing a master inventory of facility types, licensing authorities, facility contacts, corporate ownership where applicable, emergency points of contact, evacuation authorities, transportation resources, medical support needs, DME and medication-continuity considerations, receiving-facility coordination processes, resident tracking

expectations, reunification procedures, family communication responsibilities, and AFN support considerations.

The program should create and maintain a verified common operating picture for SNFs and larger residential care facilities, building on MHOAC's operational-area role as the 24/7/365 medical and health resource coordination point. It should require, or strongly incentivize through licensing, contracting, coalition participation, or preparedness requirements, facility participation in ReddiNet or an equivalent real-time reporting platform. Minimum reporting standards should distinguish between vacant beds and usable receiving capacity: facilities should report census, staffed and clinically appropriate bed availability, resident acuity categories, isolation or infection-control constraints, oxygen and power dependency, dementia or behavioral health capability, generator and fuel status, evacuation posture, transportation requirements, receiving capacity, staffing shortfalls, and critical resource needs.

During incidents, the County should activate a Long-Term Care Coordination Cell within the EOC/MHOAC structure, modeled on Medical Operations Coordination Center practices for patient movement, transfer management, and load balancing. The cell should include assigned staff from EMS/MHOAC, DPH HFID, and Aging & Disabilities supported by the Long-Term Care Ombudsman, with liaison support from facility associations and state partners as needed. It should verify bed availability and facility status, prioritize facilities at greatest risk, match residents to clinically appropriate destinations, coordinate transportation sequencing, track departures and arrivals, identify failed placements, support continuity-of-care documentation, and coordinate repatriation when conditions stabilize. The cell should maintain and disseminate a status report to operational partners, so all parties work from the same verified information.

DPH's HFID, which performs its licensing and regulatory functions under contract with CDPH, in coordination with EMS, OEM, MHOAC partners, state licensing partners, and residential care operators, should develop and implement a residential care emergency planning standard that moves beyond minimum compliance and establishes a common operational baseline for evacuations across skilled nursing, assisted living, memory care, board-and-care, and other congregate residential care settings.

Where the County lacks direct regulatory authority, it should pursue implementation through licensing guidance, mutual aid expectations, contracting requirements, healthcare coalition participation, and formal advocacy to the State. At a minimum, the standard should require each facility to maintain evacuation procedures based on realistic regional incident assumptions rather than single-site disruptions; identify primary, contingency, and out-of-area receiving sites; prioritize like-facility receiving agreements; define transportation arrangements by resident acuity and mobility need; establish procedures for moving medications, medical records, DME, oxygen, essential supplies, and care staff with residents when feasible; and document how the facility will sustain staffing, backup power, communications, resident supervision, continuity of care, and resident tracking and reunification during relocation.

For corporate-owned facilities, the standard should require corporate support plans identifying surge staffing, transportation contracts, bed-placement support, supply movement, medication continuity, and continuity-of-care responsibilities across the portfolio.

The program should include SNFs, assisted living facilities, memory care, board-and-care, independent living settings, group homes, congregate living settings, and other larger residential care environments where residents may need evacuation or continuity-of-care support.

EMS is currently developing a long-term care facility mutual aid program as an after-action improvement from the fires, beginning with SNFs. The County should use that effort as the implementation foundation by defining governance, onboarding participating facilities, piloting the reporting and coordination process in a limited geographic area, and incorporating the concept into training, exercises, and annual plan reviews, expanding over time beyond SNFs to other high-risk residential care settings.

The County should validate the residential care inventory and contacts at least annually, identify facilities or facility categories with elevated evacuation complexity, formalize notification and escalation pathways among County departments, state regulators, and operators, and pre-identify processes for requesting transportation, medical support, placement assistance, AFN resources, and MHOAC medical and health resource coordination. The program should be tested through workshops, tabletop exercises, and regional evacuation exercises involving multiple facility types, transportation partners, healthcare stakeholders, licensing authorities, and family-assistance functions, specifically testing constrained transportation, simultaneous evacuations, unavailable nearby beds, staffing shortages, and communications outages.

After each exercise or incident, the lead coordinating entity should document lessons learned, assign corrective actions, and track those actions to completion so the program functions as a continuous improvement system rather than a static planning document.

Review of Woolsey Fire AAR Recommendations

The *AAR of the Woolsey Fire Incident* provides an important baseline for assessing how Los Angeles County has strengthened, adapted, or deferred key capabilities that remain relevant to the January 2025 Eaton and Palisades Fires. Of the 85 total Woolsey recommendations, 13 fall directly within the scope of this AAR. A broader set of recommendations also provides useful context because they either informed the County's preparedness posture before January 2025, were previously addressed through the County's *AAR of Alert Notification Systems and Evacuation Policies for the Eaton and Palisades Fires*, or remain partially implemented and therefore continue to shape current recovery and repopulation performance.

Rather than treating the Woolsey recommendations as a historical appendix, this report uses them as a crosswalk for identifying where prior lessons were sustained, where implementation appears incomplete, and where similar issues re-emerged under different operational conditions. The summary below highlights the recommendations most relevant to the six critical focus areas in this report and clarifies how they connect to the current findings, recommendations, and implementation priorities.

Communications

The communications recommendations from Woolsey remain highly relevant because they anticipated many of the same coordination and public-information pressures observed during the January 2025 fires. The most directly applicable recommendation is Rec #65, which called for a PIO decision-flow process to pre-notify affected agencies and communicate repopulation decisions in phased, time-bound terms. That recommendation aligns closely with this report's findings on CJIC publication authority, checkpoint and access communications, and the need to convert operational decisions into resident-ready instructions.

The Woolsey source materials also indicate that several earlier communications recommendations were reportedly implemented before January 2025 and then tested under real incident conditions. These include Rec #5 on radio-frequency coverage and interoperability, Rec #34 on accelerating alert approval, Rec #38 on countywide PIO and Joint Information Center (JIC) policies, and Rec #44 on maintaining a qualified PIO roster with language support. Together, these recommendations help explain why the County entered the 2025 fires with stronger baseline communications infrastructure than in 2018, while still revealing unresolved issues related to governance, consistency, plain-language translation, and public-facing coordination across agencies. Other Woolsey communications recommendations were already evaluated in the County's earlier *AAR of Alert Notification Systems and Evacuation Policies for the Eaton and Palisades Fires* and are referenced here only where they materially intersect with recovery and repopulation communications.

Volunteer and Donations Management

Volunteer and donations management produced the smallest set of Woolsey recommendations of any focus area in this report, but the one recommendation it produced is directly relevant. Rec #67 called on the County to develop a program to better manage and distribute spontaneous volunteer and donation efforts, including coordination with the Occupant Support Team. That recommendation followed a Woolsey finding that donations of supplies to shelters by private centers and elected official organizations were not well coordinated under existing County plans, and that the scale of the incident called for a more robust control system to manage the volume of well-meaning donations and spontaneous volunteers, particularly in the early phase of catastrophic, multi-day events.

The conditions Rec #67 was written to address were present again in January 2025. The County had no formal countywide VDM model defining roles, operating boundaries, partner responsibilities, and activation procedures, and coordination depended on individual relationships rather than institutionalized partner pathways (VDM-F1). The County's cash donation pathway was likewise not activation-ready when public giving interest peaked (VDM-F2). This report's recommendations update Rec #67 for catastrophic, multi-jurisdictional incidents by formalizing a countywide VDM model with a dedicated Voluntary Agency Liaison function in the EOC (VDM-R1) and by maintaining an activation-ready cash donation package (VDM-R2).

The coordination element of Rec #67 also carries forward. The Woolsey Occupant Support Team function has since been superseded by Disaster Recovery Center operations, and the requirement that donation and volunteer pathways connect to the County's resident-facing service sites remains unresolved. That connection is addressed in this report through the recovery findings on DRC oversight (RCV-F3, RCV-R3) rather than within the VDM focus area itself.

Recovery

Recovery contains the largest cluster of directly relevant Woolsey recommendations. The in-scope recommendations are: Rec #70 (pre-designated Disaster Assistance Center sites), Rec #71 (convene a debris management project team capable of activating PPDR without reliance on Cal OES/CalRecycle), Rec #72 (secure standing contracts with licensed debris assessment/removal vendors), Rec #73 (adopt DPH standards and protocols for hazardous debris removal), Rec #74 (address hazardous debris removal at all scales of emergency), Rec #76 (establish an IMT for PPDR operations with trigger points), Rec #77 (work with FEMA on foundation removal reimbursement), and Rec #78 (standard policy for Damage Inspection Report collection and release). The source also notes that Rec #69—a damage-assessment annex with a common data structure—was reported as in progress and remains relevant to the Recovery Plan recommendation in this report.

The source further says several earlier Woolsey recommendations had already been implemented and provided foundational structure that supported the January 2025 recovery effort: Rec #1 (memorialize successes into policy), Rec #2 (OEM operates the EOC), Rec #22 (EOC roles), Rec #23 (Wildland Fire Plan annex), Rec #25 (EOC exercises), Rec #27 (tabletop exercises), and Rec #85 (EOC equipment funding).

Repopulation

Three Woolsey recommendations are identified as directly in scope for repopulation: Rec #62 (redesign the repopulation process and establish a decision-making process, including final authority), Rec #64 (conduct a public repopulation education campaign commensurate with evacuation training), and Rec #66 (conduct annual repopulation training for all involved

agencies). The source also flags Rec #63 (safe, timely access for evacuees to view property and perform salvage checks) as still unresolved; it was marked as needing follow-up and remains only partially addressed by this report's findings on access passes and checkpoint operations.

Shelter, Housing, and People at Higher Risk

The *AAR of the Woolsey Fire Incident* contained fewer shelter- and housing-specific recommendations, but two are especially relevant here: Rec #60, which calls for updates to Mass Care plans, procedures, and mutual aid agreements to ensure Red Cross government-liaison personnel are present at the County EOC and DPSS Mass Care and Shelter Branch during higher activations, and Rec #61, which calls for inviting DPSS and Red Cross personnel to large-scale exercises. The source also says Rec #56, although previously evaluated in the *AAR of Alert Notification Systems and Evacuation Policies for the Eaton and Palisades Fires*, remains highly relevant in this report as context for AFN sheltering and planning for people at higher risk.

Public Health and Access and Functional Needs

The two most relevant public-health recommendations are Rec #73 and Rec #74, both tied to post-emergency hazardous debris removal and integrating public health requirements into debris operations across emergency scales. The source notes that these are directly relevant to this report's public health recovery findings and that DPH reported no update on Rec #73 in the Woolsey tracker.

County Program and Funding Expansion

Current County Programs Supporting Climate Disaster Response

Los Angeles County maintains a broad network of programs that support preparedness, response, recovery, and resilience activities associated with all hazards, including wildfires, extreme heat, flooding, severe storms, and debris-flow events. Core capabilities are delivered through the CEO, OEM, DPH, DMH, DPSS, DPW, Regional Planning, LASD, LACoFD, and other County agencies, often in coordination with cities, state agencies, nonprofit organizations, and private-sector partners.

During the 2025 wildfire recovery effort, the County expanded access to recovery services through the LA County Recovers initiative, DRCs, rebuilding assistance programs,[38] debris-removal coordination, housing navigation services, and community outreach efforts.[39] Additional support was provided through disaster case management, mental health services, benefits enrollment assistance, document replacement services, and targeted assistance for people at higher risk, including older adults, people with disabilities, renters, low-income households, and individuals experiencing homelessness.[40] These programs demonstrate a strong foundation for disaster recovery but are largely activated or expanded in response to specific incidents rather than maintained as permanent climate resilience capabilities.

Current Funding Sources and Availability

Funding for disaster response and recovery currently comes from a combination of local, state, federal, philanthropic, and nonprofit sources. Major funding streams include FEMA Public Assistance and Individual Assistance programs, California disaster recovery appropriations, hazard mitigation grants,[41] County departmental operating budgets, and federally supported debris-removal programs.[42] Recovery activities are further supplemented through philanthropic contributions, nonprofit service delivery contracts, and community-based recovery initiatives.

While these funding sources provide substantial support following declared disasters, they are largely event-driven and reimbursement-based.[43] As a result, many recovery-related functions, including community outreach, recovery coordination, disaster case management, grants

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[38] Federal Emergency Management Agency (FEMA). California Wildfires Recovery: Disaster Recovery Centers and Individual Assistance Resources. Available at: *https://www.fema.gov*. Last referenced August 28, 2026

[39] *Recovery Resources for the Eaton and Palisades Fires*. Last referenced August 28, 2026

[40] *Los Angeles County Department of Public Health. Emergency Preparedness and Recovery Resources*. Last referenced August 28, 2026

[41] *California Governor's Office of Emergency Services (Cal OES). Disaster Recovery and Hazard Mitigation Programs.* Last referenced August 28, 2026

[42] *Federal Emergency Management Agency (FEMA). Public Assistance Program and Policy Guide (PAPPG)*. FEMA, 2024. Last referenced August 28, 2026

[43] *U.S. Government Accountability Office (GAO). Disaster Recovery: Additional Actions Could Improve Federal Coordination and Recovery Outcomes*. GAO, 2023. Last referenced August 28, 2026

administration, and long-term recovery support, must be scaled up through temporary funding mechanisms following major incidents. This approach can create challenges in sustaining staffing, maintaining institutional knowledge, and preserving service continuity between disasters.

Gaps in Existing Programs and Funding

This AAR identified opportunities to strengthen the County's ability to support climate-related emergencies that are increasing in frequency, scale, and complexity. Key gaps include:

- Limited permanent staffing dedicated to long-term recovery coordination and recovery planning.
- Reliance on temporary or incident-specific funding to support critical recovery functions.
- Inconsistent coordination structures across jurisdictions, departments, and external partners during recovery operations.
- Limited capacity for sustained resident navigation, case management, and outreach following the initial response phase.
- Fragmented systems for volunteer management, donations management, and recovery data tracking.
- Insufficient mechanisms to maintain recovery capabilities between disasters and rapidly scale services during future incidents.

These challenges are not unique to Los Angeles County and reflect broader national trends in disaster recovery,[44] where jurisdictions often maintain robust emergency response capabilities but rely on temporary structures to support long-term recovery.[45]

Program Expansion Opportunities

To strengthen preparedness for future climate-related emergencies, Los Angeles County could expand existing programs in several strategic areas.

Recovery Coordination and Planning

- Establish a standing recovery management function responsible for maintaining plans, coordinating partners, and managing post-disaster recovery activities.
- Develop standardized recovery and repopulation playbooks that can be activated across disaster types.

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[44] *National Academies of Sciences, Engineering, and Medicine. Building and Measuring Community Resilience: Actions for Communities and the Gulf Research Program*. National Academies Press; 2019. Last referenced August 28, 2026

[45] *FEMA National Disaster Recovery Framework (NDRF)*, 2nd Edition. U.S. Department of Homeland Security; 2016. Last referenced August 28, 2026

Community Recovery Services

- Expand disaster case management and resident navigation services to provide ongoing support for households and businesses recovering from climate-related events.
- Increase multilingual outreach and community engagement capacity to improve access to services and recovery resources.

Support for People at Higher Risk

- Create dedicated recovery support programs for older adults, individuals with disabilities, renters, low-income households, and people experiencing homelessness.
- Expand partnerships with CBOs that provide culturally and linguistically appropriate services.

Data and Technology

- Develop an integrated recovery management platform to support case tracking, resource referrals, volunteer coordination, and performance monitoring.
- Improve data-sharing capabilities among County departments, municipalities, nonprofit partners, and state and federal agencies.

Climate Resilience and Preparedness

- Integrate recovery planning with broader climate adaptation and resilience initiatives to ensure that post-disaster investments reduce future risk.[46]
- Expand community preparedness, resilience education, and mitigation programs in high-risk areas.

Funding Expansion Strategies

To support these programmatic enhancements, the County could pursue a layered funding strategy that combines local, state, federal, and private-sector resources. The programs listed below reflect several preparedness and mitigation programs that have been subject to significant change, and current status should be confirmed before the County relies on any single source.

Federal Funding Opportunities

- FEMA Hazard Mitigation Grant Program (HMGP).[47]
- FEMA Emergency Management Performance Grant (EMPG), supporting emergency management planning, training, exercises, and staffing.

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[46] *Los Angeles County Chief Sustainability Office. Our County Sustainability Plan. Los Angeles County*. Last referenced August 28, 2026.

[47] *FEMA. Hazard Mitigation Assistance Guidance*. Last referenced August 28, 2026.

- FEMA Homeland Security Grant Program (HSGP), including the State Homeland Security Program (SHSP) and the Urban Area Security Initiative (UASI), which supports interoperable communications, multi-agency planning, and regional exercises.
- FEMA Building Resilient Infrastructure and Communities (BRIC) and other FEMA resilience and preparedness grant programs.
- HUD disaster recovery and resilience funding.[48]
- CDC Public Health Emergency Preparedness (PHEP) cooperative agreement, supporting public health preparedness capabilities including rapid community health assessment.
- Administration for Strategic Preparedness and Response (ASPR) Hospital Preparedness Program (HPP) and healthcare coalition funding, supporting healthcare and residential care coordination, bed visibility, and patient movement capabilities.
- Administration for Community Living emergency preparedness funding for older adults and people with disabilities.
- HUD Community Development Block Grant – Disaster Recovery (CDBG-DR) and Community Development Block Grant – Mitigation (CDBG-MIT).
- Emergency Food and Shelter Program (EFSP), supporting mass care and sheltering.
- AmeriCorps disaster response and Volunteer Generation Fund programs, supporting volunteer management capacity.

State Funding Opportunities

- Cal OES grants.[49]
- CDPH preparedness funding, including pass-through administration of PHEP.
- State climate resilience and adaptation funding programs.
- Housing, infrastructure, and community resilience initiatives administered by state agencies.
- CDSS disaster planning and response funding relevant to sheltering, mass care, and residential care populations.

Local Funding Options

- Dedicated County appropriations for recovery coordination, resilience planning, and AFN support.
- Establishment of a climate resilience or disaster recovery reserve fund.
- Cross-departmental funding models that support shared recovery capabilities.

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[48] *U.S. Department of Housing and Urban Development (HUD). Community Development Block Grant Disaster Recovery (CDBG-DR) Program*. Last referenced August 28, 2026.

[49] *California Governor's Office of Emergency Services. State Hazard Mitigation and Resilience Grant Programs.* Last referenced August 28, 2026.

- Sustained departmental budget authority for permanent positions and recurring platform costs that grant funding cannot support on an ongoing basis.

Public-Private Partnerships

- Formal partnerships with philanthropic organizations and community foundations to support unmet-needs assistance.
- Private-sector partnerships that support recovery innovation, technology solutions, and community resilience investments.

A diversified funding strategy would reduce dependence on post-disaster appropriations and improve the County's ability to sustain critical capabilities between incidents.

Recommendations and Cost Considerations

Los Angeles County should consider a phased approach to expanding climate disaster programs and funding capacity.

Near-Term (Low to Moderate Cost)

- Standardize recovery governance and operating procedures.
- Formalize agreements with nonprofit and community-based partners.
- Improve public information systems, resident intake processes, accessible and multilingual communications.
- Strengthen grant identification and reimbursement management capabilities.

Mid-Term (Moderate Cost)

- Establish dedicated recovery coordination and grants management positions.
- Expand disaster case management and community navigation services.
- Implement integrated recovery data and case-tracking systems.

Long-Term (Higher Cost)

- Create a permanent countywide recovery and resilience capability that integrates recovery planning, climate adaptation, community resilience, and cross-sector coordination under a common governance framework.
- Establish dedicated funding reserves or recurring appropriations to sustain critical recovery functions between disasters.

Prioritizing permanent capabilities that can be scaled during major incidents would improve operational readiness, accelerate recovery outcomes, enhance service considerations, and reduce the costs associated with repeatedly standing up temporary recovery structures after each climate-related disaster.

Appendix 1: Data Sources

Publicly Available Data Sources	County-Provided Sources
Federal Guidance and Frameworks FEMA, *National Disaster Recovery Framework*, 2nd Edition (2016; web version updated May 14, 2025) FEMA, *Developing and Maintaining Emergency Operations Plans* (CPG 101, May 2025) FEMA, *Pre-Disaster Housing Planning Guide* (April 2024) FEMA, *Guidance on Planning for Integration of Functional Needs Support Services in General Population Shelters* (2010) FEMA, *National Mass Care Strategy, Sheltering Framework* FEMA, *Whole Community* glossary and guidance FEMA, *Public Assistance Program and Policy Guide* (2024) FEMA, *Hazard Mitigation Assistance Guidance* FEMA, *California Wildfires Recovery: Disaster Recovery Centers and Individual Assistance Resources* HUD, *Community Development Block Grant Disaster Recovery (CDBG-DR) Program* HHS ASPR, *emPOWER Program* HHS ASPR, *Access and Functional Needs Cross-Cutting Resources* CDC, *Access and Functional Needs Toolkit* (March 2021) SAMHSA, *People With Access and Functional Needs: Disaster Planning* U.S. Government Accountability Office, *Disaster Recovery: Additional Actions Could Improve Federal Coordination and Recovery Outcomes* (2023) **State Guidance and Regulation** Cal OES, *California Emergency Support Function 6: Mass Care and Shelter: Annex to the California State Emergency Plan* (July 2022) Cal OES, *Voluntary Disaster Registry Planning Guidance* Cal OES, *Access and Functional Needs Program* Cal OES, *Evacuation and Transportation Guidance* and *Integrated Evacuation Planning Guide* Cal OES, *Disaster Recovery and Hazard Mitigation Programs* Cal OES, *State Hazard Mitigation and Resilience Grant Programs* California Code of Regulations, Title 22, Division 5, Chapter 3, Article 5, Section 72551: External Disaster and Mass Casualty Program **Peer Jurisdiction Materials** San Diego County, *Operational Area Emergency Operations Plan and Medical and Health Services Annexes* (2022) **Research and Technical Literature** Uscher-Pines, L., et al., "Health Care and Supportive Services in General Population Disaster Shelters," *Disaster Medicine and Public Health Preparedness* (2023) National Academies of Sciences, Engineering, and Medicine, *Building and Measuring Community Resilience* (2019) National Cooperative Highway Research Program, *Report 781: A Debris Management Handbook for State and Local DOTs and Departments of Public Works* **Partner and Advocacy Organization Materials** United Way, *211: Our Impact* 211 Now 211 Virginia	**Prior After-Action Reviews** *After-Action Review of the Woolsey Fire Incident* (2019) *After-Action Review of Alert Notification Systems and Evacuation Policies for the Eaton and Palisades Fires* (2025) **Plans, Policies, and Procedures** County Operational Area Emergency Operations Plan and supporting annexes Departmental emergency operations plans, policies, and standard operating procedures across the six critical focus areas **Operational Records and Documentation** Incident Action Plans and situation reports Unified Command and Incident Management Team documentation Recovery Task Force rosters, agendas, and meeting records Coordination logs and after-action notes Health Officer Orders issued during the January 2025 fires Damage Inspection (DINS) data Right of Entry (ROE) collection and debris removal records Disaster Recovery Center operations records Shelter operations records and mass care reporting Personal protective equipment distribution records **County Systems and Data Platforms** Coordinated Joint Information Center (CJIC) products and publication records EPIC-LA GovDelivery distribution and subscriber data iTrack Child Welfare Services/Case Management System (CWS/CMS), including the Potential Child Victim List ReddiNet LA-RICS system performance and usage data 211LA call and referral data **Interviews and Surveys** Stakeholder interviews with 111 stakeholders and stakeholder groups (see Appendix 2) Primary Working Group and Sub-Working Group sessions (November 2025 through April 2026) Internal confidential survey of Sub-Working Group participants and key external stakeholders Public community survey, 1,500 responses (March 11 – June 22, 2026) (see Appendices 4 and 5) Community meeting observation across Supervisorial Districts 3 and 5

The Partnership for Inclusive Disaster Strategies, *Public Comment Opposing Disability Disaster Registries and Advancing Real Solutions* **County Public-Facing Resources** LA County Recovers (recovery.lacounty.gov), including temporary housing and rebuilding resources LA County Department of Public Health, *Emergency Preparedness and Recovery Resources* LA County Department of Health Services, *Wildfire Resources* LA County Animal Care & Control, *The Los Angeles County Firestorms* LA County Internal Services Department, *Management Services Manual* (2008) LA County Chief Sustainability Office, *OurCounty Sustainability Plan*	

Appendix 2: Stakeholder Interviews

Interviewed

County Agency/Department Stakeholders	Third-Party Stakeholders
Los Angeles County Aging & Disabilities	211LA
Los Angeles County Animal Care & Control	American Red Cross
Los Angeles County Chief Executive Office's Office of Emergency Management/CEO	California Governor's Office of Emergency Services (Cal OES)
Los Angeles County Chief Executive Office of Countywide Communications	The California Department of Forestry and Fire Protection (CAL FIRE)
Los Angeles County Chief Executive Office Poverty Alleviation Initiative	Community Organized Relief Effort (CORE)
Los Angeles County Chief Executive Office Center for Strategic Partnerships	Disability Community Resource Center
Los Angeles County Department of Children and Family Services	Emergency Network Los Angeles (ENLA)
Los Angeles County Department of Consumer and Business Affairs	Los Angeles County Commission on Disabilities
Los Angeles County Department of Mental Health	Motorola Solutions
Los Angeles County Department of Public Health	United States Army Corps of Engineers
Los Angeles County Department of Public Social Services	
Los Angeles County Department of Public Works	
Los Angeles County Department of Regional Planning	
Los Angeles County Emergency Medical Services Agency	
Los Angeles County Fire Department	
Los Angeles County Homeless Services and Housing	
Los Angeles County Internal Services Department	
Los Angeles County Probation Department	
Los Angeles County Sheriff's Department	
Supervisorial District 3 Office	
Supervisorial District 5 Office	

Appendix 3: Public Survey Questions

1. Which of the following applied to your experience during and after the 2025 Palisades and Eaton Fires?
2. How satisfied were you with the amount of advance notice you received before being allowed to return to your property?
3. Did you encounter barriers using the Resident Access Pass (Re-entry pass)?
4. How accurate were the road closure updates you received during your return?
5. Which Los Angeles County post-disaster recovery services did you utilize?
6. Please rate your experience at the One-Stop Permitting Center on the following factors.
7. Regarding the Debris Removal Process, how would you rate the speed of service from requesting (signing the waiver) to completion (having the debris removed)?
8. Was the debris removal completed to your satisfaction (cleanliness, no damage to remaining structures, etc.
9. Did you receive Personal Protective Equipment (PPE), such as masks, gloves, or suits, from Los Angeles County for sifting through debris?
10. Please describe your lived experience with recovery services and the debris removal process and provide any recommendations on how Los Angeles County can improve services to be more responsive and effective for residents.
11. Which Disaster Shelters did you utilize for the 2025 Eaton and Palisades Fires?
12. What were the primary barriers you faced in the shelter?
13. Please describe your lived experience with the disaster sheltering process and provide any recommendations on how Los Angeles County can improve services to be more responsive and effective for residents.
14. Were the emergency alerts and evacuation instructions provided by Los Angeles County communicated in a way that was accessible and actionable for your specific needs?
15. Did you receive timely notification regarding the safety or relocation of your family member(s) in Los Angeles County custody?
16. If you were unhoused prior to the fires, what was your biggest unmet need during the emergency?
17. Which volunteering and/or donations activity did you attempt with Los Angeles County for the 2025 Palisades and Eaton Fires?

18. How easy was it to find a centralized source of information on what donations were needed?
19. Did you encounter any of the following challenges?
20. How would you rate the organization of the Donation Drop-off sites?
21. How would you rate the organization of the Volunteer Check-in/Assignment process?
22. How would you rate the clarity and ease of the financial donation process (identifying a trusted fund and making the payment)?
23. Please describe your lived experience with Los Angeles County's volunteer and donations management system and provide any recommendations on how Los Angeles County can improve services to be more responsive and effective for residents.
24. From your perspective as a resident, what strengths did you notice in Los Angeles County's response efforts, and what specific areas do you believe should be prioritized to better protect the community in the future?
25. Overall, how would you rate your interaction with Los Angeles County disaster recovery and repopulation services?
26. Thank you for your participation. Are there any other concerns or important topics we haven't covered that you'd like to raise?

Appendix 4: Public Survey Results

Demographics

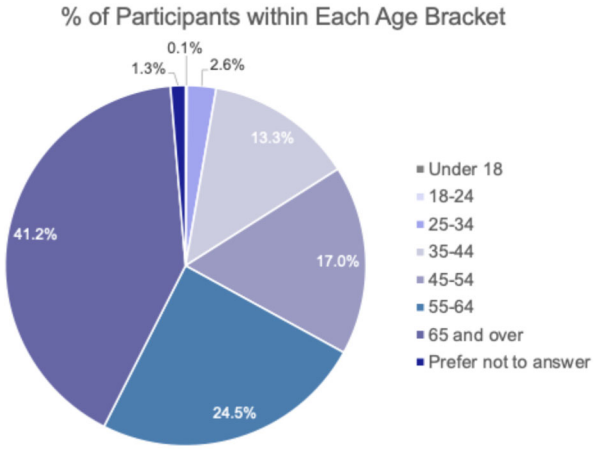

Figure A 1: Pie chart of survey participants within each age bracket

Most respondents were 65 years and older (41.2%), followed by those aged 55–64 years (24.5%), 45–54 years (17.0%), and 35–44 years (13.3%). Smaller proportions of respondents were aged 25–34 years (2.6%), 18–24 years (1.3%), or under 18 years (0.1%), while 0.1% preferred not to answer.

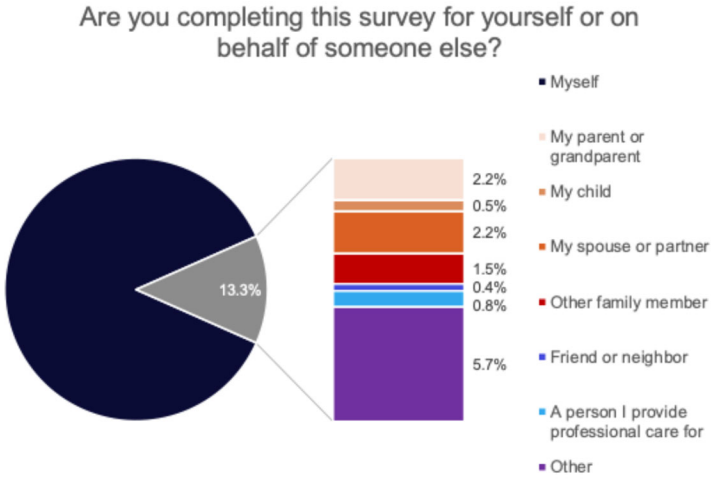

Figure A 2: Pie chart of survey participant distribution

Most surveys were completed by the individual directly affected (86.7%). Among surveys completed on behalf of someone else (13.3%), the most common respondents were friends or neighbors (6.7%), followed by parents or grandparents (2.2%), spouses or partners (2.2%), and children (0.8%). Smaller proportions were completed on behalf of other family members (1.5%),

individuals for whom respondents provide professional care (0.4%), or other relationships (0.8%).

CITY Filtered to only include zip codes mentioned 2+ times	COUNT
Agoura Hills	2
Altadena	710
Arcadia	5
Bell	2
Calabasas	6
Glendale	8
La Cañada Flintridge	25
La Crescenta	10
Lancaster	3
Los Angeles	41
Malibu	53
Monrovia	6
Montrose	2
North Hollywood	2
Pacific Palisades	281
Pasadena	201
Santa Monica	23
Sherman Oaks	2
Sierra Madre	26
Sylmar	3
Topanga	55
Whittier	3
Woodland Hills	4

Figure A 3: Cities based on zip codes and count of mentions in public survey results

ZIP CODE GROUPINGS	ZIP CODES	COUNT
Central Los Angeles	90049, 90072, 90036, 90057, 90033, 90035, 90046, 90042, 90005, 90025, 90001, 90018, 90047, 90066, 90010, 90012	34
Glendale / Burbank / East SF Valley	91208, 91206, 91403, 91601, 91207, 91230, 91316, 91423, 91604, 91606, 91502, 91608	16

Not found	89492, 89273, 99265, 90171	6
Orange County / Inland Empire	92656, 92880	2
Outliers / farther away	89060, 95005, 93664, 12345	4
Pasadena / San Gabriel Valley North	91001, 91104, 91105, 91214, 91024, 91107, 91011, 91103, 91006, 91101, 91016, 91020, 91030, 91007	985
San Gabriel Valley East / Southeast LA	90201, 91723, 90601, 90605, 91732, 90220, 91702, 91745, 91775, 91750, 90604	12
Santa Clarita / Antelope Valley	91342, 93534, 93536, 91350, 91387	8
South Bay / Harbor	90804, 90710	2
West SF Valley / Calabasas / Conejo	91302, 91301, 91367, 93011, 91364, 91356	14
Westside / Santa Monica Mountains / Beach Cities	90265, 90272, 90402, 90277, 90290, 90291, 90503, 90403, 90295, 90266, 90405	417
Total		**1500**

Figure A 4: Mentioned zip codes, groupings, and counts in public survey results

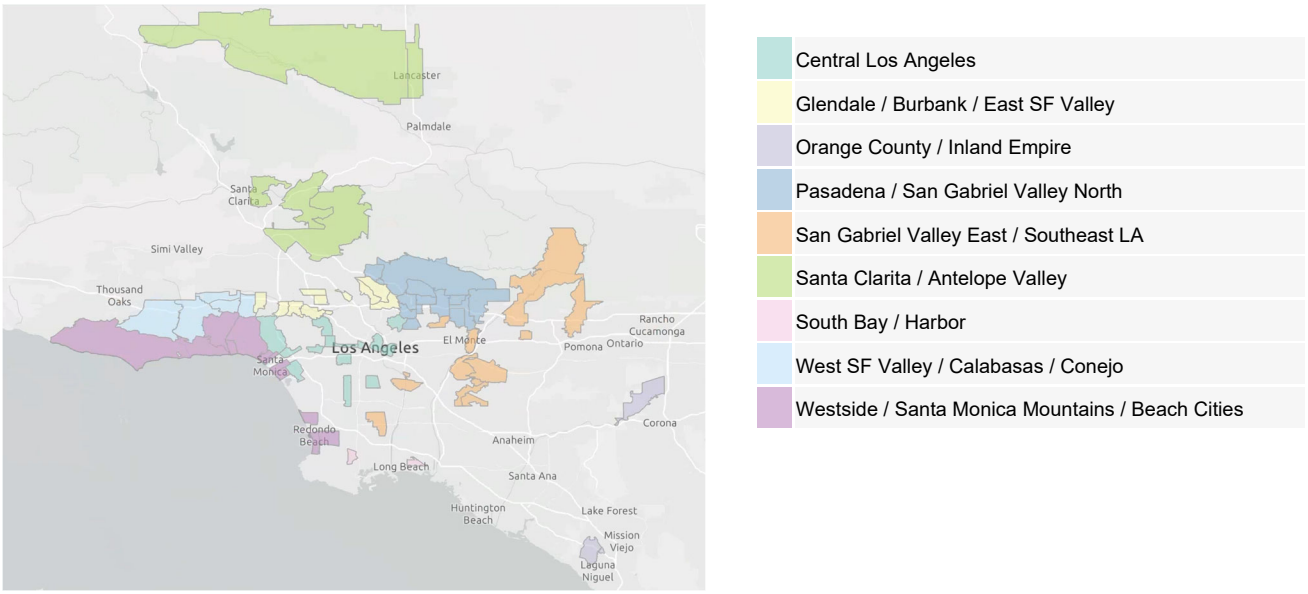

Figure A 5: Mentioned zip code groupings in public survey results

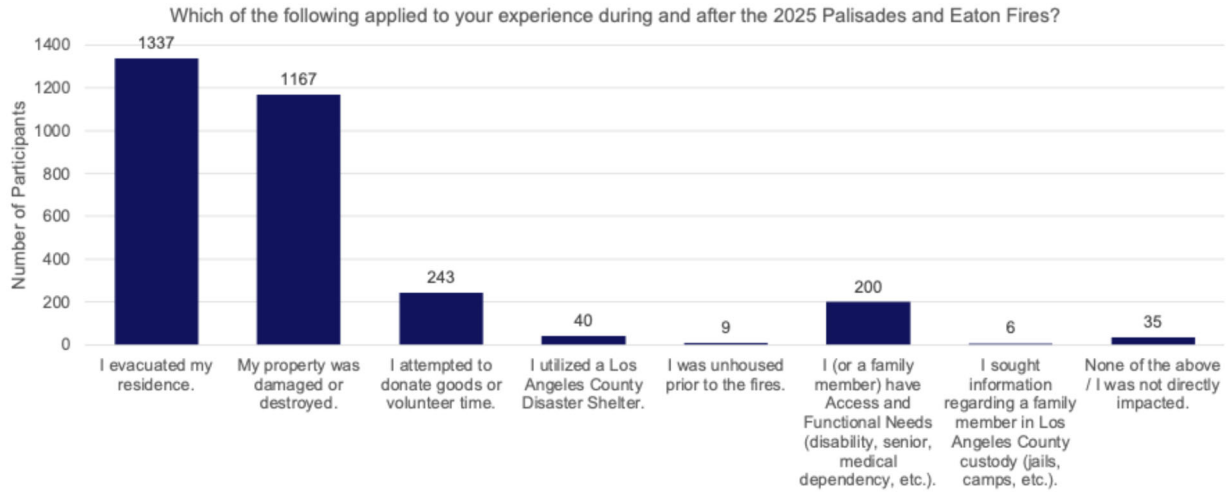

Figure A 6: Bar chart of survey participants' experience during and after the fires

Most respondents reported evacuating their residence (n = 1,337) and experiencing property damage or destruction (n = 1,167). Fewer reported attempting to donate goods or volunteer (n = 243), having access and functional needs (n = 200), or using a Los Angeles County disaster shelter (n = 40). Few respondents reported being unhoused before the fires (n = 9) or seeking information about a family member in Los Angeles County custody (n = 8). Thirty-five respondents indicated that none of the listed experiences applied to them.

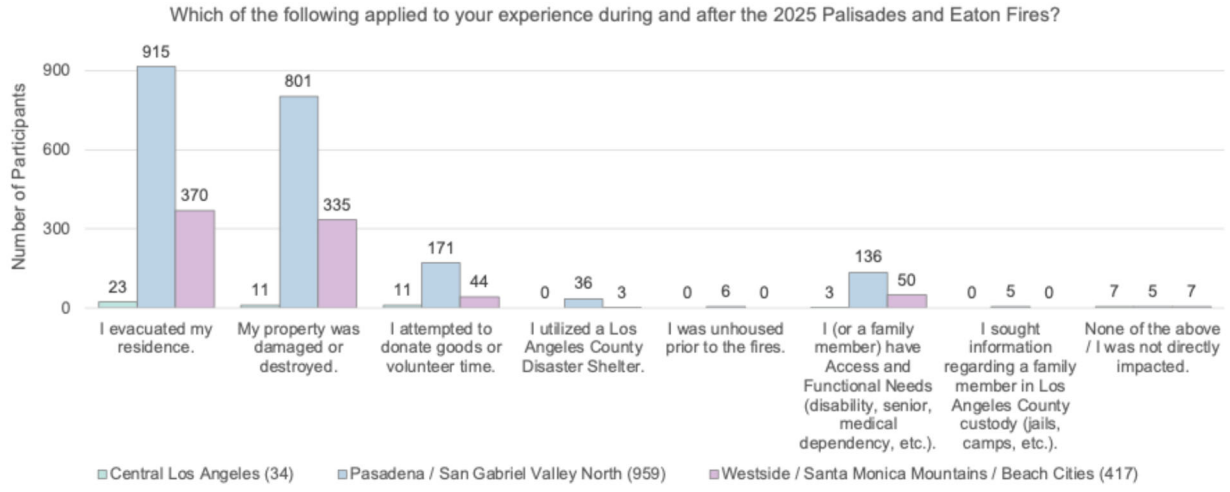

Figure A 7: Bar chart of survey participants' experience during and after the fires by zip code grouping

Across both regions, the majority of respondents reported evacuating their residence and experiencing property damage or destruction. Respondents from Pasadena / San Gabriel Valley / North represented the largest share of participants across all experience categories, reflecting the larger sample size. Reports of utilizing a Los Angeles County disaster shelter, having access and functional needs, and attempting to donate goods or volunteer were less common in both regions. Sample sizes are shown in parentheses.

Figure A 8: Bar chart of described housing situation by survey participants

The majority of respondents were homeowners (n = 1,123), followed by renters (n = 169). Smaller numbers reported living with family or friends without paying rent (n = 24), other housing situations (n = 9), living in a mobile home or trailer (n = 7), experiencing homelessness (n = 4), or residing in a nursing home or other residential healthcare facility (n = 1).

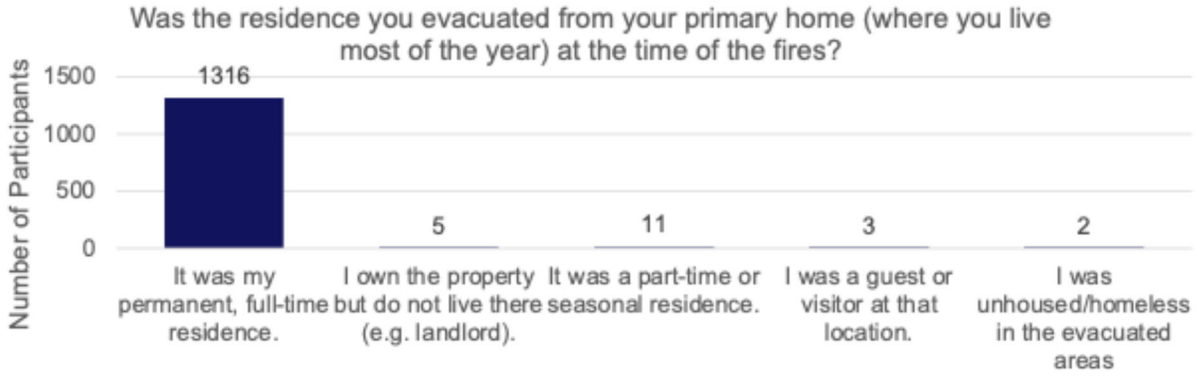

Figure A 9: Bar chart of described housing status by survey participants

Nearly all respondents reported evacuating from their permanent, full-time residence (n = 1,316). A small number reported evacuating from a part-time or seasonal residence (n = 11), a property they owned but did not live in (n = 5), or as a guest or visitor (n = 3). Two respondents reported being unhoused or experiencing homelessness in the evacuated areas.

Appendix 5: Acronyms List

ADA	Americans with Disabilities Act
AFN	Access and Functional Needs
ADRC	Aging and Disability Resource Center
ADU	Accessory Dwelling Unit
AAR	After-Action Review
AQMD	Air Quality Management District (South Coast)
AQI	Air Quality Index
ARPA	American Rescue Plan Act
Caltrans	California Department of Transportation
CA-ESF	California Emergency Support Function
CAL FIRE	California Department of Forestry and Fire Protection
CalHHS	California Health and Human Services Agency
Cal OES	California Governor's Office of Emergency Services
CASPER	Community Assessment for Public Health Emergency Response
CBO	Community-Based Organization
CDC	Centers for Disease Control and Prevention
CDPH	California Department of Public Health
CDSS	California Department of Social Services
CEO	Chief Executive Office (Los Angeles County)
CEO/CSP	Chief Executive Office Center for Strategic Partnerships
CEO PIAB	Chief Executive Office Policy Implementation and Alignment Branch
CERT	Community Emergency Response Team
CIIMT5	California Interagency Incident Management Team 5
CJIC	Coordinated Joint Information Center
CMS	Consumable Medical Supplies
CORE	Community Organized Relief Effort
COVID-19	Coronavirus Disease 2019

CSW	Children's Social Worker
CWS/CMS	Child Welfare Services/Case Management System
DCFS	Department of Children and Family Services (Los Angeles County)
DCBA	Department of Consumer and Business Affairs (Los Angeles County)
DEO	Department of Economic Opportunity (Los Angeles County)
DHS	Department of Health Services (Los Angeles County)
DINS	Damage Inspection
DME	Durable Medical Equipment
DMH	Department of Mental Health (Los Angeles County)
DOC	Department Operations Center
DPH	Department of Public Health (Los Angeles County)
DPSS	Department of Public Social Services (Los Angeles County)
DPW	Department of Public Works (Los Angeles County)
DRC	Disaster Recovery Center
DSW	Disaster Service Worker
DYD	Department of Youth Development (Los Angeles County)
ECRC	Emergency Centralized Response Center
EDSS	Emergency Disaster Services Section (Los Angeles County)
EMS	Emergency Medical Services
ENLA	Emergency Network Los Angeles
EOC	Emergency Operations Center
EPA	U.S. Environmental Protection Agency
EPRD	Emergency Preparedness and Response Division (Los Angeles County)
ESF	Emergency Support Function
FAST	Functional Assessment Service Team
FAQ	Frequently Asked Questions
FBO	Faith-Based Organization
FEMA	Federal Emergency Management Agency
GIS	Geographic Information System

HFID	Health Facilities Inspection Division (Los Angeles County)
HFSS	Health and Functional Support Services (Los Angeles County)
HHS	U.S. Department of Health and Human Services
HSH	Department of Homeless Services and Housing (Los Angeles County)
HUD	U.S. Department of Housing and Urban Development
HVAC	Heating, Ventilation, and Air Conditioning
ICP	Incident Command Post
ICS	Incident Command System
IHSS	In-Home Supportive Services
IMT	Incident Management Team
ISD	Internal Services Department (Los Angeles County)
JCOD	Justice, Care and Opportunities Department (Los Angeles County)
JIC	Joint Information Center
LA	Los Angeles
LACDA	Los Angeles County Development Authority
LAC-ESF	Los Angeles County Emergency Support Function
LACoFD	Los Angeles County Fire Department
LACOE	Los Angeles County Office of Education
LAHAN	Los Angeles Health Alert Network
LAHSA	Los Angeles Homeless Services Authority
LAPD	Los Angeles Police Department
LASD	Los Angeles County Sheriff's Department
LA-RICS	Los Angeles Regional Interoperable Communications System
LA Works	Los Angeles Works
LMR	Land Mobile Radio
LRP	Less Restricted Placement
MHOAC	Medical and Health Operational Area Coordinator
N95	NIOSH-approved N95 Filtering Facepiece Respirator
NCC	Net County Cost

NDRF	National Disaster Recovery Framework
NGO	Non-Governmental Organization
NIMS	National Incident Management System
NIOSH	National Institute for Occupational Safety and Health
OAEOP	Operational Area Emergency Operations Plan (County of Los Angeles)
ODR	Office of Diversion and Reentry (Los Angeles County)
OEM	Office of Emergency Management (Los Angeles County)
OSPC	One-Stop Permit Center
PAS	Personal Assistance Services
PIO	Public Information Officer
PPDR	Private Property Debris Removal
PPE	Personal Protective Equipment
ROE	Right of Entry
RSF	Recovery Support Function
RV	Recreational Vehicle
SBA	U.S. Small Business Administration
SD3	Supervisorial District 3
SD5	Supervisorial District 5
SF	San Fernando
SNF	Skilled Nursing Facility
STRTP	Short-Term Residential Therapeutic Program
TDSR	Temporary Debris Storage and Reduction Sites
UCG	Unified Coordination Group
USACE	U.S. Army Corps of Engineers
VAL	Voluntary Agency Liaison
VDM	Volunteer and Donations Management
VHF	Very High Frequency
VOAD	Voluntary Organizations Active in Disaster

Appendix 6: County Emergency Support Function Assignments

Reproduced from County of Los Angeles Operational Area Emergency Operations Plan (2023), Figure 7: Primary and Support Departments; Los Angeles County ESFs, page 29. Reproduced without modification.

County of Los Angeles
Emergency Operations Plan

LA County Emergency Support Functions (ESFs)							P	Primary	S	Support							
	#1	#2	#3	#4	#5	#6	#7	#8	#10	#11	#12	#13	#14	#15	#16	#17	#18
Los Angeles County Departments	Transportation	Communications	Infrastruture and Engineering	Fire and Rescue Services	Emergency Management and Coordination	Mass Care/ Human Services	Logistical Support	Public Health and Medical	Hazardous Materials	Animal Response and Agriculture	Utilities	Law Enforcement	Initial Recovery	Public Info, Alert and Warning	Personnel and Volunteers	Donations Management	Cybersecurity
Aging and Disabilities						S		S		S					S		
Ag. Commisioner/ Weights and Measures								S		S			S		S		
Alternate Public Defender												S			S		
Animal Care and Control				S		S				P		S		S	S		
Arts and Culture															S		
Assessor			S										S		S		
Auditor-Controller							S								S	S	S
Beaches and Harbors	S			S										S	S		
Chief Executive Office	P	S	S		P	S	S				P		P	P	S	P	S
Child Support Services						S									S		
Children and Family Services						S									S		
Consumer and Business Affairs													S		S		
County Counsel					S										S		
District Attorney												S			S		
Economic Opportunity													S		S		
Fire		S		P	S		S	S	P	S	S			S	S		
Health Services					S	S	S	P							S		
Human Resources						S									P		
Internal Services	S	P	S		S	S	P			S	S				S	S	P
Justice, Care and Opportunities															S		
Medical Examiner					S			S				S			S		
Mental Health					S	S		S					S		S		
Military and Veterans Affairs															S		
Musuem of Art (LACMA)															S		
Natural History Museum															S		
Parks and Recreation				S		S	S			S		S			S		
Probation												S			S		
Public Defender												S			S		
Public Health				S	S	S	S	P	S					S	S		
Public Library						S									S		
Public Social Services					S	P		S					S		S	S	
Public Works	S	S	P	S	S		S		S		S		S		S		
Regional Planning			S		S								S		S		
Registrar-Recorder/County Clerk													S	S	S		
Sheriff	S	S		S	S		S		S	S		P		S	S		S
Treasurer Tax Collector													S		S		
Youth Development													S		S		

Appendix 7: McChrystal Group Team

Erin Sutton, Partner

Erin Sutton is a Partner at McChrystal Group, specializing in public sector engagements focusing on emergency management and public safety. With over two decades of experience, she excels in developing high-performing emergency management teams, integrating innovative technologies into emergency management processes, and serving as an expert in leadership development for emergency managers.

Before joining McChrystal Group, Erin served as the Chief Deputy State Coordinator for the Virginia Department of Emergency Management (VDEM), where she oversaw daily operations and led organizational and digital transformations within the agency. As Director of Emergency Management for Virginia Beach, her leadership was instrumental during numerous local, state, and federal disasters, including Hurricanes Matthew (2016), Florence (2018), and Dorian (2019), as well as winter storms, flooding events, tornadoes, hazardous material incidents, and the COVID-19 pandemic at both local and state levels. Notably, Erin provided critical initial leadership during the Afghan repatriation at Dulles Airport and led the recovery of the mass shooting in Virginia Beach.

Erin's expertise encompasses stakeholder engagement, crisis communications, emergency plan development, strategic planning, exercise development and implementation, fiscal management, and after-action reviews. She has played a pivotal role in evaluating and refining emergency response strategies through structured after-action reviews, ensuring continuous improvement and readiness for future crises. She is known for leveraging technology to enhance processes and build effective teams capable of responding to complex emergencies.

A Certified Emergency Manager, Master Exercise Practitioner, and Project Management Professional, Erin was honored as the Emergency Management Professional of the Year for Virginia in 2019.

Shandi Treloar, Principal

Shandi Treloar is a Principal with McChrystal Group, supporting the Emergency Management business within the Government Practice group. Prior to McChrystal Group, she came from Emergency Management Partners where she was the Vice President and Preparedness Lead. In this role, Shandi built the preparedness practice area from scratch, increasing the firm's revenue by over $6 million. Shandi was also responsible for the

firms first non-FEMA federal contract with the Centers for Medicare and Medicaid Services, supporting their emergency management program.

Prior to EM Partners, Shandi had her own emergency management consulting firm, EM Strategies, LLC. As the Principal, her goal was to empower clients and partners to build stronger emergency management programs, from recovery processes and debris management planning to strategic comprehensive program development.

Chris Taylor, Senior Associate

Chris Taylor is a Senior Associate on McChrystal Group's Implementation Team, supporting public sector clients. He previously served at FEMA Headquarters in Washington, D.C., managing intergovernmental relations and deploying to federally declared disasters nationwide. Prior to that, he was an Emergency Manager in Miami-Dade County, Florida, where he led large-scale disaster planning and engagement efforts. Earlier in his career, he worked in state and local government, advising on policy areas including coastal resilience, urban planning, environmental protection, transportation, and emergency management.

Chris holds a master's degree in Homeland Security and Disaster Management from Florida International University and a B.S. in Interdisciplinary Social Science from Florida State University.

Shruti Holey, Associate

Prior to joining McChrystal Group, Shruti completed her master's in public health at Yale with a concentration in healthcare management. During her time there, she held various internship positions at Yale New Haven Health, the Hospital for Special Surgery, New York, and 500 Women Scientists, and was a consultant with the Connecticut Hospice where she worked on creating workplace cohesion and implementing leadership training. She was a fellow at the Yale Institute of Global Health and at Yale Law School's Solomon Centre for Health Law and Policy, where she worked on research on health equity, women's health, and global health.

She completed her bachelor's in dental surgery from Dr D.Y. Patil Dental College and Hospital, Pune, India. She practiced as a general dentist and founded a nonprofit that worked toward creating health equity through healthcare awareness programs in underprivileged communities.

Jake Ahearn, Associate

Jake Ahearn is an Associate on McChrystal Group's Implementation Team, supporting both public sector and non-profit clients. He most recently served as a Consultant for The Clearing, Inc., supporting the Federal Risk and Authorization Management Program (FedRAMP) project management office within the General Services Administration (GSA). Prior to his work in consulting, Jake served as an Assistant Director at the Atlantic Council, working to manage their Board of Directors and International Advisory Board.

Jake graduated from Rhodes College with a Bachelor of Arts Degree in International Studies.

Ryan Aminzadeh, Chief Data & Analytics Officer

Ryan Aminzadeh is a Partner and Chief Data & Analytics Officer at McChrystal Group, where he leads the development and deployment of advanced analytics and diagnostic capabilities focused on people, teams, and organizations. His work spans survey design, organizational network analysis, and AI- and NLP-driven insights, as well as the underlying technical infrastructure, including data engineering, modeling, and custom applications for data collection, processing, and visualization. He is responsible for ensuring that complex data is translated into practical, actionable insights that drive organizational performance.

Ryan brings deep expertise in machine learning, statistical modeling, and human language technology, shaped by a career building data-driven products and platforms. He has co-founded and served as CTO of multiple analytics firms, developing predictive talent assessment tools, custom NLP algorithms, and scalable data systems, and has led the integration of these solutions into broader enterprise platforms. Earlier in his career, he conducted advanced research in speech recognition, machine translation, and large-scale analytics systems, grounding his work in both technical rigor and real-world application.

Ché Albowicz, Ph.D., Director of Applied Analytics

Ché Albowicz, Ph.D., is the Director of Applied Analytics at McChrystal Group, where she leads analytics-driven engagements that support organizations navigating complex transformations. Her work focuses on diagnosing organizational inefficiencies, strengthening integration across teams, and aligning networked operations to drive enterprise performance. She also contributes to the firm's research and development efforts,

advancing measurement approaches tied to leadership development and the creation of inclusive, high-performing workplace environments.

Prior to joining McChrystal Group, Ché supported organizational climate and assessment efforts for a government-focused consulting firm, specializing in survey design, analysis, and data management. With a background in industrial-organizational psychology, her expertise centers on leveraging data to improve leadership effectiveness, organizational culture, and employee experience.

Morgan Silvers, Principal Analytics Consultant

Morgan Silvers is a Research Project Lead at McChrystal Group, where she designs and leads studies focused on organizational performance, network analysis, and employee engagement. Her work integrates survey data, network insights, and performance metrics to identify actionable trends, helping organizations improve decision-making and maximize people performance through clear, narrative-driven insights.

Previously, Morgan held research and analytics roles in both the public sector and higher education, where she applied quantitative and qualitative methods to inform strategy, workforce planning, and organizational effectiveness. Her background in industrial-organizational psychology underpins her focus on translating complex data into practical interventions that enhance performance, motivation, and retention.

Luisa Silva, Associate Analytics Consultant

Luisa Silva is an Associate Analytics Consultant, supporting all aspects of McChrystal Group's Diagnostic solutions, from research design through crafting data driven insights. Luisa works across industries, identifying key trends in workforce performance and strategic execution, translating complex analytics into clear and actionable roadmaps for our clients.

Prior to joining McChrystal Group, Luisa worked as a government contractor in the environmental and energy space with an emphasis in data analysis. She also has experience in grant management and project management.

Luisa completed her bachelor's degree in environmental science with a minor in sustainable energy from Boston University.

Norman Oliver, M.D., M.A., Senior Advisor

Dr. Oliver is the former State Health Commissioner at the Virginia Department of Health (2018-2022). As the head of the VDH, Dr. Oliver led the Commonwealth of Virginia's COVID-19 pandemic response.

Prior to that appointment, Dr. Oliver served as the Deputy Commissioner for Population Health for VDH (2017-2018). Before accepting the Deputy Commissioner position, Dr. Oliver was the Walter M. Seward Professor and Chair of the Department of Family Medicine at the University of Virginia School of Medicine (2011-2017). Throughout each of these three leadership roles, Dr. Oliver was focused on seeking ways to ensure the equitable health and well-being of all. Dr. Oliver worked with others in the health department, other State agencies, and healthcare systems across the State to improve the health and well-being of all citizens of the Commonwealth. He worked diligently to help build cross-agency and multi-sector approaches to implementing population health initiatives. During his years as a researcher (1998-2011), Dr. Oliver focused his research on investigating the social, economic, and cultural factors leading to racial and ethnic health inequities. As a UVA Health System clinical leader, Dr. Oliver worked to help the healthcare center address these social determinants of health affecting the patients and communities served by UVA.

Dr. Oliver attended medical school at Case Western Reserve University, where he also obtained his master's degree in medical anthropology. He trained in family medicine at Case, and he then practiced broad-spectrum family medicine in rural Alaska for 2 years before joining the UVA Department of Family Medicine in 1998.

Gracia Szczech, Senior Advisor

Gracia B. Szczech is a Senior Advisor specializing in emergency management, with more than 30 years of experience leading response and recovery efforts for major disasters. She most recently served as FEMA Region 4 Administrator, where she oversaw operations across eight states and multiple tribal nations, managing responses to more than 150 disasters, including hurricanes, floods, and the COVID-19 pandemic.

Throughout her career, Szczech has held senior leadership roles across federal and State emergency management, directing large-scale operations, contingency planning, and recovery efforts. Recognized with the Presidential Rank Award for her service, she brings deep expertise in coordinating complex, multi-stakeholder responses and strengthening organizational preparedness and resilience.

Ken Pimlott, Fire SME

Ken Pimlott is the former Director of CAL FIRE (California Department of Forestry and Fire Protection). He led the agency from 2010 to 2018, overseeing wildfire response, prevention programs, and forest management across California. With over 30 years of firefighting experience, Ken played a crucial role in managing some of the State's most devastating wildfires.

Rob Giordano, Law Enforcement SME

Rob Giordano joins us from CAS Safety Consulting. Rob previously served as the Sonoma County Sheriff. During his tenure, he led the evacuation strategy for the 2017 Sonoma Complex fires (Tubbs, Nuns, and Pocket fires). His leadership and contributions during the 2017 fires were recognized by Congress, California's State Legislature, and several local groups. Rob retired as the Sonoma County Sheriff after serving 29 years in law enforcement and started a law enforcement consulting practice.

Clint Shubel, Law Enforcement SME

Clint Shubel also joins us from CAS Safety Consulting. During his tenure as Assistant Sonoma County Sheriff, Clint served as the Sonoma County Sheriff's Office Department Operations Center Incident Commander during the 2017 Sonoma Complex fires. His additional expertise is in fire prevention, emergency action plans, and general health and safety responsibilities related to the construction industry.

Mike Keefe, SME

Mike Keefe is an experienced emergency communications and public safety leader with extensive expertise in Radio Frequency (RF), Land Mobile Radio (LMR), telecommunications, and continuity of operations support. As Tactical Systems Branch Chief with the Virginia Department of Emergency Management, he leads LMR and telecommunications activities, supports public safety communications infrastructure, and coordinates communications resources during declared disasters, no-notice emergencies, and statewide incident response operations.

In this role, Mike collaborates with State and local partners to assess communications needs, coordinate frequencies and systems, and deploy resources to support wide-area search and rescue, technological hazard

incidents, air operations, civil unrest events, and other high-consequence operations. He has served in leadership roles within the Virginia State Emergency Operations Center ESF-2 Communications function, helping identify critical communications gaps, coordinate mitigation strategies, and maintain continuity of operations during complex incidents.

Mike brings hands-on technical experience across conventional, Motorola trunking, Harris P25IP, and secure communications systems, with practical knowledge of encryption standards, key coordination, distribution, and management across local, State, and federal partners. He has led technical inputs for telecommunications procurements, supported user requirements collection and needs assessments, developed training and briefing materials, conducted vendor technology reviews, and established LMR policies and best practices for emergency management radio programs.

Mike has served as Communications Unit Leader at the regional or State level for nearly all declared disasters in Virginia since 2012 and has supported multiple National Special Security Events, including presidential inaugurations. His background also includes frequent deployments to localities experiencing communications failures involving microwave transport, LMR infrastructure, repeaters, core components, and antenna systems.

June Kailes, SME

June Kailes is a nationally recognized disability policy consultant, trainer, writer, and advocate with more than four decades of experience advancing disability inclusion, access and functional needs integration, emergency management, health care accessibility, independent living, and ADA compliance. Through Disability Policy Consulting, she advises government agencies, health plans, universities, nonprofits, and emergency management organizations on translating disability rights principles into practical policies, procedures, training, and service-delivery improvements.

June's work focuses on building actionable disability practice competencies that meaningfully include people with disabilities and others with access and functional needs before, during, and after disasters. Her expertise includes inclusive evacuation and transportation planning, sheltering, emergency power planning, public engagement, emergency registries, Functional Assessment Service Teams, drills and exercises, and whole-community preparedness.

She has served in national and State leadership roles with FEMA's National Advisory Council, HHS ASPR's National Advisory Committee

on Individuals with Disabilities and Disasters, and the California Governor's Office of Emergency Services Statewide Access and Functional Needs Advisory Committee. She also served by presidential appointment on the U.S. Architectural and Transportation Barriers Compliance Board, including as Chair and Vice Chair.

June previously served as Associate Director of the Harris Family Center for Disability Issues and the Health Policy at Western University of Health Sciences and Executive Director of the Westside Center for Independent Living. She has authored widely used guidance, checklists, articles, podcasts, and training materials on disability-inclusive emergency preparedness, response, recovery, and mitigation.

Her contributions have been recognized with the American Public Health Association's Allan Meyers Award, the National Council on Independent Living Lifetime Achievement Award, the Doug Martin Award of Excellence, and other honors. She holds an M.S.W. from the University of Southern California and a B.A. in Psychology from Hofstra University.

Cliff Maurer, P.E., SME

Clifford M. Maurer, P.E., is a proven executive, professional engineer, and public works leader with more than 35 years of experience leading complex municipal, military engineering, infrastructure, facilities, emergency response, and disaster recovery operations. He has served as Public Works Director for the cities of Santa Barbara and Coronado and as Commanding Officer of Naval Facilities Engineering Command Southwest, where he led 3,300 professionals and managed more than $3 billion in annual business volume.

Cliff brings deep expertise in infrastructure planning, public works service delivery, construction acquisition and oversight, utilities, environmental compliance, contracting, energy management, sustainability, and safety performance. He has led teams ranging from 70 to more than 3,300 personnel and managed portfolios valued from more than $1 billion to $15 billion.

His disaster recovery experience includes damage assessment, infrastructure restoration, emergency power, debris removal, contingency planning, and recovery program development following hurricanes, earthquakes, typhoons, an aircraft crash, and major electrical blackouts. During the 2010 Haiti Earthquake response, he served as Deputy Joint Task Force Commander for port opening operations and helped increase cargo throughput at Port-au-Prince to nearly ten times historical levels.

Cliff holds an M.S. in Civil Engineering from the University of California, Berkeley; a B.S. in Oceanography from the United States

Naval Academy; and completed the Advanced Management Program at the Wharton School of the University of Pennsylvania. He is a Professional Engineer in Civil Engineering in the Commonwealth of Virginia.

McChrystal Group

McChrystal Group makes it possible to optimize your organization without compromising performance. Forged in combat and proven across industries, we use our Team of Teams® framework to transform how your people, processes, and technology work together so you can optimize the organization on your terms.

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