

The operational debrief process

Background

A few months ago I had a call from a Risk Engineer who told me that he has been invited to an operational debrief. This operational debrief was conducted after a major emergency event in a large city. This risk engineer was rather reticent and did not wish to mention the event or his hosts, but he expressed dismay at the process that he observed and asked me if it was an anomaly or typical. His reaction caused me to reflect on the operational debriefings that I had either been part of, or just witnessed. My conclusion was that most of the ones I had been part of or just witnessed, had been less than satisfactory. But it was not the fault of the people conducting the 'debrief' it is an area of training and education that has been neglected.

There are a number of briefing processes such as the military model, SMEAC where the basis of the briefing is the Situation, the Mission, the Execution, the Administration and the Communications but I am not aware of a structure for the debriefing process.

I do want to emphasise that in this paper I am not talking about Critical Incident Stress Management and Critical Incident Stress Debriefing and Defusing. They are very important concepts and ones that have been well researched and documented over the last ten years.

It is the multi-organisational or single agency Operational Debriefing process that I wish to have debated.

But prior to considering the Operational Debriefing process it is appropriate to consider the Operational Briefing Process which many organisations will claim to use.

Operational briefing

Rasmussen and Jensen (1998) wrote the Coordinated Incident Management system (CIMS) Project which has been adopted in New Zealand. In the CIMS project it is stressed that the management of an incident needs an objective and a desired outcome to be identified and communicated, this is the rationale behind the Operational Briefing Process.

A briefing using the SMEAC concept could sound as simple as:

S 'The situation we are faced with is...'
'The context in which we are operating is...'

by John Lunn, Emergency Management Courses Coordinator, School of Public Health, Charles Sturt University, Bathurst, New South Wales

'What has happened is...'

M 'Our mission is to...'
'What we are trying to achieve is...'
'Our overall objective is to...'

E 'To accomplish our mission we need to...'
'To attain our overall objective the things we need to do are...'
'We need to do the following things...'

A 'The responsibilities for each objective are delegated to the following people...'
'The 'who' is going to do 'what' is as follows...'

C 'We will maintain communications by...'
'You will talk to me by...and I will talk with you by...we will all talk again...'

It has been suggested by Mr Ian Matterson, Magistrate and Coroner in Hobart, that it may not always be the case that operational briefings have been provided. I agree, and this may be because:

- until someone reaches the scene and reports back you don't know what you have and what response might be required
- it seems to be 'so insignificant' that a briefing would seem 'over the top' and a source of ridicule but with the benefit of hindsight it would in a number of situations have been a rational response
- a lack of understanding and training in the process.

It is however an appropriate process that enables events to be managed more efficiently and effectively either as a response to a known major event or upon subsequent intelligence reports of an event's magnitude. It can also accommodate the changing natures of an event as more and more information becomes available.

Operational debriefing

My initial thought was perhaps we could

use the SMEAC process for the debriefing as well as the briefing and there appeared an attractive logic in just asking 'did we do what we planned to do in each element of our briefing?' I soon concluded that was not sufficient as often the major benefits arise from identifying those things that were unexpected, not planned for and how they were managed. I therefore decided it was best to stand back and consider first ambient issues, the context, philosophy and then a strategy.

Ambient issues

There is the issue regarding litigation concerns, and in our increasingly litigious society I suspect that there is much covering of one's backside by individuals and organisations. I further suspect that this would affect evidence that people and organisations are willing to put before an operational debriefing and perhaps a coronial inquiry. Even if indemnity from criminal prosecution could be offered to individuals in exchange for evidence of malpractice, it does not overcome the prospect of civil suits and the fact that they still want their job, and 'whistle blowers' have almost always ended up as victims.

It is also important to keep in mind that critical incident debriefing and operational debriefing are different processes and have different contexts and I would say it is a bit like comparing a screwdriver with an orange. Each, when used for the purpose it was intended, may be useful, but to compare the two is a fruitless exercise. It is an observation of Mr Ian Matterson that 'at an organisational level a debrief can degenerate very quickly into either a backslapping or a back-covering exercise (depending on the success or otherwise of the operation) or may even be used to apportion blame on an individual/s'.

At a multi-agency level where, for example, police, fire services and emergency services have all been involved, similar considerations could arise.

It has been noted that single service debriefings can be more 'open' and self-critical and there is a great reluctance to 'wash ones dirty linen' in a more public forum such as a multi-agency debrief. I have heard the instruction given prior to a multi-agency debriefing that has gone along the lines of 'don't throw mud at them

then we will not get it back a another time’.

The third grouping for debriefing, i.e. at the personal level takes on a different hue and, indeed, a totally different approach is adopted. This is because not only is there a debriefing per se, but the aspect of personal counselling on issues arising from the debriefing can be immediately undertaken.

But the matter I consider to be of greatest importance is what happens with the information and ideas that arise from the debrief?

For the sake of an example, I turn again to Port Arthur. It became apparent during our debriefing at the multi-agency level that, apart from some police officers, there was little understanding of the true role of the coroner at the organisational level of a major disaster. Accordingly, in conjunction with police, hospital and emergency services personnel we drafted a Coronial Disaster Plan which set out the role of coroners, coroner’s associates and police at such an incident.

This plan was then incorporated into the State Emergency Disaster Plan to ensure a reference point should any unfortunate disaster again inflict our State, and to ensure that the leader of one organisation would not attempt to take control of a situation that is really the province of the coroner.

This move by the Coroners prompted the medicos at the Royal Hobart Hospital to complete their own disaster plan. Having these plans on paper is of course somewhat meaningless unless the contents are known and understood—to that extent field exercises and desk-top exercises involving these plans are necessary to ensure they don’t just gather dust. At least this demonstrates that some tangible good can flow from the debriefing after a disaster.

Mr Ian Matterson added that: ‘One of the difficulties in a disaster situation is the constant facing of the unexpected where there is no time for a proper briefing—where a person is faced with a problem that requires an immediate action or solution’. Praise or criticism will no doubt flow at the debrief as to the action taken, at a time when 20/20 hindsight will be available by the truck-load!

So long as the action taken has been fully documented as to the time factor and opportunity, then the debriefing process can contemplate a proper analysis from which others may learn.

Mr Ian Matterson then said that: ‘My current thoughts are that it is not an easy task to consider all the relevant factors of

the debriefing process by way of lists or rules because (a) there are different types of debriefing and (b) there may be different targets/results being sought by those performing the debrief. If this is so then we may not be comparing apples with apples’.

Operational debriefing process

Context

Understanding and recording the context is very important to management of the dynamics, the subsequent understanding and interpretation of debriefing reports.

The context should include information on:

- what happened, where, and the date and time in general terms and the time between the event concluding and the debriefing
- where the debriefing took place and which organisations and people were present
- what legislation, regulations, policies and procedures are germane to the event
- anything else that would assist in understanding the context of the event that is the subject of the debriefing.

Philosophy

An operational debrief can serve a number of different purposes and these can be either be complimentary or in conflict.

These purposes can include:

- producing a record of actions taken by whom
- blame allocation
- credit recognition
- defusing
- a learning experience.

It is therefore important that whoever is leading the debrief has a clear objective and that this is communicated to all the parties involved.

Strategy

This paper proposes the use of a consistent and logical strategy and process, which may help, address many of the issues that debriefings raise.

One such strategy is:

Step One: objective of the debrief defined

Example: The purpose of this debrief is to produce a record of ‘who’ did ‘what’ ‘when’ ‘how’ and ‘why’ and to use this record to identify what was done ‘well’ and what things could be done differently the next time a similar event had to be managed.

Step Two: the event described

Example:

- When was it first noticed that there was

a concern?...time and date

- Who first noticed that there was a concern?... name, occupation, organisation, contact details
- Who alerted other people to the concern?...name, occupation, organisation, contact details
- Who did they alert to the concern?... name, occupation, organisation, contact details
- How did they communicate the alert?
- Which organisations attended/were involved?
- When did each organisation arrive?
- Who was in command of each organisation?...name, occupation, contact details
- Which organisation was designated the lead combat authority and by whom?
- Which organisation was ‘controlling’ (managing) the response?
- Who was the designated event controller and by whom?
- What were the emergency management plans/procedures relevant to the management of this event?
- What were the legislation and or regulations relevant to the management of this event?
- How were communications established and maintained between each responding organisation?
- Where was each organisation’s command post established and why?
- Where was the control post/centre established?
- When/where did the media attend?
- What was the media management plan/strategy relevant to this event?
- Who briefed the media?...name, occupation, contact details.
- How many people attended the event from each organisation?
- What were the numbers of deaths and injuries?
- Where were the casualties transported?
- If triage was implemented, where was it located?
- What actions were taken by each responding organisation?
- What was the size of the area affected directly by the event?
- What properties were affected and to what extent?...owner/operator of each property and contact details
- What materials, equipment and other resources were used in responding to this event?...numbers, sizes, owners
- What was the cost of the response to this event?
- Who calculated the costs?...name occupation contact details
- What were losses in \$?...insured and uninsured?

- Who is the insurer?...name and contact details
- Who is accountable for the management of the recovery and restoration aspects of this event?...names and contact details
- Which organisations have which roles to play in the recovery and restoration process?...names and contact details

Step three: event management analysed

Example:

- As far as the commander of each responding organisation concludes, what were the key actions that they took that contributed to the management of the event?
- As far as the commander of each responding organisation concludes, what were the key actions taken by other organisations that contributed to the management of the event?
- As far as the commander of each responding organisation concludes what would they do differently next time they have to respond to a similar event?
- As far as the event controller concludes what would they do differently next time they have to respond to a similar event?
- What could be done to prevent a similar event in the future?
- What could be done to reduce the incidence of damage and harm if a similar event were to occur again?

Step four: Report produced

The information from steps one, two and three provide a rich source of information from which to describe the event and produce appropriate conclusions and recommendations.

It is important that the documentation process commence as soon as possible, during or after the impact. It is difficult trying to gather all the information some time after the event when memories and pieces of paper can go astray.

There is a myriad of formats that could be used for the debriefing report and the one I am suggesting is as follows:

Section one: Context of the event described including, history, relevant legislation, regulations, policies, weather conditions, season and anything else that would enable the reader to understand the 'context' in which the event took place.

Section two: Event description including location, dates, times, areal extent, severity, consequences, all the information from step two of the debriefing process and anything else that would enable the reader to understand the hazard and the effects.

Section three: Event management analysis including all the information

from step three of the debriefing process and anything else that would enable the reader to understand the event management.

Conclusion

Firstly, there are some important distinctions between operational briefings, operational debriefings and critical incident debriefings—each have their discrete purpose and the processes used are not interchangeable. Secondly, there is no universal operational debriefing process being used. Thirdly, operational debriefings currently focus on 'what' happened when perhaps that should be just an interim step to identifying the lessons learned and implemented.

In a recent Public Entity Risk Institute Internet Symposium, Wednesday October 18 2000 a paper posted by Mark Smitherman, Deputy Chief officer Nottinghamshire Fire and Rescue Service included the following observations:

'The traditional problem diagnoses and associated Post Incident Review used within the UK are frequently symptomatic, and corrective actions are often ineffective. There is a tendency to concentrate effort on equipment and human error issues, but very little on organisational, programatic, and cultural issues, ie. an over-concentration on causes that are proximal to the problem. Often the fire service needs to dig deeper than the "sharp end" issues it is so comfortable dealing with'

This is typical of much contemporary thinking on the issue where a concern and a deficiency has been identified and agreement is forthcoming on 'what' needs to be included but little is offered on 'how' to do it.

The debriefing process that I have provided does offer a way to accomplish a useful operational debrief; and if a rationale approach was adopted universally it could accomplish:

- the minimisation of negative ambient issues
- appropriate credit/blame allocation
- a consistent recording format that is more easily understood
- an Australian standard and its associated benefits.

A couple of times, when reviewing this paper to summarise and draw conclusions, I formed a view that because of the legal and political elements it has been, and would always prove to be, impossible to conduct worthwhile operational debriefings. With that thought in mind I considered that perhaps it might

be best to just recognise that fact and save the time and energy wasted on that which is not achievable. But ultimately, I concluded that if we do not try and learn from our mistakes and reinforce the lessons from our successes, we are destined to repeat our mistakes, reinvent wheels and retard our progress in managing events.

However, do not think that this paper is the definitive work on how operational debriefs should be conducted. But rather, I hope that it will be a catalyst for much more dialogue and debate which will ultimately produce something by someone that will be of use internationally to satisfy an identified need.

Reference

Mark Smitherman's paper: 'British Styles of Incident Safety; Command Decision Making and Team Knowledge' located at <http://pinta.mxdii.com/cfboard/thread.cfm>

Acknowledgments

With thanks to my colleagues Ian Manock and Allan Dodds who provided input and advice on this article. Thanks is also given to Mr Ian Matterson Magistrate and Coroner in Hobart Tasmania for his advice, encouragement and contribution to the content.

About the author

John has worked at Charles Sturt University in Bathurst New South Wales since 1998 as the course coordinator for the Bachelor of Social Science (Emergency Management) and the Master of Emergency Management.

John developed the courses during his ten years as the Manager of Training and Development for the Tasmania State Emergency Services.

Contact details

Mr. John Lunn
Emergency Management Courses
Coordinator
School of Public Health
Charles Sturt University
Panorama Avenue, Bathurst, NSW 2795
Australia
Email: jlunn@csu.edu.au