



*Queensland Fire and Rescue Service*

**State Operations Directorate**

**Operational Guide**

*Incident Debriefing*

QFRS Operational Guides		
Guide 1	Level 1 Incident Tactical Command	
Guide 2	Management of Level 2 & 3 Incidents	
Guide 3	Control and Coordination Centres	
Guide 4	Air Attack Guidelines	
Guide 5	Breathing Apparatus Safety Teams	
Guide 6	Pre-Incident Planning	
<b>Guide 7</b>	<b>Incident Debriefing (v1.0)</b>	✓
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Operational Guides have been developed to provide staff with further information and clarification on operational systems and processes.

They are designed to "bridge" the information gap between training documentation and the QFRS Operations Doctrine.

Further Operational Guides will be developed as they are required.

For further information contact the State Operations Directorate [REDACTED]

Key Points
<ul style="list-style-type: none"> <li>Incident Debriefing involves: <ul style="list-style-type: none"> <li>debriefing,</li> <li>reporting, and</li> <li>analysing collected information to identify any lesson to be learned and shared.</li> </ul> </li> <li>'Lessons Learned' can be applied from the local level to the entire organisation.</li> </ul>

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QUEENSLAND FIRE AND RESCUE SERVICE						
Relevancy Matrix						
	Urban Fire		Rural Fire			
	Full-time	Part-time	Class 4 Brigade	Class 3 Brigade	Class 2 Brigade	Class 1 Brigade
Applicable	✓	✓	✓	✓	✓	✓
Not Applicable						
May Apply*						

\* This document may apply to some Rural brigades. Check with your Senior Officer for additional information.

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 Executive Manager State Operations Directorate

## FOREWORD

Every incident together with its relevant response has the potential to improve QFRS operations and assist in ensuring the safety of all Queenslanders. We can learn from the collective experiences of Queensland firefighters so that the best approach for emergency response is identified. This learning will also provide, in the environment of continuous improvement, a safer workplace and work practices for all personnel.

For nearly all operational personnel there have been moments of reflection in where we ask ourselves after attending incidents "Could I have done better?" This simple question is the first step to the process of continuous improvement for the entire organisation. If there is the recognition that there may have been a better way of doing what we do, then it must be captured and made available across the organisation.

No review of operational performance is the forum to lay blame or to criticise individuals; rather it is to review the organisation's performance to enable actions to be taken to improve deficiencies and to recognise areas of strength. The process must be exploratory so that the reason and thought process behind actions taken can be extracted. The debriefing officer should probe and ascertain exactly why individuals and groups pursued a particular course of action.

It must be recognised that when an incident response is effective and innovation for a "better way" has occurred that it must be captured and shared across the organisation for the benefit of all.

From this point, a total package of information is developed for application across aspects of the Queensland Fire and Rescue Service - from training to operational response and on to community safety and education. This information will be made available externally (in response to requests or specific need) for other agencies or groups in a state, national or international sphere.

This Operational Guide has been developed to provide all QFRS staff with a reliable and consistent method for debriefing of incident response and training. Debriefing and incident analysis will continue to be a valuable tool for the QFRS and other emergency services for refining and improving their operational response procedures and incident management systems.



Iain S MacKenzie AFSM  
Deputy Commissioner

## PURPOSE

The QFRS has embraced a knowledge management philosophy to ensure that firefighters and support personnel across the state are encouraged to share information and pass on the legacy of their experiences.

A 'Centre for Lessons Learned' process is being developed to capture both negative and positive experiences of personnel at emergency situations. This process begins with personnel being aware of their immediate environment, their actions and the resultant outcomes. This situational awareness is crucial when recalling the "cause and effect" scenario that will be used in the operational debrief.

This guide has been developed to give personnel a greater understanding of the process of knowledge management and learning from operational response.

For incident analysis to be effective, various tools for review such as forms and report formats are to be completed appropriately as per the suggested examples provided in this guide.

Future developments include a lessons learned package for specific incidents, inclusion of "lessons learned" into firefighter competency maintenance training and a web-based, experience capturing database for QFRS personnel.

This guide involves other knowledge management approaches from within the organisation to improve understanding, learning and service delivery.

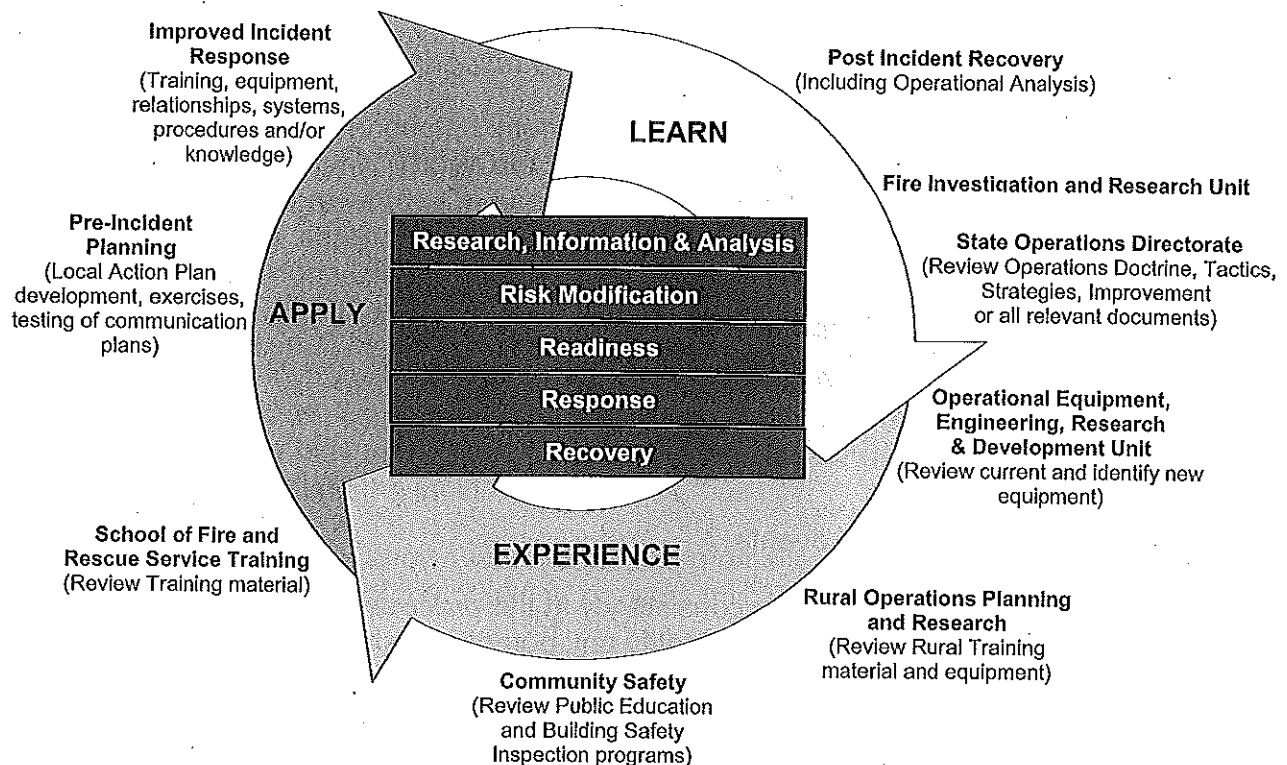
## ESTABLISHING KNOWLEDGE

Incident analysis enables the firefighters involved in an incident to identify information about what happened, why it happened, what went well, what needs improvement and what lessons can be learned and shared from the experience.

The process begins before the first firefighter arrives at the incident. It starts with having knowledge about what are the incidents most likely to occur within a firefighter's area of responsibility.

It involves persons involved in pre-incident activities as well as those directly involved in operational response. It also involves any persons that can facilitate the process and those with expert knowledge relevant to the type of incident.

### QFRS Incident Analysis System



## WHY DEBRIEF AN INCIDENT

An Incident Debrief is an overall assessment of the effectiveness of any incident planning and the operational response and recovery. The review encompasses debriefing, incident investigation and cause determination, environmental, community and organisational incident impact, near-miss reporting and inter-agency collaborations where applicable.

The review material and findings will (where relevant) be used for any enhancement of firefighter safety, equipment, operational response, and community service and may include any of the following:

- safety issues (near misses, reporting of injuries)
- human impacts (stress, fatigue and attitude)
- communications (mobilisation, incident ground, between various centres and external)
- command (roles and responsibilities)
- objectives
- tactics and strategies
- coordination of QFRS and external agencies response and actions
- performance and use of equipment
- procedural adherence issues
- pre-incident planning
- organizational issues (cultural problems)
- influences of the environment
- technical performance and tactics used
- innovations
- lessons learned
- chronological report of events

Debriefs are conducted to ensure consistency in the process of gathering information and then presenting it for review to identify any potential improvement in service delivery. Consistency in debriefs can be achieved through the use of the SMEACS format - as in briefings.

As identified in the Operations Doctrine, there are numerous types of incidents requiring varying levels of response and varying levels of escalation.

This is reflected in the manner in which the debrief is conducted - ranging from an informal debrief to a formal debrief and investigation. The first consideration is the location and the timeframe in which the debrief is conducted.



## WHERE TO DEBRIEF

The options available to the Officer-in-Charge include:

- Informally on-site with crews and other agencies involved in the response;
- Informally at the home station with available crews and other agencies; or
- Formally at a time and a location in which all personnel involved and specific personnel who can offer additional input can attend without interruption (consider alternate response strategies).

Each situation has its strengths and weaknesses in achieving a successful improvement from any identified lesson in relation to the response to the incident.

Debriefing during the course of a long duration incident such as a campaign wildfire would be best managed by an informal on-site debrief at a suitable time such as crew changeovers. The information captured is compared against the broader incident objectives within the incident action plan for that operational period.

This has an immediate impact as it will be used to review the incident action plan for all subsequent operational periods.

### On-site

On-site debriefs are conducted informally with the immediate crew members involved in the incident. These are typically for incidents of a short duration where local resources were used. On-site debriefs can be done at the conclusion of the response, after a significant event during an incident or at the demobilisation of personnel during an incident - at a time that does not compromise operational activities. On-site debriefs are best suited for a tactical, task or personal evaluation of operations.

Most information will come from personal observations and experiences. The Officer-in-Charge may use *Incident Debriefing Worksheet (INCWS 11)* or a simple 'mud map' to examine the incident particulars.

Consideration must be shown when conducting on-site debriefs in that respect must be shown to members of the public or persons involved who may be nearby.

### At Station

These debriefs are conducted at station after the incident where the format can still be informal. Where possible, such debriefs should involve all attending crews and members of other involved agencies. Some of the techniques suggested in this guide could be used to ensure that relevant information that can be passed on is captured.

It is expected that this will be the most common format. It may require the Officer-in-Charge or Incident Controller to complete an Operations Doctrine *INCFORM 09* which will be passed on to the immediate supervisor.



The debriefing officer can use a whiteboard or data projector to present information to personnel. The information being displayed may be a building or street layout or a map of the area involved together with a written sequential explanation of the incidents events or tactical benchmarks.

### **A Specific Location**

For a formal debrief, there is time available to gather information, complete the Operations Doctrine *IMS 2.10 Operational Analysis Post-Incident*, collect information from other agencies (if possible request personnel from other agencies to attend and present information) and reports from other areas such as Community Safety and the Fire Investigation and Research Unit.

This debrief may not require the presence of all operational response crews as the focus is more on the strategic considerations. Operational crews and their Officer-in-Charge may submit *INCFORM 09* relevant to their involvement to the Debrief Officer.

The debrief will be best facilitated by a venue where information technology such as computers and data projectors are used to present the information to the attendees.

***The quality of an Incident Debrief depends on the willingness of participants to be open; this is unlikely to happen if they fear they are going to be unfairly assessed or blamed.***

## DEBRIEF TYPE

Debriefing occurs at different stages of an incident and may require a special approach to how the debriefing process is managed and its objective. The type of debrief will be influenced by the complexity, duration and the impact of the incident on the organisation and the community.

### Hot / Shift

A hot / shift debrief can be conducted with personnel at the conclusion of a shift or work period or during a shift immediately after a significant event or a near miss situation. This information from this type of debrief may be used to improve or adjust the Incident Action Plan, providing an opportunity to review work undertaken throughout the shift, to identify any issues. The result can then be addressed and reported to the appropriate supervisors and personnel participating in the subsequent shift.

### Post-Incident (Formalised)

A post-incident debrief is conducted after the incident with the purpose of assessing the conduct or results of an operation. At a Level 1 incident, this debrief will usually occur immediately after the incident. In Level 2 and 3 incidents, the debrief may be conducted some weeks or months after the event. A post-incident debrief may be conducted at the crew, agency or inter-agency level.

### Tour / Campaign

A tour or campaign debrief is conducted when crews have operated at a location away from their home base (e.g. region, interstate and overseas). The purpose is to determine if there were any issues associated with mobilisation and logistical arrangements regarding the tour (e.g. transportation) and to capture information and learn organisationally from the experience.

### Agency-specific

An agency-specific debrief is conducted at an organisational level after a major event or at the end of a fire season or event. This type of debrief provides an opportunity for an organisation to identify any emerging trends and can be part of an ongoing organisational improvement process. A campaign debrief can also involve an interagency or community component if required.

### Inter-agency

Individual agencies do not respond alone to the majority of incidents; debriefs provide opportunities to improve joint operations. These debriefs normally occur at the higher or strategic levels of most interagency operations but can occur at any of the three incident levels relevant to the involvement of the agencies. Care must be taken to respect the intent and responsibilities of other agencies, organisations and individual persons that were involved. They are excellent forums to learn more from other agencies and to develop relationships across the agencies involved.

## Critical Incident Stress

Critical incident stress debriefs (CISD) are conducted by personnel with specialist training and expertise in this particular type of debrief.

This Operational Guide **does not** provide you with the expertise to undertake a CISD. The QFRS Operations Doctrine details the criteria for responding FireCare in the aftermath of a critical incident (QFRS Operations Doctrine *INCDIR 13.1 FireCare Activation*) and further information can be obtained from FireCare.

## FACILITATING DEBRIEFS

The value of using independent facilitators is the provision of a comprehensive process and one that is conducted in an open and honest forum.

The following facilitators are appropriate for the different incident levels as listed below:

- **Level 1 incident:** the Incident Controller should be the facilitator.
- **Level 2 incident:** the facilitator may be a Senior Officer from a different area or region.
- **Level 3 incident:** the facilitator may be appointed by the Assistant Commissioner or above.

For level 2 and level 3 incident, the appointed facilitators should be persons not closely involved in the incident; they can remain objective and neutral but must have a detailed knowledge of operational procedures, guidelines and the organisation as a whole.

During a review into the QFRS response to major incidents, research was conducted into various debriefs and reports. These debriefs and reports from various agencies and sections varied greatly in their structure, detail and depth of discussion.

Other issues identified included:

- questions raised over how "critically reflective" some people were as facilitators of debriefs; and
- the accuracy of information contained in reports generated from the debrief back to their respective areas to be addressed.

Whilst it is an improbable proposition to suggest that every debrief should be conducted by an independent person, some organisations are now appointing facilitators for major and significant incidents. The main functions of the independent facilitator are to:

- help the team to learn by creating an environment leading to answers, insight and the consideration of contentious issues;
- ensure every person present has the opportunity to contribute; and
- assist in creating the right environment, ensuring there is a "no blame" mentality present.

Any debrief should be carried out in a manner that can be described as being "critically reflective" yet not critical.

## PRESENTING DEBRIEF INFORMATION

When presenting debrief information at a station, a standard approach should be adopted to ensure consistency across the organisation. The presentation of information should follow these guidelines in order to analyse the incident, actions of personnel and the degree in which objectives were achieved:

1. information on pre-incident planning;
2. notification and response details;
3. chronological details of events within the incident;
4. details of approach, initial actions, information gathering and the development of the Incident Action Plan (IAP);
5. the decision-making process used and the tactical information involved;
6. layout of incident (hand-drawn map, site layout, building plans, topographical map);
7. comments and observations from other agencies (when available); and
8. post-incident recovery details.

The debrief techniques in this guide will assist the debriefing officer to get the most out of the experiences, both negative and positive, of the personnel involved.

The format below is a suggested layout that can be adjusted to suit each individual incident. The layout is to be used after an incident as a prompt to assist in the presentation of consistent information.

DEBRIEFING WORKSHEET					Post Incident Analysis Report Required	
Incident					INCFORM 09 <input type="checkbox"/>	IMS 2.10 <input type="checkbox"/>
Location					Completed by:	
<b>S A F E T Y</b>	Rescue	<b>P A C T</b>	Incident Action Plan	Incident Times	Significant events	
	Exposures		Situation	Time of call	hrs	hrs
	Contain		Mission	Acknowledged	hrs	hrs
	Extinguish		Execution	Arrival	hrs	hrs
	Overhaul		Administration	Stop	hrs	hrs
	Ventilation		Command/Comms	Under control	hrs	hrs
	Salvage		Safety	Code 4	hrs	hrs
INCIDENT MANAGEMENT TEAM			QFRS RESOURCES			
Incident Controller			CALLSIGN	CREW	ONSITE	OFF-CALL
BA Entry Officer						
Safety Advisor						
OPS Officer						
Plan Officer						
Logs Officer						
AGENCY REPRESENTATIVE		ON-SITE				
QAS						
QPS						
Elect.						
LESSONS LEARNED		ACTION REQUIRED		RESPONSIBLE PERSON		

Version: 1.0 INCWS 11

This work sheet can be accessed through the Desportal - QFRS Knowledge - Operations Doctrine - Incident Worksheets - *INCWS 11 Incident Debriefing*.

Debriefing worksheets may be used in conjunction with the incident worksheets (e.g. High-rise, Wildfire) to assist in presenting the Incident Debrief. This worksheet can be printed in a large poster size or alternatively used electronically with a data projector.

## INFORMATION SOURCES

A range of documents can be used to present information. Their use can ensure a comprehensive operational debrief leading to an overall improvement in QFRS service delivery.

1. INCFORM 09
2. IMS 2.10 Operational Analysis Post-Incident
3. Aust. Incident Recording System (AIRS) Report
4. First Attending Officer's Report
5. Near-miss Reports
6. Workplace Health and Safety Report
7. Coroners Report
8. Media Articles (Print, Photos and Audio-Visual)
9. Community Safety Report
10. Equipment Fault and Performance Reports
11. Fire Investigation Reports
12. Wordback transcripts
13. Entries into official notebooks
14. Incident Action Plans
15. All unit logs
16. Community Safety Reports
17. All relevant maps
18. Information from external sources (other state, national or international agencies or organisations)

Information is gathered from these sources and compared against current QFRS Doctrine, operational plans, practices, policies and procedures to ensure personnel operate in the safest, most effective and efficient emergency service possible.



## CONDUCTING A DEBRIEF

When debriefs are to be conducted, the intent of the debrief, the objectives of the facilitator and rules of behaviour for the group must be communicated to the personnel involved.

The considerable information presented by the facilitator, should flesh out larger amounts of information, experience, opinions and lessons drawn out from the group. It is this process that validates the effectiveness of the response, identifying meaningful recommendations and lessons learned.

While the following process is a guide only, it can be adapted to suit the specific requirements of the situation:

1. Set a time, date and location for the debrief relevant to the incident and the type of debrief required.
2. Identify the persons required to attend relevant to the incident type and sufficient time for specific persons to schedule attendance.
3. Prepare the debrief location relevant to type of debrief, incident, personnel and facilities required such as whiteboards, data projects and personal requirements such as travel time to the location, catering, toilets or accommodation if needed.
4. Greet personnel and record their attendance in the minutes of the meeting if this applicable for the type of debrief. In opening the debrief, take the opportunity to state the rules of behaviour for the group.
5. Use maps, Incident Forms and building plans to describe incident actions and developments, ensuring that all personnel can see and hear the information being presented. As information is presented, check with personnel that it is valid information.
6. Depending on the situation, the debrief may involve
  - open discussion as the information is presented
  - invitation to the group to randomly give information or opinions
  - structured order of responses for specific personnel/roles
  - open discussion after the information is presented.
7. By involving all personnel encourage an environment of succinct, calm and respectful dialogue that promotes a sense of value. A calm and respectful facilitator will encourage calm and respectful group participation.
8. Use the debrief techniques suggested in this guide to capture information, ensuring that it is recorded for further analysis and validation in the QFRS reporting process.
9. When required, follow-up on critical issues with feedback to the individual or group involved.
10. At the end of the debrief, summarise the process and openly thank everybody for their attendance and involvement.

## DEBRIEFING TECHNIQUES

Certain techniques can help a facilitator to ensure the effective capture of information from personnel.

Listed below in italics are some suggested communication strategies that the person conducting the debrief can use to facilitate the process.

### Setting the Atmosphere

*"This is a critique not criticism. It's an open, honest and professional discussion. It is about helping others faced with similar situations in the future."*

### Restating a Point

This is used to summarise a point, made by a participant that may have not been clear to everyone. *"So you're saying you think the backburn should have started higher up the ridge, and that would have prevented....."*

### Handling the Upward Delegation of Blame

Participants will often blame the "system" for being broken, and that causes failures at their level. *"OK, I agree, but that's out of our hands. We still have to live with the fact that this issue places us in increased risk. So what can we work on at our level to improve?"*

### Bringing Out the Opinion of the "Quiet Ones"

Some people just don't process through discussion, but they usually are listening closely and when asked have good insights. Wait until a little later in the debrief and then ask them by name open-ended questions. *"Well Ken, you were up on the road. What was your perspective on this?"*

### Interrupting a Dominant Member of the Group

Some people just naturally like to talk. There is also a tendency for a leader to give all the answers. Interrupt them tactfully with a comment like: *"I'm concerned we're going too deep into this issue without getting any additional input. Let's hear from...."*

### Pursuing an Issue to its Root Cause

The Japanese have a saying, 'Always ask "why" five times'. It's a good technique to make sure that you're really getting to the root cause of an issue. *"So...the torches weren't ready because they didn't get fuelled. And we've heard they didn't have fuel because the fuel cans were on the other rig. What caused that to happen?"*

## Using “Negative Polling” to Ask Questions

This is an effective way to get quick agreement/consensus. It is faster than making sure everyone agrees. *“Is anyone opposed to moving on to question #3 now?”* or *“Does anyone disagree that that was the plan, yet this is what really happened?”*

## Avoiding Win/Lose Decisions

Look for a win-win situation with the group. *“Does it have to be one way or the other? Could we agree to both?”*

## Building Up or Eliminating Ideas

This technique merges complementary pieces from different ideas or highlights agreement on pieces of an idea when the total idea is not agreed upon. *“So is there anything you could add to that suggestion to make it work for you?”* or *“What could we delete from the idea to make it work better?”*

## Asking Open-Ended Questions

This allows for a variety of possible responses while inviting involvement and participation. *“Why do you think that happened?”* or *“What could we do differently next time?”*

## Backcasting

Relate events to subsequent results using hindsight in supportive manner to highlight alternative courses of action.

## When the Group is in Denial

One or more people think (let's use “communications”) went fine and are not discussing the issues. In this order:

- Act somewhat surprised. *“Really? Interesting. Are there any other thoughts on how communications went today?”*
- Spur discussion with one of your own observations: *“OK, I saw a couple messages that didn't get passed to the crews holding the road. What was the plan there?”*
- Press a bit firmer: *“OK, what I'm hearing is that you would do this exactly the same way again?”*

## Emotion and Memory

The emotional aspect of an experience is a key point if you want to discuss human performance factors, and it is important for effective adult learning. Most people will not “technically” remember a specific situation that they were confused about. The event is then remembered within the context of that emotion.

Terms like: "frustrated", "confused", "unsure", "apprehensive", and "pissed off" can indicate the emotional manifestation of a command breakdown. As time goes by, the emotional aspect of the event fades and the event itself can be lost or reduced to its technical aspect only.

Finally, do one of two things. If the issue is minor, let it pass. If the issue is important, then you may have to make the point blank observation yourself: "OK. *You're saying communications went fine. I saw two specific instances where we had a near-miss and that information did not get to either Mike or Susan. You're telling me that is not a problem? What would have happened if we didn't get that Helitack drop?*"

Techniques prepared by: Mark Smith/Mission-Centered Solutions  
and Mike DeGrosky/ The Guidance Group, December 2003

## **REMEMBER, WHEN IN A DEBRIEF.**

**"Decisions made in real time are never perfect so don't  
second guess an operation from an armchair."**

*The Bourne Ultimatum 2007*

## REPORTING

For reporting of minor and major incidents a standard process is to be followed:

### Minor Incident

At a minor incident the Incident Controller:

1. conducts debrief on-site or at station using QFRS Debriefing Format;
2. includes observations, an assessment of the Incident Action Plan and feedback from personnel including other agencies (if available);
3. completes *INCFORM 09* as per Operations Doctrine *IMS 2.10 Operational Analysis Post-Incident*;
4. submits the *INCFORM 09* to Area Office, then to the Regional Office and on to the State Operations Directorate; and
5. review the current Local Action Plan (or develop a new Local Action Plan if required);

### Major Incident

At a major incident the Incident Controller:

1. debriefs (Hot, Shift or Tour) are conducted at shift changeovers and when personnel are demobilised (Strike Teams, Inter-region and Inter-state);
2. includes observations, an assessment of the Incident Action Plan and feedback from personnel including other agencies;
3. requests frontline supervisors (Strike-team and Task-force Leaders, Sector or Division Commanders) to complete and submit *INCFORM 09*;
4. review the current Local Action Plan (or develop a new Local Action Plan if required);
5. complete, dependant on the incident size, complexity, duration, operation performance and impact on the community, an Operations Doctrine *IMS 2.10 Operational Analysis Post-Incident Report*; and
6. submits the *IMS 2.10 Operational Analysis Post-Incident Report* to the regional office which then passes the report onto the State Operations Directorate.

The facilitator for the formal debrief should be a Senior Officer neutral to the incident. Senior Officers from a neighbouring area or region should conduct Level 2 incidents whilst facilitators for level 3 incidents should be appointed by the Assistant Commissioner or above, (Post-incident or Campaign) for the total incident response at a station or a specific location

Information from the debrief and finalised reports is made available to the relevant research and improvement areas of the QFRS

## WRITTEN REPORTS

Within the QFRS Operations Doctrine are three processes for writing reports detailing information that may be used to improve operational performance.

1. Operations Doctrine Feedback Form (General Section of the Operations Doctrine)
2. Post-Incident Analysis INCFORM 09
3. Operations Doctrine *IMS 2.10 Operational Analysis Post-Incident*

### Operations Doctrine Feedback Form

The form is used to give comment on existing documents within the Operations Doctrine based on the experiences, research or opinion of the person submitting the form.

### Post-Incident Analysis Incident Form 09\*

The minor incident Operational Analysis will occur at every incident:

- where there has been an incident-related fatality or serious injury;
- where an incident results in substantial property loss;
- where there are unusual circumstances that may provide learnings for others; or
- as request by an Inspector or higher ranked Officer.

The Post-incident Analysis Report (*INCFORM 09*) is the template used for the Minor Incident Report, which is to be forwarded to the relevant Senior Officer, who will then forward a copy to the State Operations Directorate via *QFRS Knowledge* for review.

#### PURPOSE:

This form is used at incidents to capture information relevant to any operational review for the particular type of incident. It can be used if required by Division or Sector Commanders to support the Operational Analysis Report (IMS 2.10) for Level Two -Three incidents.

#### PREPARATION:


The report is completed by the Incident Controller for Level One Incidents after the completion of the incident response. If requested by the Incident Controller, this form would be completed by Unit Leaders, Division or Sector Commanders on the completion of their duties for that operational period.

#### MANAGEMENT:

The report is submitted to the Senior Officer responsible for the location in which the incident occurred. If completed by Division or Sector Commanders at request of the Incident Controller it is to be included in the Operational Analysis Report (IMS 2.10) for Level Two -Three Incidents. The form will be sent from the Senior Officer's office to the State Operations Directorate via *QFRS Knowledge* for review.

\*QFRS Operational Guide Two

Provided below is a completed *Incident Form 09* as an example to assist with the process of collecting information.

 <b>INCFORM 09</b>	<b>POST-INCIDENT ANALYSIS MINOR REPORT</b>		
	INCIDENT DESCRIPTION: Wildfire		AIRS REPORT No.: 503778
	PREPARED BY: Terry Hunn		DATE: 03/11/05
<b>Call Details</b> <small>Attach Firecom Word Back and AIRS Report.</small>	Multiple triple 0 calls from residents in the Sandy Creek area.		
<b>Previous Incident History</b> <small>Attach or refer to previous Post-Incident Analysis Reports.</small>	Fire in same area in 2004 with similar resourcing		
<b>Pre-Incident Planning</b> <small>e.g., details of exercises, inspections; attach LAP (if available).</small>	Izone LAP		
<b>Size-up / Risk Assessment</b> <small>Describe initial observations and information gathered on-site</small>	Fire burning in inaccessible areas but predict wind change will bring front close to properties		
<b>Incident Action Plan</b> <small>Describe IAP; and attach (if available)</small>	IAP attached for first operational period indicating water bombing for inaccessible areas with fire breaks and back burning to support this action		
<b>Strategies and Tactics</b> <small>e.g., operational mode, weight of initial attack, water supply, scene security, internal attack, exposure protection, line placement, salvage, ventilation</small>	Two helicopters working northern flank (greatest risk to properties on this flank) and four rural brigades supported by council earthmovers to establish fire breaks and conduct back burn		
<b>Was the incident unique in any way?</b>	no		
<b>Lessons Identified</b>	LAP needed to be updated to indicate new subdivision		
<b>Innovations with procedures, resources and equipment used?</b>	Two portable water dams used to increase attack rate.		
<b>Supply any information to support INCFORM 09</b>	<input checked="" type="checkbox"/> DEBRIEF MATERIAL <small>(e.g. INCWS 11 summary)</small>	<input type="checkbox"/> MEDIA <small>(e.g. digital, video)</small>	<input type="checkbox"/> Other information
<b>FORWARD TO AREA DIRECTOR</b>			
<b>NAME:</b> Terry Hunn <b>DATE:</b> 09/11/05		<b>COMMENTS (Area Director):</b>	
<b>EMAIL TO</b> [REDACTED]			



## IMS 2.10 Operational Analysis Post-Incident Report

1. A major incident Operational Analysis will occur:
  - at Level 2 incidents where there is significant impact
  - at every Level 3 Incident, or
  - as required by the Assistant Commissioner.
2. Incident Management Team members and individual commanders can submit a *INCFORM 09* for activities carried out during their shift period in their area of responsibility; this can be used as information in the major incident report
3. The Operational Analysis and data collection process should endeavor to address each subject heading and sub points listed, but should not be restricted to the items listed.
4. The report is to be structured in accordance with the sections detailed in the Operations Doctrine *IMS 2.10 Operational Analysis Post-Incident* and covered under the main headings listed below.
  - Summary
  - Scope
  - Incident Description
  - Pre-Incident Planning
  - Response
  - Recovery and Rehabilitation
  - Coordination
  - Other Issues
  - Recommendation / Action Plans
  - Signature / Approval

### QFRS Commissioner's Request

To facilitate the process of improving performance in delivering service to the community of Queensland, the QFRS will seek to learn from its experiences. The task of completing post incident reports lies with Incident Controller; however, if an incident occurs and a report is not submitted, the Commissioner of the QFRS will request the relevant Region or Business Unit to provide information for incident analysis. In accordance with Operations Doctrine *IMS 2.10 Post-Incident Analysis*, a request can be made and will be forwarded to the specified Assistant Commissioner as per the following template.

### Request for Post Incident Analysis Report

Assistant Commissioner

..... Region

(Address)

(Date)

Dear >>>>>,

The completion of a 'Post Incident Analysis Report' is a key strategy in the "lessons learned" process for improving QFRS operational performance. Post incident reports provide important information for the review of command and control arrangements, training, legislation, safety issues and operational procedures.

Operations Doctrine IMS 2.10 details the incidents where a report should be submitted to the State Operations Directorate. These incidents include:

- Where there has been a fatality or serious injury;
- Substantial property loss;
- Unusual circumstances that may provide learnings for others; and
- On request of the Inspector or Superintendent

An incident has occurred in your region that may provide important learnings that can be shared with all QFRS operational personnel.

Details	
Region/District	
Location	
Date	
Type of Incident	
Firecall Number	

Can you please arrange for the Incident Controller for the above incident to complete a Post Incident Analysis Report (INCFORM 09) and submit it to QFRS Knowledge Management; [REDACTED] at their earliest convenience.

Regards

LEE A JOHNSON AFSM MIFireE  
Commissioner

## REPORT IMPLEMENTATION

The Operational Analysis (Major or Minor) will generally be undertaken by the Incident Controller or by person/s as designated by the Assistant Commissioner. On completion, it will be forwarded through the chain of command to QFRS State Operations Directorate via *QFRS Knowledge* for review.

The QFRS State Operations Directorate will determine whether the matter relates only to the region and can be addressed regionally or is a State matter. If determined that it is a State matter, it will be referred to the appropriate department for inclusion or adjustment to:

- QFRS training material
- Operations Doctrine and other QFRS documentation
- Fleet, equipment and other resources
- Community Education and Safety

If the issue has a multi-agency impact, then it may be referred to the Deputy Commissioner or relevant regional planning and coordination team to conduct a review and implement recommendations for improvement as necessary.

***If the experience of a single firefighter at one incident can be used to improve the safety of all firefighters then this experience must be recorded and passed on to where those changes can be made for the benefit of all.***

## LESSONS LEARNED

Firefighters respond to a wide range of operations and while there are broad commonalities that exist, every incident presents many variables. These variables cannot be addressed by set procedures and must be approached initially on a generic level. By understanding the generic approach, firefighters can combine existing knowledge with the incident specific information to resolve the incident.

This combination leads to an innovative approach resulting in a positive lesson learned for the organisation. Where the activities at any level (strategic, tactical or task focused) highlight a critical error in the incident response, a negative aspect which can be corrected by the organisation is thereby revealed.

Lessons learned, both positive and negative, are the result of experiences. They can be of value to the organisation only if personnel are empowered to present them in an honest and factual account of the incident.

Any experience which is recounted in an environment where there is fear of punitive actions, personnel bias or unsubstantiated claims will not assist in the process of continuous improvement.

To identify the lessons from an incident, firefighters must first maintain situational awareness during the incident and then actively participate in the debriefing process. By doing this, observations are packaged together with pre-incident planning, information from the incident and interaction from external agencies and other involved persons.

### Near- Miss

All incidents that occur within the DES or through DES sponsored activities where work-related fatality, injury, illness, dangerous occurrence, near miss, environmental incident, or property damage has resulted are to be reported.

A near-miss is an event observed during the incident; it involves an action or a series of preceding actions that were identified as having the potential to cause injury or death.

Near-miss reporting is to be undertaken in accordance with *DES Incident Reporting & Investigation Policy (OH/C15.0)* and should be included in debrief material to source the actions that lead to the near-miss. It can highlight the effect on operations if the event identified as a near-miss were to be actualised.

An operational near-miss can result in objectives being compromised such as when hose lines are placed ineffectively allowing fire spread or an incomplete backburn with the potential to allow the spread of a bushfire.

### Innovation

Firefighters are practical people who are quick to realise when there is an easier and more effective way of achieving a task. These improvements must be captured, evaluated and introduced into the organisation's response profile.

## VALIDATION

Four simple questions can be used to identify whether lessons can be learnt from the response:

1. What was supposed to happen?
2. What actually happened?
3. Why were there differences?
4. What did we learn?

From these questions, especially if there are considerable differences between what was supposed to happen and what actually happened, the lessons learned can be highlighted.

It is then that the organisation can consider its response options in possible improvements using the following categories:

### Sustain

The response measures that the organisation has in place and have been validated by the recent experience are suitable for any future response. This directly links to relevant documents incorporating all policy, procedure and training material to support issue management (may require Standing Order or Safety Bulletin).

### Review

The response measures were inadequate or challenged in their ability to manage and effectively resolve the incident but only require nominal improvement, learning from the recent experience. This directly links to relevant documents with feedback from analysis to improve documentation during annual review process (may require Standing Order or Safety Bulletin).

### Develop

Personnel encountered a situation where organisational capacity was non-existent and the response was by an ad-hoc approach with the organisation learning to prevent a reoccurrence of not being prepared. Specific gap in knowledge identified and analysis of issue conducted to develop policy, procedure, training material and the implementation of the information across QFRS (may require Standing Order or Safety Bulletin).

### Pass On

Information and response indicate that the issue is not the responsibility of this organisation but documentation has to be completed to inform other DES Divisions and/or other Government Department of identified impact.

## CONTINUOUS IMPROVEMENT AND KNOWLEDGE MANAGEMENT

From this information and research on best operational practice, the QFRS will ensure increased safety for all personnel and continuous improvement in service delivery.

Effective learning draws upon the principle that the less time that elapses between discussing a lesson and applying it at work, the more effective the application and the overall improvement.

The **State Operations Directorate** maintains information within the **Operations Doctrine** and **Field Incident Guide** within the established annual review process. When information is identified as being vital for safety and operational effectiveness, **Safety Bulletins** and **Standing Orders** provide the temporary communications until the information is captured in the next review process.

In the practical environment of emergency response we must experience the lesson before teaching it to others so that the benefit to all is built on the cost of few.

### Safety Bulletins

A Safety Bulletin is used to communicate critical/urgent information swiftly and to alert QFRS personnel to operational safety hazards, near misses, and innovations generated from the fireground and is outside the annual document review period.

In a generic sense, Safety Bulletins communicate the actions required to eliminate or manage the risk - then improve performance delivery by identifying a better practice and sharing the knowledge.

They may be revoked only by the Commissioner or Deputy Commissioner or moved to an appropriate permanent location during annual review such as the Operations Doctrine.

Safety Bulletins can be initiated by Region, Area, or Headquarter Business Unit, after the Assistant Commissioner's approval, and then forwarded to the State Operations Directorate for issue.

### Standing Orders

Standing Orders are a multi-purpose document used to communicate only critical/urgent information, new/changed policy, instruction or information relevant to QFRS operational and/or business functions;

Standing Orders enable the Commissioner or Assistant Commissioner to communicate to the relevant personnel, information that is not currently covered within policy, doctrine, business rules, templates etc. Standing Orders are used outside the annual review period or as a reminder of information needed to control a specific situation.