

# **INDEPENDENT BUSHFIRE GROUP**

## **Further information to the Select Committee Inquiry into Coronial Jurisdiction in NSW**

**by the  
Independent Bushfire Group**

**29 December 2021**

IBG proposed to the Select Committee that bushfire investigations not involving human fatalities could be more effectively managed by an independent Inspector General of Emergency Management (IGEM) to the benefit of the remaining work of the Coroner.

This submission provides further information about how an IGEM could be set up to improve the review of bushfires for the benefit of firefighters and communities. We look at the purpose of such a system, its essential elements, and then at some existing Australian models that may provide guidance.

### **Purpose of an effective bushfire review system**

To undertake timely and effective reviews of bushfire operations that identify robust and practical recommendations on how bushfire outcomes can be improved.

### **Elements of an effective bushfire review system**

To achieve the purpose, a bushfire review system needs to be:

- independent – of the organisations involved in bushfire operations
- expert – in bushfire suppression and the factors that affect outcomes
- objective – free of bias
- evidence-based – reliant on facts and testing of observations
- analytical – applies expertise to determine events and issues
- broad-ranging – interested in successful outcomes as well as adverse incidents, selecting incidents to investigate where there are lessons to be learned
- inclusive - of all relevant personnel and views
- blame-free – focused not on ‘who’, but on systems, events, actions and reasons
- powerful – able to access all necessary records, documents and personnel
- unconstrained – not fettered by issues of liability, public relations and legal processes
- constructive – focused on root causes, what went well and what can be improved
- supportive – works with bushfire agencies to improve practices and ensure lessons identified are acted upon
- accountable – to the public and to Parliament
- transparent – as open as possible in terms of processes and outcomes
- confidential – when necessary
- integrated - produces inputs to coronial investigations
- resourced – to a level which supports the above elements

## Existing models

Many models are available across a variety of industries to inform the design of an IGEM and bushfire review system for NSW. We commend reference to section 4.1 *Post-fire review of operations* in the major IBG report *Reducing the costs and impacts of bushfires* which can be accessed [here](#) and includes detailed analysis of the situation in 2020, with the need for and benefits of a better system.

Four examples of Australian review bodies are introduced below, two from the bushfire sector, one from transport and one medical. None of them are wholly suitable for replacing the coronial system for bushfires in NSW, but all have valuable elements that could be combined into an effective solution.

The two bushfire IGEMs have focused mainly on higher-level issues of control and coordination. They seem to have the authority and structure to investigate detailed operational matters, but have done little such work to date, perhaps deferring to combat agency processes to deal with issues of operational detail.

The NSW Clinical Excellence Commission oversees a convoluted system of reviewing critical incidents in the health system. The review system has several commendable elements, including the application of expertise, open disclosure and root cause analysis.

The processes of the Australian Transport Safety Bureau for investigating adverse events may be the most effective and most relevant to bushfire. Important elements of the ATSB system include a 'blame-free' approach and a strong focus on evidence, rigorous procedures and finding lessons.

All four processes are to a greater or lesser extent directed towards adverse events. A bushfire review system must also analyse successes for lessons that can be learned and acted upon.

It should be noted that none of these four systems defer to potential later coronial or liability processes.

- **IGEM Victoria**

<https://www.igem.vic.gov.au/>

*"The Inspector-General is an independent statutory role providing assurance to government and the community in respect of emergency management arrangements in Victoria and fostering their continuous improvement."*

*"IGEM undertakes objective reviews, evaluations and assessments of Victoria's emergency management arrangements and the sector's performance, capacity and capability."*

*Through reliable, evidence-based information, IGEM identifies what is working well and where improvements can be made in the state's emergency management arrangements."*

Victoria's IGEM was established in 2014 together with a suite of other reforms to emergency management under the *Emergency Management Act 2013*. The IGEM reports to the Minister for Emergency Services. The IGEM's functions mainly at a system-wide level, with the following stated function being the most relevant to incident investigation:

- *undertaking system-wide reviews, including reviewing the emergency management functions of responder agencies and departments in relation to the assurance framework.*

However at the request of the Minister, in 2020 the IGEM undertook an independent inquiry into the 2019-2020 Victorian fire season, which examined preparedness, response, relief and recovery. The [Phase 1 report on Community and sector preparedness and response](#) was handed to the Minister on 31 July 2020.

The response component (Chapter 7) was mainly about the effectiveness of arrangements for control, coordination and management. The effectiveness of bushfire operations and suppression strategies received little attention. The only observation, finding or recommendation directly related to operations was Observation 7.10, about the “*effectiveness of aerial firefighting resources and the deployment system*”.

- **IGEM Queensland**

<https://www.igem.qld.gov.au/>

Queensland’s IGEM was established under the *Disaster Management Act 2003*. The key functions include to “review and assess” the “effectiveness of disaster management” and performance at all levels. The IGEM prepares [Review Reports](#) which “*include findings and base recommendations for improvement on lessons identified, research and good practice*”. The IGEM has prepared three recent reports on bushfires:

- [K’gari \(Fraser Island\) Bushfire Review](#)
- [Queensland Bushfires Review 2019-20](#)
- [2018 Queensland Bushfires Review](#)

The 2018 review focused mostly on high level issues to do with the disaster management system. It involved “*Robust scrutiny of evidence and insights collected through public consultation, submissions, interviews and surveys*”. Only one recommendation extended into the operational arena, regarding “*fire simulation and predictive capabilities*”.

The 2019-20 review includes “response”, however analysis of operational issues was limited to two high-level topics, “Incident management skills and knowledge” and “Operational information and intelligence”.

The K’gari review includes two recommendations that relate to bushfire response and operations. Recommendation 12 addresses appropriate training of Incident Controllers for significant events. Recommendation 15 calls for “*expanding specialist Remote Area Firefighting Team capability*”.

- **Australian Transport Safety Bureau**

<https://www.atsb.gov.au/>

The ATSB is Australia's national transport safety investigator. It is an “*independent Commonwealth Government statutory Agency...and is entirely separate from transport regulators, policy makers and service providers*”. The ATSB is constituted under the *Transport Safety Investigation Act 2003*, which empowers it to investigate transport safety matters in aviation, marine and rail transport.

The ATSB takes a ‘no-blame’ approach:

- “*It is not a function of the ATSB to apportion blame or provide a means for determining liability. The ATSB does not investigate for the purpose of taking administrative, regulatory or criminal action*”.
- “*...disciplinary action and criminal or liability assessment are not part of an ATSB safety investigation and should, if necessary, be progressed through separate parallel processes*”.

ATSB investigations begin with an evidence collection phase, followed by examination and analysis, then a rigorous and multi-step phase of report drafting, review and revision. The early phases are directed towards establishing what happened and safety factors involved. Note that the ATSB only investigates adverse events, although its other functions include “*safety data recording, analysis and research*” and “*fostering safety awareness, knowledge and action*”.

- **NSW Clinical Excellence Commission**

<https://www.cec.health.nsw.gov.au/>

The CEC is “*the lead agency supporting safety and quality improvement in the NSW Health system*”. The CEC is a board-governed body whose role is to “*lead, support and promote improved safety and quality in clinical care...*”.

The CEC reviews incidents within the NSW Health system. An incident is an unplanned event that results in, or has the potential for, injury, damage or loss, including near misses. So the CEC is focused on adverse events. Incidents are reviewed using principles of open disclosure, expertise and root cause analysis.

*“Open disclosure is a process for ensuring that open, honest, empathic and timely discussions occur between patients (and/or their support person) and health care staff after a patient safety incident”.*

The CEC maintains a Clinical Expert Panel of “clinician and health professionals with skills and expertise in investigative processes” who can assist review teams.

Root Cause Analysis (RCA) investigations are overseen is managed by a RCA Review Committee.

The [Incident Management policy directive \(2020\)](#) “*provides direction for consistency in managing and effectively responding to clinical and corporate incidents and acting on lessons learned*”. It sets out processes for reporting and review of incidents, depending on severity.

## Conclusion

The IBG does not presume to design a bushfire review system for NSW. This would require international and cross-disciplinary benchmarking (including military) and is beyond our capacity to deliver. However, to be effective, such a system should include all the elements we list above. The process should be driven independently of the four NSW bushfire combat agencies and other emergency delivery agencies (Resilience NSW, Police, Ambulance, SES, local government) but will require engagement with them. A NSW IGEM could be based around the Victorian or Queensland models extending the review scope to include combat systems, preparation, planning, operations and recovery.

Thank you for considering this information.

Yours sincerely.

Ian Brown  
Secretary  
**Independent Bushfire Group**