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CRISIS LEARNING STRATEGY:

FROM CRASH RESPONSE TO IN-DEPTH PREPARATION

by Patrick Lagadec 1

Introduction

Major crises — from Challenger, Bhopal, Tylenol, or Chernobyl to Exxon-Valdez and Braer —, are no longer exceptional events. Indeed the risk of crisis is even becoming structural as large networks become more complex, more vulnerable and more interdependent, as every event or rumor is immediately captured by the media, and above all, because organizational systems are often poorly prepared to face these disruptive situations.

Some actors, especially those specialized in emergency response, are well practiced in taking urgent action – but this does not mean they are really equipped to face crises. Many others, particularly those belonging to the complex systems that become involved (with all their interfaces), very often lack the necessary preparation. These actors need to work before the crisis comes to prepare tools and establish procedures. Yet to face crises —and not just emergencies—organizations have to do more: they must develop appropriate corporate culture. Without this, even the best technical measures are useless.

Significant training activity must be developed in this area.

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This article has three goals:

- To define what a crisis is.
- To identify specifically the gaps in preparedness commonly seen in this field.
- To propose a learning process in order to undertake the necessary changes.

Crises continue to become more frequent and more destabilizing. Being better prepared means discovering how to innovate in order to keep up with the crisis as it develops. Organizations who fail to do so expose themselves to a danger much more serious than crisis: they risk chaos.

I – CRISIS: THE LOSS OF THE REFERENCE FRAMEWORK

Concrete examples are the best means of grasping the often slippery world of crisis.

A crisis can arise as a result of an event that immediately and brutally overwhelms its surroundings: Bhopal with its thousands of dead, Chernobyl and a radioactive cloud spreading over a continent, or Amoco-Cadiz spilling 230,000 tons of crude. Yet it doesn't have to stun with big numbers: most of the time, what counts is that the previously accepted framework is suddenly violated. This was the case with the Tylenol tampering, which suddenly gave a company devoted to promoting health the image of causing death ("Your father works for a company that kills people").

In contrast, a crisis can emerge from an inocuous event that propagates in such a way as to bring a complex system to its knees. In New York on September 17, 1991, faced with especially heavy demand for electricity, Consolidated Edison Corp. asked some of its customers to disconnect from its network and use their autonomous power supplies. In response, one of AT&T's telephone exchanges turned on its generator sets. These were defective, so the supply switched over to the emergency batteries, but no one noticed. Six hours later, the batteries were dead, and the telecommunications system collapsed. As a result, New York and New Jersey's three major airports were forced to shut down, which in turn overloaded airports in Boston, Philadelphia, Baltimore, and Washington DC. Hundreds of flights were cancelled or delayed.

A crisis can stem from an insidious, undetected event that is noticed through its actual or symbolic impact. For example, 41 drums of waste from the Seveso region disappeared in Autumn 1982. The potential risk was slight. But a cloud of lies, shady business practices, and suspicion soon spread across all of Europe. The media caught the story in Spring 1983, with devastating results: border controls lost all credibility, the image of the Swiss chemical industry was tarnished, waste management policy was criticized, and numerous industrial waste dumps

came under outside scrutiny. France's contaminated blood scandal is another, more tragic, illustration of this phenomenon.

The growing list of examples can be classified in any number of ways. Crisis is protean, and it can surge from any corner of organizational life. The point is that a crisis is not an accident, i.e. a well-understood event for which clearly defined procedures are available, involving a limited number of actors working within a simple, clearly defined authority structure.

A crisis is the extension of what we have described as the *major technological event*, in contrast with the classic accident. The table below summarizes its highly disruptive features.

Features of major technological events

- Enormous quantitative difficulties
- Qualitative difficulties :
 - * unusual problems;
 - * vital resources affected;
 - * combined breakdowns
- Snowball effect of the emergency
- Emergencies that do not play by the rules:
 - * insufficient, inadequate, obsolete, or counterproductive procedures
- Extreme uncertainty
- Long duration, and evolving threat
- Convergence: growing numbers of organizations involved
- Critical problems of communications :
 - * within and among the organizations in charge
 - * with the media and the concerned public
- Huge stakes

Source: Lagadec, Preventing Chaos in a Crisis, McGraw-Hill, 1993, p. 18-19.

In the presence of these parameters, a three-fold dynamic process tends to develop, combining:

- a "tidal wave": an acccumulation of problems overwhelms the available capacities for response;
- a disruption of rules and procedures;
- an irruption of fundamental questions, requiring crucial choices.

In other words, there is too much to do. Networks lose their operating mechanisms; the most basic values are called into question. Everyone wants to act quickly, but no one knows just what to do, based on what data, when, or in the name of which principles.

The risk for managers is that the event will snowball if appropriate crisis management responses are not found. This results in a common tableau: the organization is rapidly overcome by the crisis. Incapable of reacting, powerless to mobilize, ill-prepared to inform, it is soon discredited.

The crisis becomes a long ordeal that saps organizational energy. Crisis lays down its law, and the organization is increasingly shaken, crushed by a challenge it could not meet.

This is the key to the prognosis: anyone who has not obstinately prepared in advance will quickly be left behind. The question, then, is: what is the current level of preparedness in organizations to face crisis situations?

II - A HUGE NEED TO PREPARE

Crisis after crisis, the same conclusions are drawn. Managerial weaknesses and cultural blindspots expose organizations to terrible risks of failure. The following is a summary of a few such difficulties.

1. Managerial failings

1) Warnings, watchdogs, mobilizing, first reflexes

Without basic resources and minimal procedures, warnings are only given and people mobilized late in the game. The problem is even thornier when it comes to identifying the very feeble early warning signals of a crisis. And a crisis is merciless with late movers.

2) Crisis centers, crisis teams

Very often, the management team meets where it can, nothing having been planned beforehand. Sometimes this problem goes unnoticed: as there is no designated crisis team, no one feels the lack of a specific center. A few people simply take charge, more or less, of the situation from two or three more or less communicating offices. Referring to this as a "crisis center" is a misnomer.

3) Preparing communication

A certain amount of basic information (plans, figures, various points of comparison) will be requested at the outset. In most cases, there are no pre-existing files of such data. Considerable time is lost at the beginning of the crisis collecting it.

4) Expert advice

Insufficient preparation means no one knows which experts to consult; different sources of advice cannot be integrated; poor use is made of resources that are either undervalued or overestimated.

5) Relations with victims

Due to a lack of both physical and organizational preparedness, the legal department is very slow to appear on the scene. By the same token, efforts to provide psychological or social services generally fail to materialize, when they should be organized quickly and effectively.

6) General organizational capability

Regularly, we see organizations entangled the countless twists and turns of the event, unable to take any distance. Our experience shows that in this area, many a crisis team that exists on paper tends to dissolve in a few minutes, because it lacks a minimum of know-how. The same is true throughout the organization: information fails to circulate, as each major technical realm holds onto its data and analyses and refuses to answer the needs of other departments in-house, let alone anticipating what these needs could be.

7) Strategic management capability

At the heart of crisis management lies the aptitude of top executives promptly to set the tone of the response, based on the organization's fundamental values and its key choices. Behavior in this area is usually a flagrant weak point. In fact, when a company chairman seizes the rudder (as was recently the case in France following a railway disaster), immediately calls a press conference, announces that his entire company assumes collective responsibility without trying to hide or designate a scapegoat, acknowledges that the victims have rights, and does not forget to communicate with his employees, an in-house public that is equally affected by the circumstances, everyone is flabbergasted! Such astonishment speaks volumes about the "skill" usually displayed in such circumstances.

2. Cultural barriers

Underlying managerial failings are often deeper problems. Crisis management presupposes an appropriate corporate culture. This includes constant awareness of potential vulnerability, openness to outside actors (including the press), an ability to anticipate and take initiative, networking, and a clear sense of responsibility and ethical position - and of course acknowledging and taking care of victims. On all these points, organizations have developed and firmly rooted often counterproductive habits and references.

1) Technical assurance excluding all self-doubt

The fundamental corporate philosophy is often "it could never happen here". Repeated and erected as a standard, this attitude is hardly conducive to vigilance, prompt attention to the warning signs of a crisis, or even to accepting overwhelming evidence. In such cases, it becomes impossible to see warnings during a crisis, or to heighten awareness in times of doubt. And it is pointless to suggest warning systems or emergency plans: they'll gather dust on the shelf.

2) Refusal of any external questioning

The glue binding organizations together often consists of closing off the outside world - as represented by government, competitors, unions, journalists, or the press. Every action, statement, or communication is defensive. These are just the ingredients that ensure instant

defeat in a crisis. No handful of techniques for handling the media can mask these deep-set attitudes.

3) An incapacity to function in teams or networks

Organizations are often structured around extremely intense competition - which increases as one climbs the corporate ladder. This way of operating may suffice during periods of calm. But in a crisis, the cracks open into yawning voids, and lack of solidarity becomes a cause of unrecoverable failure.

4) Serious hesitations about taking charge

A crisis will not tolerate indecision or careful calculations about how to waffle through events. Yet the common conviction is that it would be dangerous to stick one's neck out and, for a single issue, risk the capital patiently acquired in years of politics and jockeying for power. Before deciding to move, everyone tends to wait until the crisis absolutely forces his hand. In such cases, there is no point in hoping for early action or proactive courage, which are the only ways to stop a crisis before it develops its full power.

References like these make any effective crisis management impossible. Worse yet, they offer crisis a terrain on which it develops to its fullest. It is critical, then, to design new tools and renew organizational culture. To achieve this, certain processes have proven effective.

III - IMPLEMENTING THE PREPARATION PROCESS

How do we start the learning process in an organization, especially when it is racked by fear about crisis issues? What specific exercises can be used to mobilize actors, open minds, and forge skills? This is a constant challenge.

The path is naturally full of pitfalls, as the field of crisis is highly visible and explosive. Consequently, there are no ideal models for this process. As in any crisis (and the process of dealing with crisis, even in a training situation, is very similar to crisis management), good judgment and the ability to analyze the situation are crucial. There are a few guidelines for this process.

1. The seminar, to build a collective positive attitude

This seminar raises awareness of how to handle crises. Offered to management teams, it serves to break down barriers. Daring to discuss crisis in an organization - and to do so in groups - is a great step forward. People can work openly on a taboo subject, evoke situations that overstep accepted boundaries, think about their responsibilities, take preventive measures, and be creative.

These introductory seminars, combining teaching and simulations with management teams, are a mandatory first step in any learning strategy.

2. The vulnerability audit, to clarify the risks to be taken into account

Several categories of vulnerability should be explored: classic risks to which insufficient attention has been paid; abnormal risks not picked up by the usual controls; public opinion risk, until recently given little consideration; and major changes that could affect the environment. The point is not so much to draw up exhaustive lists as it is to set the organization on track towards a more inquiring outlook and greater attentiveness.

3. Debriefing: to learn from experience and not forget once the event is over

After a crisis, there is a rush to forget. This bodes ill for the future. Instead, every crisis experience should lead to critical examination: What were the strengths and weaknesses of the responses given? What are the lessons for the future? Lessons can be learned at all levels: from the tools, procedures, and even the cultural foundations underlying the life of the organization, its implicit and explicit references, its reflexes, its outlook and its values.

4. The audit of the response system: beyond paper plans

Announcing that "we've provided for everything" is not enough. The capacity for response should be examined in depth. Nor is it enough to ensure that the equipment and the written procedures really work. Beyond this, one should consider whether the system is robust enough to face not just a classic accident, but a crisis - with all that the phenomenon entails of destabilization and the need to adapt, anticipate, and take initiative. This means the examination must go far beyond a look at paper plans, taking into account actual practices, existing knowhow, corporate culture, of the people and the organizations involved.

5. Simulations: specific drills followed by in-depth debriefing

Effectively implementing crisis managment systems, and more generally, responding both as individuals and as a group to an exceptional situation, requires continuous training in facing exceptional situations. Everyday experience is not the best way to learn: trial and error, which is costly in both human and economic terms in a crisis, is best replaced by the use of simulations. The natural purpose of crisis simulation exercises is to ensure that the physical systems and emergency procedures provided actually function correctly. Experience has shown, however, that under exceptional circumstances, the most important failures were caused by group behavior. Adjusting such behavior should therefore be one of the prime objectives of these exercises.

6. Training for specific people: crisis team leaders, CEO's, experts and others

At least at the outset, special attention must be paid to training crisis managers, top executives, "on-call" managers, departments in the firing line (e.g. safety, communications, legal) and

experts. Each category of actor has specific training needs, and particular emphasis should be given to the roles of the chairman and CEO during a crisis.

In conclusion, let us stress again the difference between emergency and crisis. To face an accident or classical emergency, you must have the ability to respond quickly and to apply preplanned capacities. Everyone knows his role and responsibility precisely. The approach is basically. Speed is the key.

To face a crisis, a major social turbulence and risk of destabilization, you have to adapt collectively not only to urgency, but to uncertainty and ambiguity; you have to forge a collective answer. This means making value judgement, having cognitive capacity to analyse a complex and evolving phenomenon, coordinating, adaptating in-depth. The key is no longer reflex reaction (though this is still necessary), but collective intelligence, judgement and response ability.

Our organizations are far from being able to face this challenge. A huge training action is necessary. The subject is difficult, sensitive, and it arouses much resistance, because all over the world, people and organizations, both public and private, are afraid to enter such difficult territory. Hence the necessity to begin rapidly, to encourage all efforts, to provide help wherever it is requested, and of course, to develop international programs to promote this innovative approach to our collective vulnerability.

As an illustration of this approach to learning, I will show a video – a debriefing after a crisis. The main strength of this video lies in the fact that the people involved actually agreed to review the event and their management of it with a critical eye. That is extremely rare. The film is currently used as a training tool. Other concrete examples, dealing with the preparation and management of seminars and simulations, will be given during the presentation.

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