



FIRE SERVICES  
COMMISSIONER  
VICTORIA

# REVIEW OF THE PORT OF PORTLAND EMERGENCY REPORT

June 2012

LEADERSHIP  
INTEGRATION  
ACCOUNTABILITY

WORKING IN CONJUNCTION WITH



# Table of Contents

1.	Introduction.....	1
1.1.	Purpose of the review .....	1
1.2.	Review process .....	1
1.3.	Follow-up.....	1
2.	Incident overview .....	1
3.	General comment .....	2
4.	Discussion of key issues .....	2
4.1.	Strategic risk assessment .....	2
4.2.	Liaison with major industry .....	4
4.3.	Communication with small business .....	4
4.4.	Liaison with local government .....	4
4.5.	The format and timing of warnings and alerts.....	5
4.6.	Identification of vulnerable people.....	5
4.7.	Agency representation .....	6
4.8.	Traffic management .....	6
4.9.	MECC function .....	6
4.10.	Restoration and rehabilitation .....	6
4.11.	The role of EPA and WorkSafe .....	7

The review of the Port of Portland emergency was conducted on Monday 26<sup>th</sup> March 2012.

The following people participated in the review:

Anna Georgalis	Department of Business and Innovation
Deborah Jepsen	Department of Business and Innovation (Facilitator)
Peter Higgins	Department of Human Services
Sarah Harvey	Department of Justice (Facilitator)
Lisa Jones	Department of Justice
John Haynes	Country Fire Authority
Ross Sullivan	Country Fire Authority
Ross McNeill	Victoria Police
Julian Meagher	Department of Health
Jim Cooper	Port of Portland
Linda Evans	Environment Protection Authority
Graeme Prentice	WorkSafe
Sharon Kelsy	Glenelg Shire Council
Samantha Sharpe	Glenelg Shire Council
Joe Buffone	Officer of the Emergency Services Commissioner
Andrew Zammit	Metropolitan Fire Brigade
Andrew Campbell	Department of Premier and Cabinet
Donovan Croucamp	Department of Transport (Facilitator)
Tony Murphy	Fire Services Commissioner
Prue Dobbin	Fire Services Commissioner (Record Keeper)

# 1. Introduction

## 1.1. Purpose of the review

The Fire Services Commissioner conducted the review of the Port of Portland emergency under the powers of Section 10 of the Fire Services Commissioner Act 2010. The purpose of the review was to learn from the emergency and to improve systems and processes for future emergencies wherever possible.

## 1.2. Review process

The review comprised a meeting on the 26<sup>th</sup> March 2012 involving representatives of the key agencies involved in the emergency. The review discussion focused on the effectiveness of the Victorian emergency management arrangements in providing a framework for the management of the emergency.

A local debrief was held to review the incident management and tactical response. The findings of this debrief are not included in this report.

## 1.3. Follow-up

Once complete, the Fire Services Commissioner will present this document to the Central Government Response Committee (CGRC), along with a process to resolve the issues identified. Agencies involved in the review will receive a copy.

# 2. Incident overview

The Country Fire Authority (CFA) received the report of the incident at 3pm on Saturday 18th February 2012. The incident involved liquid pitch (tar) leaking from a 4000 tonne storage tank at a rate of 5 tonnes per hour. The bunding (area around the tanks designed to prevent a breach) could hold only 1000 tonnes of liquid pitch. The leak had the potential to emit benzene, a potential carcinogen.

As control agency, CFA established a Level 3 Incident Management Team, which operated from an Incident Control Centre at the Portland Fire Station, to control the incident. Over 600 response personnel from 16 agencies were involved in the response phase.

The emergency held state significance due to issues regarding the security of the smelter, the number of agencies and response personnel involved, the possible evacuation of the town and the potential economic impact of the emergency on Portland.

The Incident Controller identified the following priorities:

- Safety of the community and fire fighters;
- Warnings to the community;
- Containment of the spillage;
- Protection of essential infrastructure (smelter and port area);
- Minimising disruption to commercial interests;
- Protection of environment;
- Information flow at local, regional and state levels; and
- Planning for evacuation.

CFA controlled the incident using the following strategies:

- Use of water to cool the liquid pitch – to slow the rate of flow and suppress gas emissions;
- Preparing for the transfer to the bulk carrier on Wednesday the 22nd of February;
- Increasing the gas monitoring;
- Systematically opening the port;

- Keeping the community informed; and
- Ensuring all stakeholders were engaged.

On 24 February 2012, the response phase concluded and control agency handed the emergency over to the owners, the Port of Portland and the Glenelg Shire Council, for recovery.

### 3. General comment

Review participants unanimously agreed incident management did an excellent job managing the emergency under extremely complex and arduous conditions. Given the nature of the situation, this was a significant achievement.

Review participants praised the following areas for working well:

- Those performing the Incident Control function, for their leadership particularly during times of high stress.
- The multi-agency strategic risk assessment process, as it led to the identification of significant risks, such as risk involved in transferring the liquid pitch to a bulk carrier.
- The CFA and MFB scientific assessment team, for its work in modelling the flow of the liquid pitch in the weather conditions. The team identified the risk to be less than previously thought with the highest risk around the tanks. This led to the resumption of industrial and community activity within the port.
- The Public Information Section, for its work in conducting community meetings and keeping the public informed. Several well-attended community meetings were held. There were separate meetings held for the business community and the general community to allow specific interests and questions to be addressed.
- The CFA Media Unit, for its professional approach to managing media relations under difficult circumstances.

The following areas generated significant discussion in the review:

- Strategic risk assessment;
- Liaison with major industry;
- Communications with small business;
- Liaison with local government and incorporation of local knowledge into decision-making processes;
- The format and timing of warnings and alerts;
- Identification of vulnerable people;
- Agency roles and representation;
- Traffic management;
- The Municipal Emergency Coordination Centre (MECC) function;
- Transition from the response to the recovery phase of the emergency; and
- Clarification of the role of the Environment Protection Authority (EPA) and WorkSafe in this type of emergency.

Further information on these subjects is included in the next section.

## 4. Discussion of key issues

### 4.1. *Strategic risk assessment*

Following discussion with the State Fire Control Team (SFCT) and endorsement by the State Emergency Management Team (SEMT), the State Controller requested CFA to deploy a Strategic Assessment Group (SAG) to support the Incident and Regional Controllers. The

SAG was tasked with developing a Strategic Plan identifying key consequences (including flow-on consequences) of the emergency on people, community, infrastructure and the economic, natural and built environments using a risk-based approach and options to mitigate these risks. CFA continued to keep the State Controller informed of the situation in accordance with operating procedures.

The SAG comprised senior representatives of the Office of the Emergency Services Commissioner, Metropolitan Fire Brigade, Department of Health, Department of Transport and Victoria Police.

The SAG identified a range of significant risks including:

- Containment of the spill;
- Transfer of the product to the ship;
- Transfer of emergency management arrangements from the response phase to the recovery phase;
- Potential serious impact on three major industries;
- Economic loss to the grain industry;
- The catastrophic failure of the tanks;
- Potential environmental damage; and
- The provision of public information and public perception.

The risk summary prepared by the SAG was used to inform decisions made by Incident Controller in consultation with the Incident Emergency Management Team (EMT). Treatments were undertaken to either eliminate or mitigate the risks identified (for example rehearsing the transfer of the pitch to the bulk carrier and deployment of the scientific team to quantify the risk).

Review participants acknowledged the function performed by the SAG was within the existing scope of responsibility of the IC, relating to risk identification, and that in less complex emergencies the IC would normally perform the function.

The SAG process has been used in a number of other emergencies but the process has not been formalised. The review participants suggested consideration should be given to formalising the function within the state emergency management arrangements as follow:

- The State Controller to establish the SAG based on their assessment for the incident to have significant consequences to people, community, infrastructure or the economic, built or natural environments.
- A process for determining the composition of the SAG be identified, including maintaining the multi-agency cross-functional composition of the SAG but possibly varying its composition and skills mix according to the type of incident and incident dynamics.
- Establishing a standard set of criteria for the risk assessment.
- Authorising the SAG to identify and engage with groups and representatives external to the incident management (for example industry representatives) in order to gauge the current and potential impact of the emergency on all sectors of society.
- Embedding the SAG within the emergency management framework (that is, confirming its role to provide advice to Controllers through the relevant EMT to ensure the effective flow of information and to ensure normal lines of communication are maintained).
- Communicating the role of the SAG – in particular to distinguish it from audit processes.
- Including a senior local government representative in the SAG to provide local knowledge on the physical, social, economic, political and environmental aspects of local area.

- Including a senior representative of both the EPA and WorkSafe in a SAG established for future industrial emergencies.

## **4.2. *Liaison with major industry***

Portland has three major industries that hold considerable influence over the local (and possibly state) economy and the resilience of the community either directly through employment or indirectly through a flow-on effect.

Several of the major industries were at risk of catastrophic failure. The Alcoa smelter, for example, is unable to shut down for even the shortest period, as it would be unable to start up again. It was essential that the smelter continue to receive supplies through the port.

The review determined it was critical that the impact of an incident on major industry be included within the incident risk assessment and analysis of control options.

The review identified that early in this type of incident, incident management may need to make direct contact with industry potentially affected and establish a formal arrangement for identifying risks. Inclusion of industry representatives in the IEMT was suggested.

From a state perspective, the Department of Premier and Cabinet advised they could assist communication with a range of industry sectors through their Security and Emergency Network.

## **4.3. *Communication with small business***

Incident management held meetings with small business owners, similarly to community meetings. Glenelg Shire Council representatives explained these were well received because incident management could respond directly to questions.

The Council explained the incident affected many small businesses as follows:

- A number of local businesses did not receive the emergency alert because their telephone billing address was outside the local area. Consequently, several business owners arrived in the morning to prepare for the day's trade.
- The central business district closed down for most of the weekend, resulting in business loss.
- The fishing industry was unable to recommence until the incident management identified the port as safe, which took longer than Council thought necessary due to confusion over the management structure of the port. There were two ports at Portland and the local fishing industry used a port run by the local council away from the incident scene.
- There was significant 'brand damage' to the Portland economy because of association of the incident with the Portland name.

The Glenelg Shire Council identified timely communication with small business owners as being critical to limiting loss, as the businesses needed as much notice as possible to put their business continuity arrangements in place. Council explained they could have assisted with communication with businesses through their local business network.

The impact of the incident on local business has not been formally quantified, as there is no state standard for the collection of this type of information including 'brand' impact. The Glenelg Shire Council used an in-house survey methodology for a preliminary assessment of impact.

## **4.4. *Liaison with local government***

Glenelg Shire Council representatives identified their knowledge of the physical, social, economic, political and environmental aspects of the local area could have added value to a number of decisions made, not just regarding the impact of the incident, but also regarding incident management arrangements and the selection of incident control strategies.

The Council was represented at IEMT meetings, which is the normal practice for including local council in emergency arrangements, but they would have preferred greater contact with

the IMT and the SAG - as these forums undertook the strategic assessment and made the key decisions.

In particular, the Council identified that they could have added value by:

- Explaining port management arrangements;
- Assisting with communications with local businesses and the community;
- Identifying evacuation centres as these have been pre-planned through the municipal emergency planning process;
- Advising on vulnerable people and providers;
- Advising on the likely impact of incident control options (for example, 'Option A' could result in the 'temporary' shutdown of a major industry which, due to the nature of the industry, would be unable to recommence operations and be forced to close, resulting in a major economic loss to the area and possibly the state);
- Identifying their local landfill site as unsuitable to receive the contaminated waste; and
- Explaining their limited capacity and capability to participate extensively in cleanup operations.

The Council advised that, in future incidents, incident management could benefit extensively through early and on-going contact with local council, in particular contact with the Chief Executive Officer. They suggested a local government representative be included in all decision-making forums such as the Incident Management Team and the IEMT.

#### **4.5. *The format and timing of warnings and alerts***

The emergency alert system operated but was ineffective in reaching a number of business operators whose billing addresses for telephone numbers (used to identify recipients of the emergency alert) were not located in the targeted area.

Glenelg Shire Council advised that warnings and alerts posted on the CFA website reached a limited audience because not everyone in rural communities, in particular those classified as vulnerable (for example the elderly and disabled) had access to the internet.

Other review participants confirmed their sectors would have appreciated early notification of the incident to assist with their preparedness arrangements.

Council representatives advised:

- Information needed to go out as soon as the incident was known;
- Warnings and alerts needed to be distributed using a multi-faceted approach, including door knocks; and
- Their local business network could be used to contact all local businesses.

#### **4.6. *Identification of vulnerable people***

Participants required clarification of the process to identify vulnerable people in the community and the constraints around the handling of this type of information.

The following process was confirmed:

- Council only held the names of their own clients;
- There were 32 providers who needed to be contacted and a list of these could be obtained through the Department of Human Services (DHS);
- The provider list did not include facilities such as aged care centres, for example;
- There was no issue regarding the privacy of the names of vulnerable people, when they appeared in operational documents, because the lives of these people could be at risk; however
- The names of individuals should not be included in lists provided for information to other agencies, for example through the IEMT.



The DHS representative advised the issue of vulnerable people was well managed in this emergency.

#### **4.7. Agency representation**

Sixteen agencies were involved in the industry response with commanders/representatives attending the IEMT and community meetings.

Review participants identified it was important that:

- Agency representatives are sufficiently senior and authorised to make decisions;
- Agency representative attend community meetings; and
- Agency representatives are comfortable speaking in public and responding to questions.

Participants noted the presence of a number of senior representatives from across government assisted to diffuse confrontational situations during the community meetings.

#### **4.8. Traffic management**

Following the request of the Incident Controller, the Victoria Police established Traffic Management Points to restrict access to the incident area. Entry through these Points was controlled with an entry permit (sticker) issued by the Incident Control Centre. A suggested improvement was the identification of standard criteria for the issuing of stickers.

#### **4.9. MECC function**

The Incident Controller conducted agency briefings and IEMT meetings at the Incident Control Centre rather than at a MECC.

Glenelg Shire Council advised they appointed staff to perform the functions normally performed at a MECC and advised that delivering these functions from the 'mobile MECC' was more effective and efficient than if they had conducted the function from a formal council MECC facility.

The Victoria Police representative at the review confirmed the MECC was a function rather than a facility. The review was advised the Municipal Association of Victoria has prepared a paper on this subject.

#### **4.10. Restoration and rehabilitation**

The review extensively discussed the management of the transition between the response and recovery phases of the emergency, in particular the management of restoration and rehabilitation activities.

The Victoria Police are the coordination agency for response and the Department of Human Services is the coordination agency for recovery.

The Emergency Management Manual of Victoria (EMMV) has well developed procedures for the response phase including processes for incident and emergency management, for ensuring the control function is continuous throughout the response phase and for directing support agencies to provide assistance.

However, the EMMV is less clear regarding the procedure for the management of the restoration/rehabilitation phase of an emergency. Greater clarity is needed regarding:

- Agency responsibility for restoration/rehabilitation in hazardous materials incidents (except for regulatory matters which involve the EPA or WorkSafe);
- The management arrangements for organising restoration and rehabilitation (as there is no emergency management structure in place at this time); and
- Payment arrangements for agencies involved in restoration and rehabilitation of a site following an industrial incident, as this phase can be very costly.

The participants suggested:

- The coordination agencies should ensure management arrangements are in place during the transition between response and recovery, particularly through the restoration/rehabilitation phase; and
- The coordination agencies need to take into account the capability of agencies to undertake clean-up actions when allocating responsibilities.

#### **4.11. *The role of EPA and WorkSafe***

A number of agencies required clarification of the role of EPA and WorkSafe in both the response and the recovery phases of this type of incident. Both agencies confirmed they acted in accordance with their respective obligations in the EMMV Part 7.

Participants noted agency responsibilities changed over time. State emergency management arrangements needed to include a process to ensure all agencies kept up-to-date with changes in responsibility so their expectation of the performance of other agencies was realistic