Learning lessons and implementing recommendations

The argument

There is an urgency to learn lessons, implement review findings and incorporate findings from royal commissions, reviews and inquiries. What needs to change (i.e. legislation, expectation, policy) to enable lessons to be learned and implemented?

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The question implies that lessons are not learnt and the learning is not implemented. It would be wrong, however, to infer that a subsequent disaster means the lessons from the last disaster have not been learnt nor incorporated. While the Bushfire and Natural Hazards CRC Inquiries and Reviews Database[1] hosts inquiry recommendations, there is no data set to identify how many recommendations have been implemented, how they have been implemented and whether they have been effective. This creates room for the assumption that recommendations must not have been implemented or have not been effective. The *2009 Victorian Bushfires Royal Commission final report*[2] recommendation for an implementation monitor was unusual and gave some feedback on implementation, but the monitor and the various reports did not attract the same attention as the inquiry itself.

Even so, there is concern across the sector and the community generally that a great deal of time and money is spent on formal post-event inquiries. They are often opened with great fanfare, reported on with interest and reports are handed over to ministers and/or chief officers with solemn ceremonies and promises to implement the lessons identified. And a few years later, the process is repeated after the next catastrophic fire or flood, and we can anticipate that heatwave and pandemic will, in due course, be added to that list.

So, is there a failure in government or the emergency management sector to properly incorporate findings from royal commissions, reviews and inquiries? Is there a simple fix such as a change of legislation, expectation or policy that will ensure that what the next inquiry recommends will be adopted? And if there is a simple fix, should it be implemented?

Inquiry limitations

All inquiries have their limitations that must be recognised, and which mean it would be unwise to have legislation, expectations or policy to the effect that once an inquiry is called, government or the emergency services organisations must adopt all the recommendations that are eventually handed down.

Inquiries respond to a particular event and problematically, each event is necessarily different, so it may not be possible or appropriate to apply findings from one event to another. The lessons learnt from the response to one fire may not be transferable to the next fire, and even less so to the next disaster if it is a flood. State-based inquiries deal with the policy and management regime of the jurisdiction in which they are established. While there will be situations where the learning from one event is transferable to the next event or another jurisdiction, differences, both physical and in terms of governance and policy, between the jurisdictions and events may mean that the recommendations from one cannot be applied in the other.

The report by Cole *et al.*[3] identified that the great bulk of recommendations (at least until 2018) targeted state agencies and very little on the private sector, households or volunteers.

1. Bushfire and Natural Hazards Cooperative Research Centre, Inquiries and Reviews Database, at *https://tools.bnhcrc.com.au/ddr/dataspace-home*.
2. *2009 Victoria Royal Commission final report,* at *http://royalcommission.vic.gov.au/Commission-Reports/Final-Report.html*.
3. Cole L, Dovers S, Gough M and Eburn M (2018) *'Can major post-event inquiries and reviews contribute to lessons management?', Australian Journal of Emergency Management, 33(2):34–39.*

Governments manage and can direct agencies so those sorts of recommendations may be implemented while a failure to make recommendations directed at, or an inability to compel compliance by, the non-government sector may mean that vulnerabilities remain. It has been observed that analysis failed to consider First Nations Australians because the inquiries themselves did not address issues affecting First Nations populations. Inquiries are often and necessarily partial in their focus. Thus, their recommendations may not address the source of vulnerabilities nor identify all relevant lessons. Even when the recommendations are adopted, the vulnerabilities remain.

Recommendations designed to deal with one type of event may conflict with other competing interests. An inquiry into the death of a rescuer may lead to very different, and even conflicting, recommendations as that made by an inquiry into the death of a person waiting to be rescued. A royal commission may consider how decisions in other policy sectors impact on emergency management and, in particular, on the event that they are investigating. But they have much less capacity to consider the implications of their recommendations on other policy sectors. For example, a royal commission could recommend that homeowners should clear land around their home as a suitable solution to the problem of homes being lost to bushfire due to close proximity of vegetation. But the commission, subject to its terms of reference, cannot consider how that might effect amenity or environmental and other issues. An inquiry into wildlife protection, on the other hand, might recommend that people should not be allowed to clear native vegetation without an impact assessment and local council approval, but that would not consider the bushfire threat. Governments that are responsible for both ecological preservation and fire management have to consider how to balance these competing demands, but royal commissions, coroners and other inquiries, bound as they are by their terms of reference or legislation, do not.

Post-event inquiries do not and cannot consider the budget implications of their recommendations although this is something governments must do. The 2009 Victorian Bushfires Royal Commission recommended the buy-back of fire-prone land and that single-earth wire return and 22-kilovolt distribution feeders be replaced with aerial bundled or underground cabling. These were originally rejected by the Victorian Government in part on the basis of cost and research undertaken by the Powerline Bushfire Safety Taskforce, which found that the Victorian community was unwilling to pay the cost of meeting that recommendation. In 2005, the South Australian coroner recommended that the Minister for Emergency Services give further consideration to acquiring a firefighting helicopter (and he had in mind a Sikorsky Sky Crane/Erickson Air Crane) to be permanently or primarily stationed in South Australia without having to regard the cost or feasibility of investing in such an expensive, dedicated resource.

Inquiry recommendations are necessarily counterfactuals, that is, they are predictions that some other approach or some reform will work better but the future possibility is being judged against a past, known outcome. The recommendation may be implemented but it may not solve the problem. For example, the inquiry into the Ash Wednesday bushfires that swept across parts of Victoria and South Australia in 1983[4] recommended that:

> *'… a Minister is designated as Co-ordinator-in-Chief of disaster affairs and is responsible for direction and control across the whole spectrum of preparedness, combat and relief activities.'*

That was adopted into Victoria's emergency management legislation but was critiqued by the 2009 Victorian Bushfires Royal Commission that recommended the Parliament 'remove the title of Coordinator-in-Chief of Emergency Management from the Minister for Police and Emergency Services' and 'designate the Chief Commissioner of Police as Coordinator-in-Chief …' The 2009 bushfires did not demonstrate that the 1983 lessons had not been learnt and implemented, only that they were not effective.

Every proposed solution is someone else's problem. An inquiry can make a recommendation, but it falls on others to work out how to implement it and who must pay for it. A recommendation for stricter building controls in response to bushfire or flood hazards creates problems for homeowners who must pay for them and councils that have to implement them and who may face strong community resistance and a rise in candidates seeking election to oppose perceived government overreach. Those political realities must be managed, which may see an implementation that does not and cannot match the inquiries intent.

Finally, minds may differ on whether recommendations have been adopted. An inquiry may recommend that there is a public education campaign, or the development of resources, or training or that agencies cooperate. These may be accepted and implemented but different people may have different views on whether the implementation is effective or achieves the desired outcome. And it may be that it is only the next hazard event that 'pressure tests' the implementation. In that case, the fact that a continuing vulnerability is exposed does not mean that the past recommendation was ignored or not implemented.

Conclusion

We hope that post-event inquiries will identify valuable lessons from devastating experiences and come up with recommendations that, once adopted, will enhance resilience (or reduce vulnerability) to make society safer and secure. In fact, many of them do, and looking at the wide range of post-event inquiries can reveal common themes and cumulative insights that can inform the emergency management sector.

What is important to acknowledge is that merely adopting the recommendations for the next inquiry will not guarantee that there will not be a future disaster. Inquiry recommendations may be impractical, unaffordable, conflict with other important goals, may remove one vulnerability but expose another or may

4. Victoria Government (1983) *Report of the Bushfire Review Committee: on bush fire disaster preparedness and response in Victoria, Australia, following the Ash Wednesday fires 16 February 1983.*

simply end up not being the right recommendation. Further, the occurrence of another disaster does not mean the lessons from past events have not been implemented. The Black Saturday fires in Victoria in 2009 may have been devastating but they were less devastating than they might have been because of the lessons learnt from previous fires. The 2019–20 bushfire season affected many jurisdictions but had fewer deaths than the less extensive Victorian bushfires because of the lessons learnt and recommendations implemented post 2009.

Therefore, there is no single answer to the question 'what needs to change to enable the lessons to be learned and implemented?' What is needed depends on the event, the vulnerabilities exposed and the lessons identified. These will be different with each event and each inquiry.

References

Eburn M and Dovers S (2015) *Learning lessons from disasters: alternatives to Royal Commissions and other quasi-judicial inquiries, Australian Journal of Public Administration, 74(4):495–508.*

Eburn M and Dovers S (2017) *Learning for emergency services: looking for a new approach, Bushfire and Natural Hazards CRC.*

Eburn M and Dovers S (2017) *Reviewing high-risk and high-consequence decisions: finding a safer way, Australian Journal of Emergency Management, 32(4):26–29.*

Cole L, Dovers S, Gough M and Eburn M (2018) *Can major postevent inquiries and reviews contribute to lessons management? Australian Journal of Emergency Management, 33(2):34–39.*

Bushfire and Natural Hazards Cooperative Research Centre (n.d) *Inquiries and Reviews Database. Retrieved: https://tools.bnhcrc.com.au/ddr/dataspace-home.*

Responses

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Dr Eburn and I agree that lessons have the power to create dynamic change in processes and operations. However, I would argue that changes to legislation, policy and expectations are not the only avenues available for creating and cementing change in complex systems.

Establishing a lessons culture is critical to continuous improvement and should be the goal of every high-calibre organisation. But we should not be limited to using lessons like a rear vision mirror to analyse past events.

The premise that we see reoccurring themes (such as coordination, near real-time situational awareness, communications and loss of agency for communities) as an indicator that we have not learnt any lessons is unsubstantiated. I would argue that the reoccurring themes are entrenched characteristics of disasters. The real value of lessons lies in identifying common themes and insights across complex events and institutionalising adapting systems to minimise the impacts and effects of these entrenched characteristics, while still drawing on the benefit of history. The system should not, by design, wait for the wheels of government policy making to disrupt, adapt and drive change.

Our environment is rapidly changing. The 2023 Intergenerational Report (IGR) considers five of these major forces: an ageing population; technological and digital transformation; climate change and the net zero transformation; rising demand for care and support services; and geopolitical risk and fragmentation. This – coupled with more frequent, more intense disaster events and the consecutive, concurrent and compounding effects of these risks intersecting – means that Australia faces a challenging future that Australia's emergency management system needs to operate in.

With a changing operating environment, the lessons system must also adapt. The success factor in this environment is not how many lessons were identified and fully implemented in a post-hoc review, but how quickly emergency managers made sense of the situation; the speed to action and how quickly they identified and prioritised the critical areas in the system that needed to be stabilised; the speed to decision to clearly articulate the lines of effort that were required to mitigate and stabilise the situation; and finally, how effectively they communicated.

While disasters are complex, what the community wants to know remains the same. They want to hear: *what we know; what we do not know; what we are doing to mitigate the risks we have identified; what we want others to do; and what our communication tempo will be.* Using this information as our guide, and finding multiples channels, repeatedly, to communicate with the public will maintain public trust in the system and will be another measure of our success.

The lessons system therefore needs to be dynamic, adaptable and should operate using near-real time methodology, allowing rapid changes to be incrementally made within the system, and ensuring change that is in the public interest is immediately realised.

The seed article refers to inquiries, reviews and lessons systems that with hindsight – and often undertaken by lawyers or

auditors outside the emergency management system – make judgements without having the context of the people operating in the environment at the time, and in the fog of disaster. The near-real time lessons approach does include looking at previous reports and recommendations, but it also encourages and enables dynamic change while the event is unfolding.

NEMA fosters collaboration, inclusivity, and adaptability for lessons on a national scale, charting a collective course towards more effective problem-solving that will position Australia to better prepare for, respond to and recover from disasters today and into the future.

The National Coordination Mechanism (NCM) provides an opportunity for identifying and informally sharing real-time lessons across agencies nationally. But we also look for continuous improvement like desk top data collection and analysis, hot debrief, after action reviews and multi-agency debriefs. The data we collect and the insights we identify are integrated rapidly into our approach, priorities and capabilities without waiting for lengthy reviews or lessons processes.

The change is not in the lessons methodology, but how it is applied. We should shift from drawing on hindsight to a focus on near real-time or foresight and be prepared to make incremental adjustment that can be measured immediately. This can be achieved while still referring to previous reviews and lessons to measure our performance with the collective goal of building adaptable, complex systems that support and build national resilience.

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> The question raised by Dr Eburn of what needs to change to enable lessons to be learnt and implemented has many perspectives. When lessons are not properly institutionalised, they will be forgotten across time.

Post-event reviews need to develop implementation and delivery guides to accompany their recommendations, together with leadership and oversight mechanisms, to help meet the risk of institutional amnesia and ultimately wasted effort. Where the existing mechanisms do not already incorporate pre-event assurance, those need also to be included.

This was the approach taken by the Royal Commission into National Natural Disaster Arrangements[1] in 2020, which found that quality assurance and monitoring supports accountability and builds consistency across all levels of disaster management arrangements. With the goal of promoting best practice and continuous improvement across all phases of disaster management, these encourage the best use of resources, and best possible outcomes for our communities. The process of assurance, particularly when conducted by an external and independent body, enables a statement of confidence to be made as to the effectiveness of agencies operating within disaster risk mitigation and management arrangements. Assurance can also reinforce a shared responsibility for better disaster risk mitigation and management outcomes for the community.

The 2020 Royal Commission recommended that each of the Australian, state and territory governments establish these accountability and assurance mechanisms. Has this been implemented in any comprehensive or meaningful way across our nation? No, it seems not. Does a combination of institutional inertia or resistance explain the continuance of this unsatisfactory status quo?

As the Commissioners acknowledged, Australia's natural disaster risk is already alarming. As the CSIRO observed in its February 2024 report *Understanding the risks to Australia from global climate tipping*[2], there are dangerous climate tipping points that will affect Australia. The risks are real and cannot be ignored. The time to act is now.

1. Royal Commission into National Natural Disaster Arrangements, at *www.royalcommission.gov.au/natural-disasters*.
2. CSIRO (2024) Understanding the risks to Australia from global climate tipping. At: www.csiro.au/-/media/Environment/CSIRO_Tipping-Points-Report.pdf.

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> The analysis by Dr Eburn shows the complexity of post-event inquires and I agree that such inquires have some benefit, but must be combined with proactive assurance mechanisms.

Shouldn't we move beyond a dialogue dominated by post-event reviews and pose the question of how do we best provide proactive assurance that we are prepared? Meaning, wouldn't it be prudent to be proactive in identifying risks and issues and putting management measures in place to ensure risks are reduced before disasters strike, rather than being reactive post event?

Post-event inquiries have been catalysts for successful nationwide policy changes. They provide political expedience and an opportunity for communities to engage in the debriefing process. However, they have their limitations and should not be the sole source of formal assurance and accountability.

Post-event inquiries tend to be ad hoc, narrow, hazard specific and backward-looking. Unless they provide recommendations that are reflective of the broader 'riskscape' they risk distracting governments with a focus on preparing for a recurrence of the last disaster rather than the next one, which may be very different.

Following the 9/11 terrorist attacks, inquiries led the United States Government to prioritise preparing for terrorism, not natural hazards. Then Hurricane Katrina occurred, and America's response failed. I have seen this in Australia too, with the 2009

Victorian Bushfires Royal Commission[1] focusing solely on the Black Saturday bushfires, excluding the concurrent extreme heat[2] that had taken more lives. This was followed by record floods in 2010–11 that led to another inquiry. The Victorian Floods Inquiry[3] not surprisingly found that many of the issues with Victoria's flood response were the same as those with the Black Saturday bushfires a year earlier. In the meantime, opportunities for change had been lost. It is commendable that the Royal Commission into National Natural Disaster Arrangements[4] in 2020 took a broader perspective.

Given the rapidly changing riskscape of our communities and the scale of continuous disaster operations, the need for proactive and pre-event assurance in addition to post-event inquiries is critical. We can't just assure our preparedness for the next major disaster through the lens of the previous one, nor through the next one. It will be too late.

There is a need for transparent, systematic, pre-event and risk-based assurance frameworks that provide assurance within the emergency management system and on key risk controls. These should be implemented and empowered by dedicated independent agencies with supporting legislation. Such organisations exist in Victoria and Queensland through the role of the Inspector-General Emergency Management. A recommendation of the Royal Commission into National Natural Disaster Arrangements was for each jurisdiction to establish an independent accountability and assurance mechanism; however, this has not occurred.

In establishing the Victorian Inspector-General Emergency Management, it was stated that a 'strong performance-monitoring and review body is essential for sector accountability'.[5] Such assurance mechanisms extend critical inquiry into preparedness for major disasters, providing for a proactive, continuous and risk-based perspective, with the opportunity to monitor and evaluate the extent of continuous improvement.

There is an answer to what needs to change. It is greater investment in proactive assurance mechanisms. We need to move from a focus on post-event reviews to pre-event foresight and assurance.

1. 2009 Victorian Bushfires Royal Commission, at *www.disasterassist.gov.au/Pages/disasters/previous-disasters/Victoria/Victorian-bushfires-January-to-February-2009.aspx.*
2. 2009 heatwave, at *https://knowledge.aidr.org.au/resources/health-heatwave-south-eastern-australia-2009/.*
3. *Review of the 2010–11 Flood Warnings & Response,* at *https://knowledge.aidr.org.au/media/4456/review-of-the-2010-11-flood-warnings-plus-response_victoria.pdf.*
4. Royal Commission into National Natural Disaster Arrangements, at *www.royalcommission.gov.au/natural-disasters.*
5. *Victorian Government (2012) Victorian Emergency Management Reform White Paper. Retrieved: www.emv.vic.gov.au/publications/victorian-emergency-management-reform-white-paper-dec-2012.*