Effective Command:

Command Skills – Decision Making & Operational Discretion

By Dr Katherine Lamb

Introduction

Command skills are the cognitive and interpersonal qualities critical for assertive, effective and safe incident command. To apply them, incident commanders should be able to:

- Identify and prioritise problems and develop a plan to resolve the incident
- Communicate this plan to others
- Co-ordinate and control activity in line with their plan
- Display the leadership needed to resolve the incident and operate effectively under the pressures of an incident

These qualities are known as command skills.

Professional Judgement

Risk Based Approach

Operational Discretion

Inter & Intra Operability

Organisational Assurance

Public Expectations

Assertive, Effective & Safe Commanders

Operational Accountability

Command Skills

- Leadership
- Incident Commander Communication
- Personal Resilience
- Situational Awareness
- Command Decision-making
- Operational Discretion

We will look at in little more in depth

Decision Making

Incident Command is easy?

The Decision Making Process

Incident Commanders make decisions throughout an incident, the decisions involve;

- Deciding what the problem is
- Assessing risk
- Identifying and prioritising objectives
- Deciding tactical priorities.

Decision Making Processes

- Automatic Response (AR)
- Analytical Decision Making (AD)
- Recognition Primed Decision Making (RPDM).

Decision Making Processes

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- Are primed by a specific cue and may not relate to a goal, objective or plan
- Decision maker reacts to elements of the situation as opposed to tactical planning
- E.g. which seat do you pick on the bus

Automatic DM		Analytical DM	
	Fast		Slow
	Unconscious		Conscious
	Automatic		Effortful
	Everyday Decisions		Complex Decisions
	Error prone		Reliable

- Involves analysing the situation
- Emphasises conscious deliberation of the situation and possible solution
- E.g. which house do you want to buy

Recognised Primed Decision Making

Recognition Primed Decision Making

Key Features

- Emphasises the role of previous experience in selecting actions
- Emphasises workable and satisfactory actions rather than optimum
- Emphasises reacting to the situation rather than generating options
- Experienced as automatic by the decision maker

Advantages

- Fast Decision Making
- Useful for familiar and routine situations
- Can provide workable actions
- Requires little conscious deliberation
- Relatively resistant to stress

Disadvantages

- Relies on the accuracy of the mental model for decision making – no checking process
- Rationale not considered during process making justification difficult to articulate
- Requires experience of similar situations
- Can bias situational assessment i.e. focus on evidence that supports

Decision making in an Operational context

To resolve the incident , Incident Commanders should

- Understand their starting position (A)
- Know their desired end position (B)
- Develop a plan that gets from one position to the other

A B

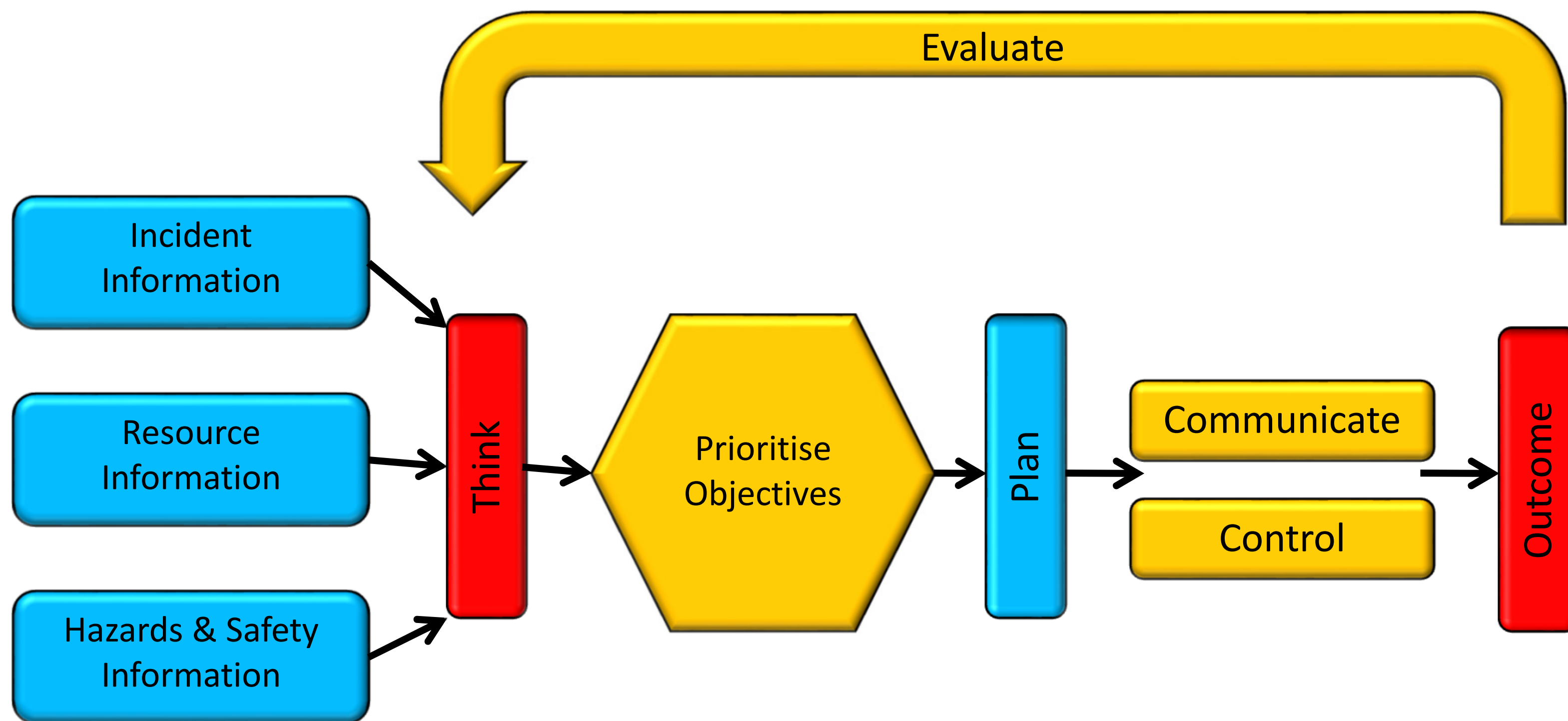
What factors may affect your Decision Making ?

Situational factors	Emotional factors	Mental factors	Organisational factors

▪ Time pressure
▪ Moral pressure
▪ Stress/Fatigue
▪ High stakes
▪ Uncertainty
▪ Accuracy of information
▪ Missing information
▪ Changing environment
▪ Ill-structured problems
	▪ Anxieties over:
	  ▪ Accountability
	  ▪ Public scrutiny
	  ▪ Peer scrutiny
	  ▪ Legal scrutiny
	▪ Experiencing/
	▪ anticipating negative emotions
	▪ Trust
		▪ Mental capacity
		▪ Competence
		▪ Technical expertise
		▪ Risk appetite
		▪ Distraction
		▪ Information overload
		▪ Understanding of role
		▪ Uncertainty of options
		▪ Multiple goals
		▪ Incident goals
		▪ Organisational goals
		▪ Other agency goals
		▪ Competing priorities
			▪ No clear policy
			▪ Policy too restrictive
			▪ Organisational Culture
			▪ Safety Culture

Decision Making Models

London Decision Making Model



JESIP Decision Model

Risk Based Decision Making

Remember – Risk vs Benefit

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- Life
- Benefit
- Property

- Crew Safety

Operational Discretion

Galston Mine Incident

Strathclyde July 2008

Background

- Alison Hume a 44 year old lawyer died of a cardiac arrest brought on by acute hypothermia on the morning of the 26th July, having fallen down a disused mineshaft some hours earlier
- Alison was badly injured but alive when emergency responders attended the site in Galston
- It was over five hours after their arrival that rescuers were able to remove her from the mine shaft.

"It is absolutely clear that, for those charged with her rescue, the collective lack of focus on rapid medical intervention and the risk of hypothermia significantly decreased the likelihood of her survival."

(S.Torrie QFSM, March 2012, A Report To Scottish Ministers – The 2008 Galston Mine Incident, pg:3)

Strathclyde Fire & Rescue Service

- 1 × Heavy rescue vehicle carries enhanced SWAH equipment such as additional ropes, stretchers (including basket stretcher) and fire fighters trained to conduct rescues by raising or lowering

March 2008

- Specifically ruled out providing specialist line rescue and chose to defer to other organisations (coastguard, police, mountain rescue)
- The Safe Working at Height equipment at that time was not to be used to effect rescues, but only to create a work restraint, work positioning and fall arrest systems of work for operational personnel
- "SWAH equipment cannot be used to effect the rescue of non Fire and Rescue Service personnel using work positioning systems of work".

Incident Background

- Alison, a criminal lawyer was celebrating becoming a partner with her two daughters at her sister's house half a mile from her own home
- At around 11:00pm her daughter Sophie headed home following a well used path across a field separating their homes
- At 11:45pm Alison took the same shortcut home
- 12:30am daughter Jayne arrives home to find no sign of her mother and starts searching for her
- 02:12am Jayne hears her mothers cries and calls 999.

Incident Response – 26th July 2008

- 0hrs 15 mins

Initial Call

02:13 am

- Call to control from Jayne Hume, states her mother is stuck down a "massive, massive, massive hole"
- Location: Field behind new housing estate

Mobilising

Mobilised to "Female trapped 25ft down hole".

- Categorised as "special service":
- 2 × Fire appliance
- 1 × Heavy Rescue Vehicle
- On call officers informed

Incident Response – 26th July 2008

- 0hrs 0 mins

Attendance

02:28am	2 Fire Appliances in attendance Incident Commander: Watch Commander Rooney
02:30am	Ambulance (with paramedic) in attendance
02:45 am	Police in attendance
02:51am	Heavy Rescue Vehicle in attendance.

Initial Actions

VICTIM'S HOUSE, YARDS FROM SHAFT

© Daily Record

Initial Actions

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+ 0hrs 0 mins

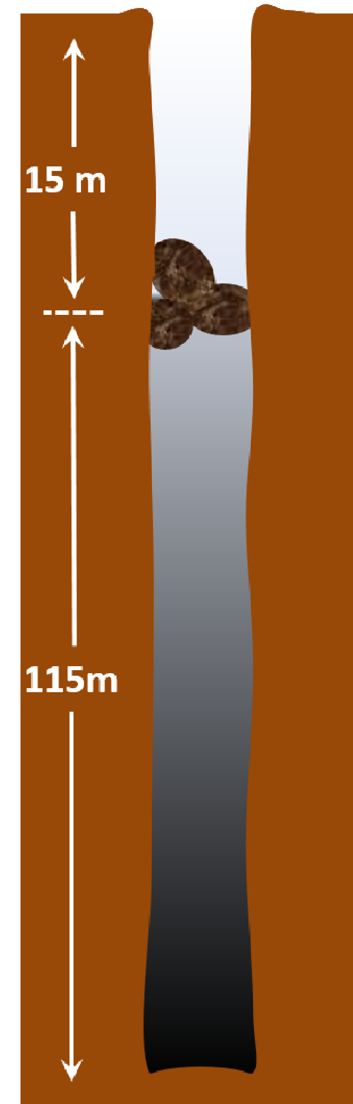
Incident Commander: Watch commander Rooney:

- Met by family members
- Large hole (estimated 10m diameter)
- Cordon & Lighting set up
- Alison heard calling out but could not be seen
- Discussions about being a disused mine not communicated.

Tactical Plan

+ 0hrs 0 mins

Unknown at time that collapse had formed cap in shaft which continued for another 115m.



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Tactical Plan

+ 0hrs 48 mins

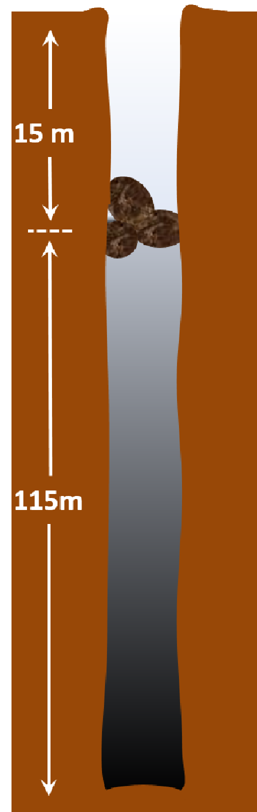
03:16am

HRV Crew lower FF Dunn to assess Alison (No record of rescue plan should he need to be removed).

FF Dunn moves Alison from water and covers her with blankets and give O^2. Assess she has trauma injuries and is very cold and wet, continues to relay condition to surface

03:25am

Following discussion, paramedic Galloway agrees to don harness and enter shaft to treat Alison.



+ 0hrs 57 mins

03:25am

Incident Commander: Group Commander Howe agrees to proceed with paramedic lower. HRV crew carry out R.A, advise I.C they can rescue Alison Hume.

Plan agreed, equipment laid out and Fire-fighters don harnesses preparing to enter shaft

03:15 – 03:30am

Sergeant Whittington contacts police to request Police Mountain Rescue (Based 50 miles away).

Tactical Plan

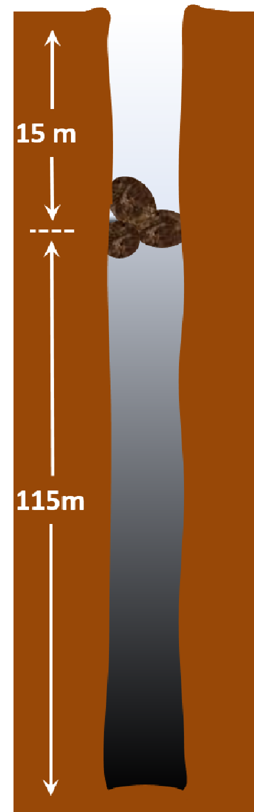
+ 1hrs 08 mins

03:36am

Group Commander Stewart (Media Liaison). He was informed of plan to lower paramedic in Fire SWAH kit

He instructs service member with radio to contact I.C Howe and request ceasing of operations until he arrives on scene to discuss strategy

On arrival G.C Stewart makes the decision that the HRV crew and Paramedic are not to enter the shaft



+ 1hrs 17 mins

03:45am

Sergeant Whittington, informed Police Mountain Rescue would muster a team ETA +40 mins

04:03

G.C Stewart takes over as I.C believes insufficient control at incident i.e. committing of paramedic

No evidence of discussion with HRV crew on discussing a plan or understanding crew capability.

Tactical Plan

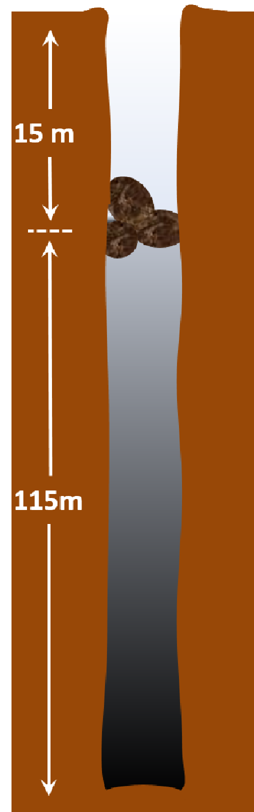
+ 1hrs 47 mins

04:15am

Fire, Police & Police Mountain rescue, conclude that Mountain Rescue Team are properly equipped to carry out rescue

Planning assumptions based on G.C Stewarts understanding of current line rescue policy

G.C Thomson (on call Commander) decides to attend after receiving detailed informative message



+ 2hrs 29 mins

04:57am
G.C Thomson takes over as I.C.
He is happy to continue plan of waiting for Police team

05:13
Area Commander Shaw attends following contact with control, happy to proceed with plan

05:22am
Last member of Police Mountain Rescue Team arrives, preparations begin…

The Rescue

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+ 3hrs 53 mins

06:21am

Preparations complete, PC Parker enters shaft with stretcher

Working with FF Dunn, Mrs Hume is secured in the stretcher

PC Parker and Mrs Hume are raised together by the Police Mountain Rescue Team assisted by a large number of emergency workers pulling on ropes

At the same time FF Dunn is raised by two Fire-fighters operating SWAH equipment

1.5m from surface, an overhang creates difficulty in exiting the shaft

Edge transition overcome with improvisation from Police and Fire-fighters

During edge transition Alison goes into Cardiac Arrest.

07:42am Alison Hume is extricated from the shaft and immediately transported to hospital by air ambulance

5 Hours and 14 Minutes after the first appliance booked in attendance.

<u>Almost 8 Hours after her accident</u>

Incident Conclusions

The injuries Alison sustained when she fell into the disused mineshaft included:

- Broken Jaw
- Collapsed Lung
- Broken Sternum
- Several Broken Ribs

NONE of these injuries were responsible for her death

Alison died shortly after arriving at hospital due to a cardiac arrest caused by hypothermia

She had a body temperature of 24°C

Why Did This Happen?

Incident Conclusions

- There was a complete failure to recognise the urgency of the rescue
- There was a lack of understanding of the skills and capabilities of the specialist crews in attendance
- Restrictive and prescriptive policies encouraged a risk averse culture
- The Heavy Rescue Crew were arguably better trained and equipped than the Police Mountain Rescue Team but were restricted by the rigid implementation of operational guidelines
- Commanders stressed a high level of concern of further collapse and other risks as a reason not to deploy Fire Service Personnel
- However, they did nothing to mitigate these risks prior to the Police entering the shaft 4 Hours later.

Incident Conclusions

- During the incident 4 officers took command, 3 of these were group commanders
- On one occasion a Group Commander Stewart who was sent on as media liaison takes over from Group Commander Howe as he believes he knows better
- Group Commander Thomson takes over because he is nominated ‘Command Officer’ on the duty rota
- Command & Control arrangements overly complex
- Inaccurate assumptions were made on the arrangements with third parties
- *‘Senior Officers rigidly stood by their operational guidelines’.*

  Sheriff Desmond Leslie

UK Operational Discretion

UK Incident Command Guidance

There may be circumstances where strictly following guidance and procedures stands in the way of successfully resolving an incident. In these cases an incident commander should consider exercising their professional judgement to act more flexibly.

This informed and considered judgement is termed **Operational Discretion**.

Operational discretion is important. It can save lives by allowing incident commanders to apply guidance flexibly.

Rare and Exceptional!

Operational Discretion relates to these **rare** or **exceptional circumstances** where strictly following an operational procedure would be a barrier to resolving an incident, or where there is no procedure that adequately deals with the novelty of the incident. Commanders need to be sufficiently aware of procedures, the skills and qualities of crew members, and the capability of resources available.

Operational Discretion

Outcomes which would justify applying operational discretion include:

- Saving human life
- Taking decisive action to prevent an incident escalating
- Incidents where taking no action may lead others to put themselves in danger

Any decision to apply operational discretion should be the minimum necessary and only until the objective is achieved.

Standard Operational Procedures or Guidance?

In normal circumstances, Fire and Rescue Authorities' standard operational procedures can be seen as a guide providing a framework of good practice to support common ways of working and to assist an Incident Commander to resolve operational incidents safely and effectively.

Summary

- Situational Awareness
  - Gathering Information
  - Interpreting Information
  - Anticipating Future States
- Command Decision-Making
  - Types of decisions – Analytical, Recognition Primed & Automatic
  - Decision-Making Process
- Operational Discretion

Any Questions?