NSW GOVERNMENT Department of Primary Industries

Guide

Emergency Management Unit
Biosecurity and Food Safety
Email: emergency.preparedness@dpi.nsw.gov.au

Briefing, debriefing and handovers in emergencies

Briefings, debriefings and handovers are a critical component of the communication process and critical to information flow during an emergency event.

- Briefings ensure all personnel involved, including contractors, understand the objectives, strategies, safety issues, roles and responsibilities and reporting relationships.
- Handovers are briefings at a changeover of personnel in the same role.
- Debriefing is a feedback process that provides information on the progress of the event against the Incident Action Plan (IAP), new information and any risks.

Briefing

- The Incident Controller must ensure briefings occur at all levels of the incident management structure.
- Supervisors must conduct briefings of their teams, units or functions.
- All personnel must be briefed before attending the emergency, before being deployed at the emergency (e.g. induction), at regular intervals during the emergency and when circumstances have changed (e.g. safety, tasks).
- When conducting a briefing:
    1. ensure relevant personnel are present
    2. meeting times account for operational activity
    3. the location is suitable (e.g. safe) and/or suitable communication is in place
    4. distractions are minimised
    5. presenters and briefing materials (e.g. visual displays, handouts) are appropriate.
- The SMEACS-Q format (Situation, Mission, Execution, Administration, Command and communication, Safety, Questions) should be used (see Table 1). It informs:
    1. what is to be done (with priorities and timeframes)
    2. how its intended to be done (with standard of work)
    3. the role of the group or individual (with reporting arrangements and delegated responsibilities).
- The person conducting the brief should:
    1. respond promptly to identified inaccuracies or gaps in the briefing information
    2. seek feedback on the conduct of the briefing and rectify issues identified
    3. retain a record of the briefing in the emergency registry system.

Handovers

Handovers relay current situation information in a briefing format to the next person filling the same role.

- The person currently in the role compiles a summary of actions (completed and outstanding) and any information relevant to the role in the SMEAC-Q format (Table 1).
- Replacement personnel should make themselves familiar with emergency information prior to the handover e.g. role description, situation report (sitrep), IAP, policies, procedures, risk assessments, maps, hazard specific information.
- Handovers are conducted after the replacement has been inducted into the emergency and according to circumstance e.g. face-to-face with written support, written only (with information in a specific document, email or role event log) or remotely (by phone, video conference etc).
- A record of the handover must be retained in the emergency registry system.

Debriefing

- Personnel can be debriefed during shifts (hot debrief), at the end of their shift (i.e. daily), post-emergency, and/or when critical incidents occur, as detailed in Table 2.
- The Incident Controller must ensure debriefings occur at all levels of the incident management structure. Supervisors must conduct debriefings of their teams, units or functions.
- After action reviews (AARs) are more formal debriefs conducted post-incident/response, tour and/or campaign (see Table 3) and are the responsibility of the Agriculture and Animal Services Functional Area Coordinator (AASFAC) for natural disasters, Plague Locust Commissioner for locust emergencies and the relevant Biosecurity and Food Safety Director for biosecurity emergencies.

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- Planning for debriefs/AARs is similar to briefings and also requires a clear idea of the intended outcomes/ objectives (as in Table 2) and a process to record issues and actions identified.
- Debriefings use standard questions as detailed in Table 3 to:
    1. identify the organisational strength that can be built on
    2. identify areas for improvements
    3. validate the participation of the teams and individuals.
- The person conducting the debriefing should ensure:
    1. Provision of prompt feedback and guidance for organisational improvement to debrief participants by providing reinforcement of successful practices or alternate 'best practice' treatment options.
    2. Report of debriefing outcomes – the detail required and format will vary with the debrief complexity.

Table 1: The SMEACS-Q acronym and key information contained in a briefing

Briefing component	Detail provided
Situation	The current and predicted situation including: • An overview of incident • Current and expected weather • Life and property at risk • A summary of resources deployed
Mission	Statement of intent and the specific objectives set for the incident or tasks.
Execution	How the mission will be accomplished including: • Strategies and tactics • Constraints • Task and resource allocation • Access to the incident • Times- shift or tour of duty • Immediate tasks after briefing • Contingency plans
Administration	Administration and logistics for the operation including: • Key support locations and roles • Incident staging area • Catering • Supply • Ground/medical support • Check in/out requirements • Arrangements for checking records
Command and communication	Incident management structure including: • Sectorisation • Reporting relationships and times • The Communication Plan • Contact numbers, radio channels
Safety	Identification of known or likely hazards including: • Weather • 'Watch out' situations • Safety equipment required and protective clothing standards • Welfare – hydration, first aid
Questions	Questions for clarification, or to seek additional detail, are asked at the end of the briefing to ensure participants have full understanding of what is required and their role. A record of questions, feedback and follow up actions should be maintained.

Sourced from The Australasian inter-service incident management system (AIIMS) 2017, p83.

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Table 2: Debrief types and objectives for different situations

Debrief type	Description	Objectives of the debrief
Hot	Conducted during a shift immediately after a significant event or near miss situation.	• How the emergency or near miss occurred • Who was affected and any action required • Any ongoing potential hazard/s or risk/s to personnel • Action to mitigate risk/s • Appropriate reporting and recording arrangements
Shift	Conducted at the conclusion of a shift (e.g. daily) or work period to review work undertaken, identify any issues so they can be addressed and reported to subsequent shifts.	• Validate the contribution of the individuals in the group • Identify operational issues likely to affect the group during the current activity • Identify suggested mechanisms to resolve those issues • Provides shared situation awareness
Post-incident / response **(i.e. After Action Review)**	Conducted after the emergency response to assess the conduct or results of the operation. Can be conducted at crew/work group, agency and inter-agency levels.	Objectives will vary with the level of the debrief: • Operational effectiveness (e.g. clarity of objectives, strategies and tactics, communication flows, resource issues, value of training and procedures/processes) • Crew/work group debriefs – summarise issues raised • Agency – improve organisational response, logistical and/or coordination arrangements • Inter-agency – discussing and identifying coordination issues
Tour **(i.e. After Action Review)**	Conducted when crew/s have operated away from their home base (e.g. region, interstate, overseas).	• Effectiveness of mobilisation and logistical arrangements • Smoothness of operations and what worked well (reinforces the value of training, procedures) • Lessons learned and areas for further improvement
Campaign **(i.e. After Action Review)**	Conducted at an organisational level after a major event or at the end of a season. Requires collection of intelligence across the organisation to identify any emerging trends or patterns.	• Validate the contribution of individuals, teams and parts of the organisation • Confirm the effectiveness of established policies, arrangement and procedures • Identify organisational and operational issues • Identify effectiveness of reporting and recording processes
Critical incident	A process for individuals involved in, or witness to, a critical incident.	A specific debrief conducted according to the guide critical incident stress which provides assistance and support to impacted personnel by specifically trained personnel. This debrief process is different to hot debriefs and post-incident debriefs.

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Table 3: Standard questions for debriefing

Debriefing component	Detail provided
1. What was planned?	What were the goals/objectives? • Incident action plan • Team incident goals • Other team goals • Individual goals • Were there additional unstated (informal) goals
2. What actually happened?	Participants should focus on what transpired. Full participation should be encouraged so that all can add their perspective of what happened. Resolve inconsistencies in the story and/or fill in gaps in the story.
3. Why did it happen?	Find the root causes behind identified successes and failures. Discuss and agree on the reasons for the differences. Identify the factors that contributed to success or lack thereof. Successes - The need to determine why a crew/response was successful or effective is just as important as discussing failures, as it is these actions and behaviours you are trying to replicate in the future. For example, when: • A situation was sized up correctly. • A potentially dangerous change was noticed and communicated immediately. • An action was executed exactly as planned or taught. • Someone had a good idea or an option about how to handle a situation. Failures - Inquiries and analysis should concentrate on **what** is right, not **who** is responsible. When a failure is identified, determine what should have happened, and secondly what did not happen (or happened wrong). Identifying an individual's failure is permissible, as long as it goes to the source of the problem. The result needs to be pointed at what should have happened, not at the personal integrity of the individual(s) involved.
4. What can we do next time?	1. What went well and why? Seek to build on best practice and identify strategies to ensure that successful practices are built in to future work and repeated. 2. What can be improved and how? Identify the stumbling blocks and pitfalls, so they can be avoided in the future.

References

The Australasian inter-service incident management system (AIIMS) 2017