CHAPTER SAMPLER

Risk and Crisis Management in the Public Sector

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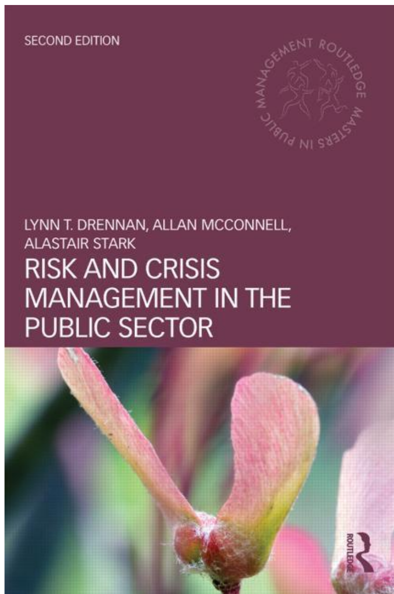

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Chapter 2

Risk and crisis management

Drivers and barriers

LEARNING OBJECTIVES

By the end of this chapter you should:

- be aware of the justifications for the practice of risk and crisis management in the public sector;
- have developed an understanding of the drivers and barriers to effective risk and crisis management;
- be aware of the factors through which crises can be caused; and
- have developed an understanding of sense-making processes that can identify potential threats as they develop.

KEY POINTS OF THIS CHAPTER

- Risk and crisis management must be justified as a means of achieving the core business of a public sector organization.
- Key benefits include enhanced quality management, increased partnership working, better internal coordination, effective implementation and greater efficiencies.
- A range of external drivers motivate the practice of risk and crisis management, including inquiries, legislation, regulatory principles, audit and inspection regimes, and the expectations of society.
- Potential barriers to effective risk and crisis management relate to efficiency concerns, organizational values, political constraints and a lack of understanding and training.

- Crises may be caused by human error, technological failure, management systems failure or societal/governmental behaviour. More commonly, a crisis involves a combination of these factors.
- Enhanced sense-making processes can help an organization identify, prevent or moderate crises before they strike.

KEY TERMS

- **Corporate governance** – the way in which an organization is managed. Many countries around the world now have codes or standards for corporate governance, to which publicly listed companies are expected to adhere. These codes and standards have also been adopted by many public service organizations.
- **Enterprise risk management (ERM)** – an integrated approach to the management of all of the risks that the organization faces. This is also referred to as holistic, integrated or enterprise-wide risk management.
- **Responsive regulation** – a model of regulation which promotes guidance and principles rather than legal enforcement. This model was a key factor in the development of the global financial crisis.
- **Sense-making** – identifying problems at an early stage as they begin to manifest into larger threats. Making sense of threats as they emerge requires constant environmental scanning, willingness to think about worst-case scenarios and a capacity to collate and interpret multiple sources of information.
- **Social responsibility** – consideration of the social and environmental consequences of any organizational decision or action. Closely linked to the concept of sustainability.

ADOPTING A SYSTEMATIC APPROACH TO RISK AND CRISES

The largest justification for engaging in processes of risk and crisis management is as self-evident as it is convincing. As more and more of the risks and crises typified in Chapter 1 become prevalent in our public sectors, the need to mitigate threats and prepare properly for catastrophes seems compelling. We have to ask, therefore, why, if this justification is so profound, is it that public organizations still neglect to adopt systematic approaches to risk and crisis management?

One answer to this question relates to the pressures of leadership within busy public organizations, particularly those that do not appear to be risky or crisis prone. Managers who are responsible for our hospitals, schools and public transport systems, for example, must prioritize the efficient and effective delivery of their core services (Stevenson 2013). This is a hard enough task in itself and, as a consequence, a range of issues surrounding risk and crisis management can be deprioritized or even squeezed

off organizational agendas completely. What this means is that would-be risk and crisis managers must be able continually to justify their activities by showing how their work complements the core business of any public organization. Yet incentivising risk and crisis management practices in this way is no easy task. One of the largest hurdles can be seen in the simple fact that when risks or crises are prevented effectively, nothing actually happens! There is a lack of a definable output which can be used as evidence of success and this means that risk and crisis managers can struggle to justify their existence (Boin and 't Hart 2003). Consequentially, we provide a number of clear rationales in this chapter which public managers can use to promote risk management practices to organizational decision-makers and colleagues.

A second answer to the question of why some organizations systematically protect against risks and crises and others don't relates to the complexities of the internal and external organizational environment. Just as there are a wide range of threats and opportunities facing public service organizations, multiple environmental influences provide the motivation for, and drive the practices of, risk and crisis management. These drivers are often a combination of what might be described as 'push' and 'pull' factors. Aspects of the external environment, such as the need to comply with health and safety legislation or the need to be seen to be acting in socially responsible ways around climate change, can certainly push organizations into forms of risk management. However, there may be a number of factors within an organization, such as the need to ensure high levels of efficiency or a conservative organizational culture, which can pull public managers away from making changes that privilege risk and crisis preparedness (Stewart 2009). This chapter therefore provides an understanding of the drivers and the barriers that can push and pull the creation of a risk and crisis management agenda in a public body.

A third answer to our opening question is more straightforward. One reason why public sector organizations may not prepare for the worst might simply be that there is a lack of understanding about the way in which crises can be created (and therefore avoided). Failures to understand deeper causes of crises, how they incubate and how they then translate into reality mean that the public manager is left without a road map that can help them take those vital first steps towards increased safety. For this reason, we also include a discussion of the causes of crises in this chapter and a discussion of sense-making processes. These sections provide a blueprint for thinking about how action can be taken to moderate or prevent crises.

JUSTIFYING RISK AND CRISIS MANAGEMENT

In recent years, there has been a growing awareness of the risks arising from failing to act on opportunities to deliver better and more cost-effective public services (NAO 2011) and that a certain amount of risk-taking is inevitable if an organization is to achieve its objectives and improve its performance (OGC 2004). In this context, the

management of risk and the preparations for managing a crisis have to be seen as part of everyday good management. There are strong relationships with other management initiatives, such as those relating to quality assurance and enhancement. Furthermore, the increasing use of partnership agreements, both internally and externally (the latter often with private providers), has produced a further driver for addressing risk issues. Clear financial benefits can be achieved and this is one of the most persuasive arguments for senior executives who may be reluctant to invest time and money in risk and crisis management initiatives. Unfortunately, it is the actual experience of a crisis that proves to be the strongest incentive for change in some organizations. Yet directors and managers will still need to be convinced that there is a clear cost–benefit case before committing resources to risk management measures. In preparing such a case, it is important to remember that costs and benefits are not confined to financial measurement and that, equally, the cost of *not* taking a particular course of action must be considered. Let us explore here the rationales that can be used to build a case for risk and crisis management.

Ensuring organizational quality

If risk management is viewed as yet another management 'fad', or as the responsibility of a named individual (such as the 'risk manager'), it is likely to fail, quite possibility to a substantial degree. The management of risk must be accepted as a normal part of everyone's job, from the CEO to the most junior employee in the organization. It therefore needs to be integral to all functions, processes and initiatives within the PSO. One way to ensure that this process takes place is to show how risk management is coterminous with quality assurance. Many employees in a public service organization are likely to be familiar with aspects of quality assurance/enhancement. Even if the organization has not chosen to follow a total quality management (TQM) route, it is possible that it will have sought to achieve 'kite marks' and quality standards that are externally validated and publicly recognizable. Such approaches seek to ensure, whatever the individual, department or organization is seeking to deliver, that it does it 'right first time' and that in doing so it avoids waste and inefficiency. The management of risk can be viewed as an inherent part in the process of managing quality (Toft and Reynolds 1997) because, unless threats to the achievement of the delivery objectives are identified, evaluated and appropriate controls put in place, it is less likely that services can be delivered with the level of quality intended.

Integration across organizations

No organization can operate as a silo in today's complex public sector environment. Any public body that does not have the capacity to build strong partnerships across public, private and voluntary sector borders will certainly struggle to fulfil their mission. This is because today's social problems are themselves complex and need to be

addressed through more sophisticated ways of joint working than those that have defined public services in previous eras. The global reach of 'joined-up government' and 'whole of government' initiatives and the increasing respect given to network management as a coordination tool both pay testimony to the fact that partnership working is the order of the day – particularly in local government. An obvious example is in the area of child protection, where those responsible for education, social welfare and health all have to be involved in ensuring the well-being of an individual child, who may be at risk. A second example can be found in the complicated network of actors – both private and public – who come together to build and then supervise large infrastructure projects for public sectors, such as schools and hospitals. One of the largest issues within these complex networks relates to the incongruence that can exist between the different organizational cultures, objectives and attitudes of the respective parties. In this area, however, the practice of risk management can provide a mechanism through which the differences of various partners can be bridged (Jennings 2012). One of the largest examples of this benefit can be seen in the preparations for so-called 'mega-events', such as the Olympic Games (see Box 2.1).

Integration within the organization: enterprise risk management

Whether at the planning stage of a new project or as part of day-to-day strategic and operational management, risks need to be managed in an integrated fashion, encompassing potential threats at each level of the entire organization (Fraser and Simkins 2010). Risk management can therefore be a powerful tool for enhancing synergies within an organizational structure. This is where enterprise risk management (ERM) becomes important because, as Lam (2003) highlights, ERM means that:

- the organization requires to be integrated;
- the risk transfer strategies require to be integrated; and
- risk management requires to be integrated into the business processes of the company.

If we translate these three elements into the public sector environment, we can see that 'integration of the organization' is equally applicable to this sector. Both at the national level and at the local level, the value of operating the organization as an integrated entity is now being recognized. With regard to integrating 'risk transfer strategies', decisions are required to be taken at the highest levels as to the risk 'appetite' of the organization, as this will determine the extent to which it is prepared to retain as opposed to sharing risk, by outsourcing or by insurance. We will deal with this issue in more depth in Chapter 4. However, what we can say here is that the concept of ERM is much more embedded now than it was in 2007 when the first edition of this book was written. One consequence of this is that there is now more of a holistic approach to risk management across public and private sectors. By this we mean that risk management can no longer

BOX 2.1 PARTNERING AROUND THE GAMES: AN OLYMPIAN EFFORT

In preparing for an Olympic Games, host cities need to coordinate a huge range of very different partners with very different objectives. In preparations for the London Olympics, a number of organizations were responsible for ensuring that the games were delivered on time and within budget. At the national government level, the Government Olympics Executive was created to provide strategic direction and accountability to the taxpayer. At the operational level, the London Organizing Committee was created as a private company to take the key implementing decisions. This body was complemented by the London Development Agency, the Mayor's Office, the Olympic Park Legacy Company and the Olympic Delivery Authority, who all had to quickly plug into and work alongside the pertinent central and local government agencies. All of this, moreover, was done under the watchful gaze of the International Olympic Committee. We must also consider the athletes and their organizations in this complexity. The British Olympic and Paralympic Associations, for example, were less concerned with project management issues than they were with the performance of their member athletes. And finally, we cannot forget the massive number of private sector companies in this mix, all seeking to make profit from the many contracts and mass-marketing opportunities that these events bring.

Will Jennings is a risk analyst who has examined the coordination of Olympic Games preparations. His analysis shows that the shift from an insurance approach to an integrated and comprehensive form of risk management in preparation for such 'mega-events' enhances the degree of coordination across partnerships. As more and more organizational objectives and performance measurements are framed in the language of risk, a 'colonizing effect' is said to take place in which the narrative of risk management crosses organizational boundaries affects the perceptions of different actors and effectively brings organizations together around a common understanding of threat and mitigation. From this view, the language of risk can bring organizational strangers together around common purposes.

Source: Rothstein et al. (2006); Jennings and Lodge (2011); Jennings (2012).

be seen as a distinct activity located at the periphery of the organization. It is now, more than ever before, a 'whole-of-organization' or 'organization-wide' competence. And, although 'enterprise' has a corporate feel to it, it is important for public managers to understand that, at its essence, the concept of ERM can be understood in this cross-sectoral manner.

In turn, this means that public sector organizations are generally much more aware of the importance of understanding organizational culture as a means to integrate risk management within an organization. Therefore, they are now more focused on understanding how this culture influences 'appetite' for risk (the extent to which an organization wishes to take risks to ensure returns of some sort) and the relationship between this appetite and management decisions.

An additional benefit of the ERM approach is the ability to provide evidence, through regular and relevant risk reporting, that the organization is taking the issue of risk seriously and that assessment and evaluation of risk is being undertaken in a systematic, comprehensive and coordinated manner. Such reporting provides some degree of assurance to stakeholders that the CEO and senior executives are conducting their responsibilities in line with current expectations of good governance and, in particular, may reassure funding bodies that financial resources are being used efficiently and effectively. A key feature of this approach is the establishment of both a philosophy and a culture of risk management, with the objective of creating a set of organizational goals and expectations that each manager and employee can use to help frame their specific risk management responsibilities and decision-making. This approach is the antithesis to a centralized risk management function, which runs the danger of being viewed as 'the department that does risk management'. Instead, it reinforces the need for risk to be dealt with at its source, by the people closest to it and within the ethos and values set by the organization.

Finally, the integration of risk management into the 'business processes' of the organization needs only the addition of the words 'and services' to make it applicable to a public service organization. The PSO has the objective of delivering a service or services to the public, and the integration of risk management into the daily operations of the departments that provide these services is essential. At the same time, PSOs themselves are supported by a range of business processes, including administration, IT, human resources and finance, which, in turn, need to address their own risk issues if they are to provide the level and quality of support that the PSO needs and expects.

As discussed in Chapter 1, managing risk is not simply about reducing loss, but is also a means of maximizing opportunities and ensuring successful achievement of organizational objectives. In order to achieve efficiency gains and supply innovative services or new modes of service delivery, risk management needs to be integrated with, and supported by, the business processes of the organization. Thus, ERM/ORM requires a structured and disciplined approach that aligns strategy, processes, people, technology and knowledge with the purpose of evaluating and managing the uncertainties the organization faces (DeLoach 2000) and that puts in place policies and processes to deal with such uncertainties. Rather than being viewed as a separate, stand-alone function, risk management is best viewed no differently than sound general management (Toft and Reynolds 1997; Culp 2001). This narrative should be continually emphasized and promoted at all times in every aspect of the PSO.

Enhancing implementation

Every new venture is a trade-off between loss and opportunity and involves competing demands for resources not only within but also between projects. We also know that organizational decision-makers have a tendency to underestimate the challenges of implementation (Hill and Hupe 2009). What seemed like a simple process at the strategic planning table can somehow become something far more tortuous as more actors, interdependencies and resource demands materialize across the life of a project. Adopting a risk management approach, however, enables better decision-making at the strategic level, by providing information about risks that might affect programme implementation. At the project level, risk analysis should be an integral part of the project life cycle, with each stage of the project being broken down into its component parts, and the risks to the successful achievement of each stage assessed and treated (Chapman and Ward 1997). This is not just a matter of safeguarding against an unlikely failure, however; it must instead be understood as a standard way in which reliability and efficiency can be promoted from the bottom up.

The big one: saving money

This is a big argument especially during those periods of austerity when public sectors need to retrench. Risk management can create financial savings in such contexts, particularly with regard to insurance premium costs and claims against the PSO. Insurance companies base the premiums they charge for policy covers such as fire, theft, employee injury or public liability on the experience of the public sector as a whole. These premiums are then adjusted according to the level of risk that the individual PSO presents.

In practice, this means that those organizations with better than average protection against the risks insured (i.e. better risk controls) and/or better than average claims experience (i.e. fewer and less costly claims) compared with similar organizations are likely to be able to negotiate lower premiums and better cover than those with a poorer history. Taking this one step further, the PSO may find that it is able to reduce losses to such an extent that buying insurance cover is no longer necessary or financially sensible. Such losses that do occur can be budgeted for as part of normal operational costs, and absorbed in this way, with insurance being purchased only for what might be described as 'catastrophic' events.

Financial benefits can also accrue from a reduction in actual claims against the organization. These benefits accumulate not only from costs saved in compensation payments but also from the hidden cost of time spent administering such claims. Enhanced street lighting, replacement of broken paving stones and better street cleaning have been shown to protect the public from trips, slips and falls that might result in successful claims for compensation. Similarly, improved staff training and education along with robust supervision results in fewer mistakes being made within professional service providers.

ENVIRONMENTAL DRIVERS

The previous section has outlined a range of factors that can incentivize the practices of risk and crisis management within an organization. This section moves the discussion onwards by reviewing a number of drivers that are located in the organizational environment. Inquiries about previous events can certainly act as a spur for action. A second factor relates to the need to comply with legislation. Failure to do so will result in criminal and, in some cases, civil charges being brought. Third, we can see many principles, often created by quasi-governmental or professional institutes, against which the organization and its officers are expected to abide. Finally, pressure from consumer groups and non-governmental organizations (NGOs) may be responsible for changing attitudes towards the management of issues that fall within the general heading of 'social responsibility'. Hence compliance with inquiry recommendations, legal instruments, regulatory principles and social expectations are likely to form key planks in any public audit and inspection regime, and the results will be open to scrutiny by wider stakeholders and the general public. We will deal with each of these aspects in turn.

Learning from previous events

When things are going relatively smoothly, organizations can become complacent about the need for proactive management of risk. Unfortunately, the absence of an extreme and damaging event in the past does not mean that it will fail to happen in the future. Sometimes organizations are simply lucky. However, when that luck runs out, the results can be disastrous. In such circumstances, mistakes in judgement may be made that, in the case of vulnerable children or the elderly for example, can prove fatal. In order to manage such risks, it is essential that lessons are learned from previous events and that recommendations for improved practice are put in place. Inquiry reports often prove the driver for change and improvement in the management of risk and crises in this sense (see Box 2.2). Depending on the gravity of the problems, inquiries can range from independently contracted consultations that tend to focus on managerial issues, to legislative inquiries that seek political explanations, through to full judicial inquiries where issues of corporate manslaughter and criminality could be put on the table. These inquiries will be discussed further in Chapter 7, where we will see that change and learning after a crisis is not always inevitable. However, the smart public manager would do well to search out, and give respect to, the recommendations of inquiries in their field. Failure to view inquiries as an impetus for reform, even if the recommended changes are small-scale, opens up an organization to accusations of blame and culpability when its luck runs out.

BOX 2.2 THE UK FUEL PROTESTS: A CRISIS FORESEEN

The UK fuel crisis began at the Stanlow refinery on the night of 7 September 2000, when approximately 150 farmers and hauliers blockaded the site's exit in protest over the high cost of fuel taxation. The apparent success of the Stanlow blockade encouraged further protests around the UK and by 11 September most of the country's oil refineries were effectively closed. By 13 September, widespread panic buying by motorists meant that 90 per cent of petrol stations – reliant upon a cost-efficient 'just in time' delivery strategy – had run out of fuel. Commuting via public transport had become difficult; fuel rationing was implemented; supermarkets had reported panic buying of groceries; schools began to close; and, according to the government at least, fuel shortages within the NHS meant that lives were at risk.

The fuel protests were begun by groups such as Farmers for Action and the People's Fuel Lobby, who viewed themselves as political 'outsiders' prepared to take direct action. In the run-up to the crisis, these groups had engaged in a number of smaller protests, including a 'go-slow' demonstration in central London during which lorries were driven at walking pace around Parliament Square while a parliamentary debate on fuel duty was taking place in the House of Commons. In July of that year, the Environment, Transport and Regional Affairs Committee published an inquiry report which recorded a 'vigorous campaign against what they [hauliers] perceived as unfair levels of taxation, particularly on fuel and Vehicle Excise Duty, which included attempts to disrupt the flow of traffic in cities and towns, and on motorways' (HC 296: 2000, para. 1). This inquiry, which clearly identified the threat of a potential crisis in the near future, was ignored by the government. This decision to ignore the inquiry, whether intentional or unintentional, would return to haunt the government in September as the stand-off between the protestors and the Treasury brought the country to a standstill.

What the fuel protests show is that public inquiries must always be treated seriously as insights into the potential for the escalation of problems to crisis proportions.

Source: HC 296 (2000); Robinson (2002); Stark (2010).

Compliance with legislation

As society has developed, so too has the extent to which legislation is used to control aspects of our personal and professional lives. The process of industrialization in the nineteenth and twentieth centuries led to increasingly stringent expectations relating to health and safety in the workplace. This had an impact not only on directors and managers, but also on the behaviour of individual workers. For example, while it may be incumbent on management to provide personal protective equipment such as hard hats or fluorescent jackets to workers that need such protection, there is also an obligation on the individual to use the protective equipment or clothing that is made available to him/her. If this is not provided, the organization may be in breach of health and safety legislation, while the worker who chooses not to use such equipment is likely to find that any subsequent claim for injury is reduced because of this contributory negligence.

While it may be easier to see the relevance of such legislation in a manufacturing environment than in an office environment, the principles remain the same. Many PSOs will be involved in 'risky' activities to a greater or lesser degree. Examples can be found in building and roads maintenance, waste collection and disposal, school sports and other activities involving children, such as day trips and group holidays. Even the office environment is not without its risks, with trailing computer and phone cables and problems associated with visual display units being just a few examples. Accountability for the death of an employee or someone in the care of the organization can result in criminal charges being brought against individuals, their line managers and senior executives, depending on the exact nature of legislation relating to corporate manslaughter in the country concerned.

In addition to raising concerns about health and safety, industrialization also increased levels of pollution and, as a result, highlighted the need to control such emissions. From smog-filled air to contaminated rivers and streams, legislative controls were deemed necessary to limit the damage that industrial organizations were doing to the environment and public health. Today, there are additional concerns relating to the dangers inherent in the disposal of nuclear and biological waste, the toxic gases in domestic appliances, asbestos removal and the dumping of plastics and other non-biodegradable substances in landfill sites.

To the list of physical risks associated with health and safety or environmental pollution we can now add a range of less tangible risks that often present themselves in office and other workplace environments. Examples include bullying and harassment, gender or racial discrimination, age discrimination, pensions entitlement and human rights. The latter issue has raised debates over the extent to which employers are entitled to invade the privacy of their employees, for example by monitoring telephone calls or email usage, or dictating dress codes. Many of these employment risks have resulted in employees taking legal action against their employers in special industrial tribunals and courts.

A further risk arises from the need to protect sensitive information and ensure that it is used only for the purpose for which the information was originally gathered. This duty has now to be balanced, in many countries, with the demands for 'freedom of information' and a public 'right to know'. Public service organizations that fail in any of these statutory duties risk criminal penalties ranging from fines to imprisonment. In addition, they are likely to suffer reputation damage and increased scrutiny of their activities by government agencies, including their primary financiers.

Compliance with regulation

While the law regulates many aspects of our personal and professional lives, as well as the way in which organizations conduct their business, some dimensions are subject to recommended principles and codes of best practice, which are expected to be followed unless exceptional circumstances dictate otherwise. Critical to the study of risk drivers in the public sector, therefore, are regulatory practices relating to corporate governance and public sector 'morality'.

Influential in the development of many codes of corporate governance has been the report of the UK committee chaired by Sir Adrian Cadbury, *Financial Aspects of Corporate Governance* (1992). Cadbury outlined three fundamental principles of good corporate governance: openness, integrity and accountability. The implication of the report for senior executives lay in the emphasis it placed on their responsibility for ensuring that the necessary internal controls over all the corporate activities were in place and functioning effectively. This significantly raised the profile of risk management in many organizations and acted as a driver in its implementation.

A subsequent report from a committee chaired by Nigel Turnbull in 1999, *Internal Control: Guidance for Directors on the Combined Code*, went on to emphasize the changing nature of risks facing the business enterprise and the role of internal control in managing those risks appropriately rather than trying to eliminate them (Financial Reporting Council 2005). Turnbull recognized that profits were, in part, the reward for risk-taking in business. Without innovation, society cannot hope to progress, but innovation brings with it some degree of risk, which requires to be managed in order to achieve a successful outcome.

This view was echoed in a speech made by the Auditor-General for Australia in September 2005 when he referred to Principle 7 of the Australian Stock Exchange (ASX) *Corporate Council's Principles of Good Corporate Governance and Best Practice Recommendations* (issued in March 2003), which mandates the requirement to establish a sound system of risk oversight and management and internal control by identifying, assessing, monitoring and managing risk. In his opinion, risk management was a cornerstone of good corporate governance, and resulted in better service delivery, more efficient use of resources, better project management, as well as helping to minimize waste, fraud and poor value-for-money decision-making (McPhee 2005).

- Agreed upon values and norms
- Consensual relationships
- Freedom of regulated to respond to environment
- To be effective there must be hierarchical authority

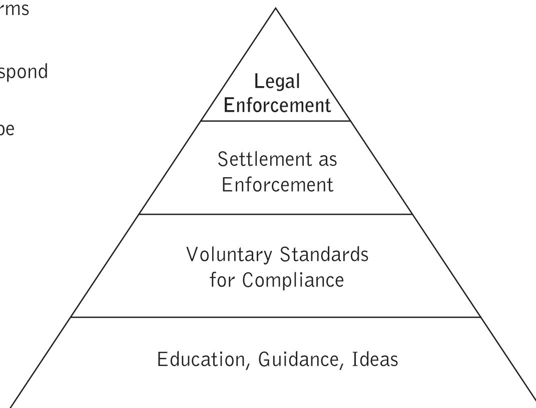


Figure 2.1 *Responsive regulation pyramid*

Source: Adapted from Parker (2002) and Ayres and Braithwaite (1992).

Over the past two decades, an influential system of corporate governance has also proceeded through what is known as responsive regulation (Ayres and Braithwaite 1992). This system is interesting because it seeks to balance a small amount of legislative authority, usually enforced by a regulatory agency, with a 'light touch' approach that attempts to steer organizations by promoting good practice and principles. Responsive regulation therefore promotes a small number of sticks and a large number of carrots in order to incentivize self-regulation. This is encapsulated in Ayres and Braithwaite's (1992) pyramid. What the pyramid shows is that regulators often seek to create flexible regimes which will trade on goodwill and sound values first and then enforce punitive measures second (see Figure 2.1).

A typical example comes from the United Kingdom in the form of the old Financial Services Authority (FSA), which provided the financial industry with a broad set of principles through which it was expected to regulate itself. A second example, also from the United Kingdom, comes in the form of the Press Complaints Commission, which, prior to the Levenson Inquiry, also sought to regulate with a light touch. It is telling that each of these regulatory models have been entangled in two of the biggest crises that the United Kingdom has faced recently – the global financial crisis and the 'phone hacking' scandal – and both are in the process of being fundamentally reformed so that the respective regulatory agencies have more 'teeth' to punish those who derogate from regulatory principles. In the case of the former, that means punishing investment bankers who are prepared to exploit moral hazard and in the latter, reporters, editors and newspaper owners who ignore ethics in the search to fill column inches.

These changes in regulatory regimes reflect pre-existing research which has shown how responsive regulation will only work effectively if a regulator has the capacity to sanction those who transgress. A comparison between two responsive

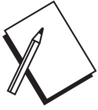
regulatory regimes in Australia, for example, found that the more effective regulator was the one with a greater capacity to operate at the top ends of the responsive pyramid (legal enforcement) as this promoted a tougher image, which in turn encouraged self-adherence to regulatory principles (Parker 2002). As one study of regulatory governance has noted wryly, 'self-regulation works if, as well as speaking softly, the state carries a big stick' (Bell and Hindmoor 2009: 90). Hence regulators who speak softly can be a driver of risk management practices if the principles they promote are relevant. Regulators who carry the threat of sanctions, however, cannot be ignored.

In the public sector, good governance tends to be encouraged through a range of principles enshrined in various documents, which attempt to instil the public sector with a 'public service ethos' – a morality rooted in a widely held view that public servants should embody the principles of neutrality, integrity and servitude to a public that sits above party political interests (Rhodes et al. 2009). These values are often collated in informal codes of practice and guidance. In the European Union, for example, the public service ethos is enshrined in the *Code of Good Administrative Behaviour*, while in the United Kingdom it is expressed through the Civil Service Code. In Australia, the concepts of accountability, responsibility, transparency, ethics and probity were described by the former Secretary to the Department of the Prime Minister and Cabinet, Dr Peter Shergold, as 'values intrinsic to professional public service' and first articulated in the Public Service Act 1999.

In seeking to enhance confidence in local democracy and promote ethical governance both at committee and at individual levels, local authorities have arguably moved ahead of the private sector (Kirkbride and Letza 2003). A significant development in the United Kingdom was the establishment of an Independent Commission on Good Governance in Public Services, which produced *The Good Governance Standard for Public Services* in 2004 (see Box 2.3). The Standard is intended to complement existing codes and guidance, and is to be used by all organizations and partnerships that work for the public using public money. It comprises six core principles of good governance, each with supporting principles and suggestions about how these might be put into practice. Explicit within this is the need to manage risk.

Compliance with audit and inspection

The remits of internal, external and government-funded auditing agencies have considerably widened in recent decades. Once focused primarily on financial matters, audits have expanded to include non-financial issues and management practices. Indeed, the prevalence of auditing cultures has led to arguments that they are now a defining feature of our societies and our political systems (Power 2008). Within the public sector, the need to ensure accountability and transparency in the utilization of public funds is obviously paramount. However, inspections are now being conducted into the overall



BOX 2.3 THE GOOD GOVERNANCE STANDARD FOR PUBLIC SERVICES IN BRITAIN

The Standard produced by the UK's Independent Commission on Good Governance in Public Services in 2004 promotes a risk management system that addresses the full range of organizational activities and responsibilities. It recommends the implementation of an effective risk management system and suggests the following steps be taken by the governing body of a PSO:

- identifying key strategic, operational and financial risks;
- assessing the possible effects that the identified risks could have on the organization;
- agreeing on and implementing appropriate responses to the identified risks (internal control, insure, terminate, modify, accept);
- putting in place a framework of assurance from different sources, to show that risk management processes, including responses, are working effectively;
- reporting publicly on the effectiveness of the risk management system through, for example, an annual statement on internal control, including, where necessary, an action plan to tackle any significant issues; and
- making it clear that the governing body carries ultimate responsibility for the risk management system.

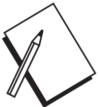
Source: Adapted from Section 4.3 of the Good Governance Standard, Independent Commission on Good Governance in Public Services (2004).

performance of such bodies, particularly, in the case of the United Kingdom, those in the local government sector. Such assessments measure how well councils are delivering services for local people and allocate a rating that can be used to benchmark improvements in services within and between these local government organizations. The extent to which potential risks are identified and managed forms a key element in these assessments. By publishing the outcomes, it is expected that less well-performing authorities will be challenged to match the pace of those that are improving more quickly and achieving better results.

Compliance with the expectations of society

As previously discussed, there is an expectation that a PSO will act in an ethical manner and ensure that it has robust corporate governance processes in place. With a broad range of stakeholders, there is also an expectation that the organization will act in a manner that is socially responsible.

Social responsibility is a term that is used to describe an organization's obligation to be sensitive to the needs of all its stakeholders and is closely linked with the concept of 'sustainability'. This requires consideration of the social and environmental consequences of any decision, in addition to its financial and economic dimensions. In some countries, regulation relating to environmental and social issues has increased, with some of this being driven at a supranational level, for example by the European Commission and the United Nations. Pressure from NGOs and local issue groups on proposals for waste disposal, the installation of mobile phone masts or wind farms, open cut mining, genetically modified crops and nuclear power stations have led to greater consultation and communication with those stakeholders who are most likely to be affected by such developments (see Box 2.4). The message from one of the largest international NGOs, Friends of the Earth, to 'think globally, act locally' also brings a focus on wider issues such as climate change and nanotechnology. The public service organization now needs actively to manage the broader social and environmental risks arising from its activities and to demonstrate to its stakeholders that it is behaving in a socially responsible manner. PSOs that are perceived as not treating their employees well, not being energy efficient, or careless in their attitude towards waste management, may find that this is costly not only in financial terms but also in terms of the esteem in which they are held by the community.



BOX 2.4 NON-GOVERNMENTAL ORGANIZATIONS

A non-governmental organization (NGO) is an organization which is independent of government. This means that the NGO can pursue its own objectives, structure itself freely and create and implement its own policies as long as it remains within legal parameters. The term often refers to lobby or advocacy groups, whose aim it is to influence government policy-making and/or implementation, but NGOs come in a variety of shapes and sizes, including private companies and voluntary bodies. They range from small, local community action groups campaigning against, for example, the location of mobile phone masts, to national trade unions, to large, multinational groups such as Greenpeace and Friends of the Earth. However, NGOs can also be directly involved in the formulation and implementation of risk and crisis management. For example, private consulting companies, such KPMG or Deloitte & Touche routinely provide evidence for policy-makers upon which risk management policies are built, while humanitarian relief organizations, such as the Red Cross or Medicine Beyond Borders, implement disaster management policies on behalf of governments and international actors like the UN.

BARRIERS TO EFFECTIVENESS

In an ideal world, there would be no barriers to effective risk and crisis management. The necessary resources would be in place, organizations would be structured around an awareness of the qualities required to respond to threats, staff would be trained to identify risks and to manage any crises that might occur and politics would not be an issue. Unfortunately, this is simply not the case for most public sector organizations.

The reality is that most PSOs are under considerable budgetary constraints, and competition for funds within the organization is likely to be fierce, especially in light of austerity measures and debt management programmes coming in the aftermath of the global financial crisis. As such, the pursuit of efficiency is an inevitable reality for all PSOs. This can be problematic in at least two ways. The first relates to prevention measures, which often rely upon redundant resources. Redundancy in this regard describes auxiliary resources, which are not optimally efficient, yet may be crucial as a backup in terms of identifying faults and preventing failure. The second, often superfluous, safety check that catches the one in 1000 fault is the most obvious expression of redundancy in action. Nine hundred and ninety nine times, the second safety check is wasteful and inefficient – it is redundant and does nothing. Yet that single 'catch' can be absolutely crucial in preventing disaster. Hence as an organizational value, redundancy has a pedigree amongst certain crisis analysts as a means of preventing accidents and disaster and promoting 'high reliability' (La Porte and Consolini 1991; Sagan 1993). The problem, however, is that being highly reliable often means being highly inefficient, at least in the short term, which is a price that few PSOs can afford to pay. What this means is that there are organizational values within public sector organizations that pull public managers away from effective risk prevention.

We can say the same thing about crisis management. Consider, for example, the need for adaptation in the face of fast-paced threats. Crisis managers must be able to innovate just as quickly as the crises that they are required to control. Yet it has been shown that the pursuit of efficiency within public management processes can mean that the organizational apparatus surrounding the crisis manager will be more intransigent than adaptable (Stark 2014). Hence when public services are made too lean through efficiency savings they cannot always promote the 'rapid customization' that is essential to good crisis management (Ansell et al. 2010). In effect, organizations that pursue efficiency to an extreme will become error prone because of this lack of adaptability (Landau and Chisholm 1995).

Other organizational values, often taken for granted as virtuous, can also cause problems. Highly procedural forms of organization, for example, may be extremely effective at dealing with routine and small-scale emergencies (Moynihan 2009). However, there is a real danger that too much proceduralism can stifle innovative leadership in crises and create deterministic forms of procedure that can mean a lack of adaptive capacity (Stark 2014). Hence crisis management can be viewed in terms of an organizational paradox because 'on one hand, emergency response requires meticulous organization

and planning, but on the other hand it is spontaneous. Emergency managers have to innovate, adapt, and improvise because plans, regardless of how well done, seldom fit circumstances' (Waugh Jr and Streib 2006: 132). A lack of organizational 'nimbleness', caused by problematic organizational values, can therefore be a real impediment to effective crisis management.

A further inhibitor is a lack of understanding of the language of risk and of the tools and techniques that can be employed to identify, evaluate and treat threats to the achievement of the organization's objectives. The management of risk needs to be undertaken at the source. In other words, staff at every level in the organization need to be aware of, and trained to deal with, the risks that occur in their everyday employment. This also applies to directors and senior executives in the organization, who are furthermore required to think beyond their immediate areas of expertise and consider broader strategic threats to the whole enterprise. Effective education and training in the management of risk is necessary throughout the organization, as is appropriate preparation and training for the management of crises.

Conflicts may also exist between long-term and short-term political goals, requiring difficult decisions to be made today by elected members and their executive that may impact on the future well-being of the communities they serve, as well as their future careers. Improving air quality, for example, by excluding private cars from sections of a city or implementing congestion charging, may be good for the long-term health of the local community. However, such issues are often highly emotive and politically charged. This can result in compromises being made that fail to achieve the original aims.

UNDERSTANDING THE CAUSES OF CRISES

Two questions are addressed in this section. The answers to each one are designed to provide public managers and policy-makers with an understanding of how to think about the threat of crises from an early stage, so that they can begin meaningfully to prepare for the worst. The first question is why do crises occur? This is obviously a crucial question that public managers and policy-makers must consider if they are to have any hope of preventing, moderating or coping through catastrophes. Perhaps more significantly, we also want to ask, why does history often repeat itself in terms of the human errors that help cause crises? Addressing this question moves the discussion onwards from an understanding of causation generally to an understanding of what actions can ensure that public managers are part of the solution to crises rather than part of the problem.

At a general level, we can identify two causal pathways through which crises arrive at the doorstep of the public organization. One is a slow-paced pathway where seemingly benign issues translate gradually into risks, which in turn incubate and become transformed into crises. These crises tend to be endogenously created, meaning that the risks, vulnerability and subsequent hazards will come from within an organization or policy sector. This is not to say that the crisis events themselves will not be fast-paced or sudden but rather that hindsight will identify a long process of internal incubation

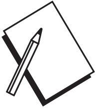
within a discrete set of institutions (Turner 1978; Alink et al. 2001). The second causal pathway is typically seen in the natural disaster. In these events, a very sudden trigger event, such as an earthquake or a flood, presents a hazard to a community. This hazard will materialize into a disaster if there is a level of social vulnerability, which will typically have developed over a long historical period. In this sense, causation emerges through the combination of a short, sharp but external threat in conjunction with a lack of social protection within a community, which may be the result of a diffuse range of factors, such as poverty or race relations (Wisner et al. 2004). Focusing more specifically on issues of public management, we can say that crises can occur because of a failure in one or more of the following elements:

- human behaviour (human error);
- technology;
- management systems;
- government behaviour.

Human error

Generally, human beings make decisions and take action based on the best information available to them at the time. That said, human beings are not logical, detached machines. They make misjudgements despite good intentions, get tired and careless, make mistakes due to lack of training, override systems when they are insufficiently supervised, and sometimes deliberately commit sabotage or fraud in the work environment. Almost all crises feature elements of human error.

One strand of research, conducted by political psychologists with an interest in crisis management, is particularly illuminating in this area ('t Hart 2010 offers a good overview of this field). For example, motivational theories of psychology have been applied to examine the specific leadership traits of American presidents. These analyses have led to conclusions that certain styles of leadership can encourage forms of ‘policy drift’ which, in turn, increase vulnerability to crises and hamper preventative crisis management efforts (Cottam et al. 2004; Preston 2008). Applying such perspectives to public management indicates that certain leadership behaviours can have a bearing on the frequency and nature of the crises that a public sector experiences. A second example from the psychological literature can be found in the concept of ‘groupthink’, where incentives and pressures for group harmony and cohesion can override a group’s ability to assess problems, process information and take decisions. The erroneous rationalizations arising from a groupthink situation can lead to symptoms of invulnerability, overconfidence, excessive optimism, unquestionable belief in morality and a process of self-censure during decision-making. Janis (1982) has argued that groupthink cultures caused some of the worst crises in US history, including the Bay of Pigs episode, Pearl Harbour and the escalation of war in Vietnam. The theory has also been used in explanations of contemporary policy failures, such as the Iran–Contra scandal (see Box 2.5).



BOX 2.5 GROUPTHINK AND THE IRAN–CONTRA CRISIS

The Iran–Contra affair is the perfect example of a relatively modern groupthink situation causing a crisis. In the mid 1980s, with the approval of the then President of the United States, Ronald Reagan, Colonel Oliver North and a small group of White House officials and career military men began to sell weapons, through various private middlemen, to Iran in an attempt to gain leverage in the Middle East. The arms sales were conducted so that the US administration could broker the release of American citizens being held hostage in Lebanon. However, the plot thickened as it emerged that this group then used the funds that it received from the selling of the weapons to fund Nicaraguan Contra rebels who were waging a terrorist war against a communist government. Paul 't Hart's account of this affair indicates how this small group of decision-makers fell victim to a groupthink process because:

- The group was isolated from surroundings and public scrutiny.
- Members of the group were either 'in or out' depending on their ideological views.
- Secrecy bound them together and emphasized the need to stick together.
- They believed they were acting heroically in the best interests of the United States.
- Their mandate from the president led to a belief that they were invulnerable to blame.
- Initial successes (two hostages were released) emboldened them and their cause, leading to the Contra funding.

These factors ultimately led the group down a path to conviction that their actions were right despite the political, democratic and ethical issues involved. What the Iran–Contra affair shows is that human error can emerge from a decision-making process where group dynamics are put before more rational, clear-headed evaluations of right and wrong.

Source: 't Hart (1994).

Technological failure

Failures in technology can have physical impacts, as well as an impact on the continuity of services. In safety-critical environments such as nuclear power plants, chemical factories, space shuttles, airplanes and railways, risk controls must be sufficiently robust to enable 'fail-safe' situations. These systems are highly complex and, according to Perrow (1999), will inevitably experience accidents of one kind or another. The questions that society has to ask itself are: do the benefits outweigh the risks, and are there any alternatives? Double and triple backups, manual and automatic overrides, 'dead man's handles' and automatic shutdowns are all examples of features built into safety-critical systems in an attempt to protect life, should one part of the technology fail. However, redundancies such as these are not foolproof. Within many PSOs, failure in power or IT systems can effectively disable the organization and prevent it from being able to conduct its operations. This situation becomes increasingly grave as organizations move towards greater provision of e-services. When technological failure does occur, plans need to be in place that will firstly protect life, and then protect property and ensure continuity of the service.

In large, complex organizations, imbalanced goals and ineffective learning combined with pressure to achieve targets can lead to shortcuts being taken and mistakes being made. Analysis of the Columbia Space Shuttle disaster found that many historical, social, political and technological factors interacted across different organizational technologies to create unsafe conditions, unrealistic expectations and faulty decision-making (Starbuck and Farjoun 2005). Given the complexity of many organizations, where multiple and unexpected interactions of failures are possible, if not inevitable, these can be viewed as 'normal accidents' or 'system accidents' (Perrow 1999: 4).

Management systems failure

There is no doubt that we live in a 'blame' society with the media always eager to attribute responsibility for failure to one or more individuals within an organization. Thus it was the sailor who failed to close the bow doors of the roll-on roll-off ferry who was to blame for it sinking; the pilot who shut off the wrong engine who was to blame for the crash; the social worker who did not insist on entering the house to inspect conditions who was responsible for the child's death. And so on.

Although human error may well have been a component in these scenarios, it was only part of the picture. Where there is human error, even in circumstances where the situation has been caused by deliberate or negligent action on the part of an individual, there are often signs that management systems are inadequate. Lack of robust policies and guidance documents, lack of training and supervision of staff, poor record-keeping, inadequate communication (vertically and horizontally within the organization), cultures of mistrust between employees and management, the swift application of blame for mistakes and an inability to learn from previous incidents all contribute to the

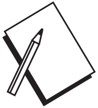
emergence of crisis situations. The organizational model for managing safety views human error more as a consequence than a cause (Reason 1997). Errors are perceived as symptoms of latent conditions that exist in the system as a whole, rather than as merely the result of individual human inadequacies. However, we must be careful here. Following on from Chapter 1, we must learn to disentangle political accusations about systemic failure from real systemic problems or smaller-scale (and less blameworthy) issues. When isolated or relatively benign issues are framed as symptoms of a larger systemic mess, opportunistic actors can politicize minor issues into full-scale crises (Brändström and Kuipers 2003). In such situations, deeper causes of crisis can be masked by rhetorical political explanations.

Government behaviour

The attitudes and actions of society in relation to government behaviour may also influence the likelihood of crises occurring. Decisions about spending on infrastructure such as roads and railways (where these are under public control), water treatment, waste disposal, health and social services are balanced against issues of cost and public willingness to pay. While it is likely that a straw poll would find almost everyone in favour of improvements in all of the above public services, it would almost equally find resistance to the idea of increased taxation to pay for such improvements. Government, therefore, has the difficult task of balancing varying and sometimes conflicting demands from citizens for increased levels of service and safety, sometimes at no extra cost. Failure of government or government-funded agencies adequately to maintain critical infrastructure, such as rail tracks, has been a factor in several major rail crashes around the world. The introduction of new computer systems, without adequate testing or training, has resulted in disruption, huge financial costs and public dissatisfaction. These were labelled as 'policy fiascos' in Chapter 1, and are characterized by decisions that are associated with negative impressions of the individuals and agencies responsible (Bovens and 't Hart 1996). Case study 2.1 gives an example. If these impressions exist on a large scale, PSOs will not have the legitimacy and credibility to prevent problems being perceived in a negative light and, inevitably, problematic events will be labelled as crises.

IDENTIFYING CRISES BEFORE THEY ARRIVE

As we noted above, many crises emerge from an incubation period during which problematic decisions or failures to act heighten the potential for a problem to develop. When organizations fail to see the warning signs that are present in this period, or alternatively identify relevant problems but undervalue their significance, there is a much greater likelihood of a crisis occurring (Fink 2002). Every day we are surrounded by hundreds if not thousands of small risky events, on which we have to make decisions



CASE STUDY 2.1 THE AUSTRALIAN LOFT INSULATION DEBACLE

In response to the global financial crisis, the Rudd government introduced a series of policies across 2008 and 2009 that were designed to stimulate the Australian economy. One of these measures was a Home Insulation Program (HIP) through which citizens received a subsidy of $1600 dollars in order to insulate their house. This subsidy effectively meant that most homeowners could have their buildings insulated for free, as claims of $1600 dollars or less were directly paid to the installers. The policy had three objectives: (1) to stimulate the building industry; (2) to increase employment; (3) to promote energy efficiency.

However, the implementation of the HIP can be considered to be an example of a policy fiasco:

- Four inexperienced workers died while installing insulation.
- A large number of fraudulent claims by homeowners and builders ensued.
- Over 200 fire incidents were reported as a consequence of poorly installed insulation, and $1 billion dollars had to be spent implementing a number of remedial policies, including safety checks in homes.
- The scheme was cancelled with less than half of its $2.45-billion budget allocation being spent.
- The Australian Energy Minister, Peter Garrett, was shuffled out of his post.

Numerous investigations into the HIP have identified that:

- The scheme was implemented without adequate consultation with industry experts.
- A risk management review conducted for the Department of Environment as it established the policy had identified nineteen potential risks, including the issue of fraud, waste and inadequate levels of training in the building industry, but it was ignored by ministers.
- The concerns of officials in the Department of Environment about the speed at which the policy was to be rolled out were also ignored by ministers.
- The government had not identified a clear set of qualifications for builders who wished to be registered for the scheme nor had it anticipated the volume of demand for the scheme amongst homeowners.

This is a particularly interesting case study because it shows how a knee-jerk reaction to a larger crisis led to a series of hasty decisions through which a domestic policy fiasco developed. However, in many ways the Rudd government

was caught between a rock and a hard place. Without economic stimulus policies like the HIP, they would have almost certainly been criticized for a slow or neglectful response to the global financial crisis. Yet their quick response, conducted as it was with minimal regard to proper risk management, created a completely new and unanticipated crisis domestically.

Source: Auditor-General (2010); Lewis (2012).

and take action. Most of these are of little consequence, or may appear to be, yet when combined with other factors they can take on a more serious dimension. What this means is that the process of 'sense-making' is an absolutely crucial aspect of preventative crisis management, which must be taken seriously by crisis managers (Boin et al. 2005). Fink (2002) takes the view that when an organization is not actually in a state of crisis, it is instead in a pre-crisis mode when, if it is vigilant, it may see something that needs to be addressed quickly, before it escalates and contributes to the creation of an acute crisis. For some crises, there is little or no warning stage. Arguably, the terrorist attacks of 9/11 would be an example of this. Few could imagine the new methods of destruction that would be employed on that day. However, for the majority of serious incidents, subsequent investigations normally reveal a catalogue of small events and failings that, had their significance been fully understood and addressed, might have prevented the incident from occurring. An example here can be seen in the lack of prudential regulation and global oversight of the banking industry prior to the credit crunch of 2007–8. Looking back with hindsight, we can now observe the development of a 'perfect storm' as relaxed mortgage rules spurred on exponential increases in housing market prices, which in turn encouraged investment banks to leverage huge sums of money in order to trade in mortgage-backed securities with little in the way of regulatory scrutiny or credit agency oversight. Ultimately, what emerged, according to one prominent economist, was a system 'designed to encourage risk taking – but it encouraged excessive risk taking. In effect, it paid them [bankers] to gamble. When things turned out well, they walked away with huge bonuses. When things turned out badly – as now – they do not share in the losses' (Stiglitz 2008). Thus, a risk-inducing system was created and was only identified as such after that risk had escaped to paralyse markets and governments around the world.

Therefore, if we seek greater capacity to prevent future crises from occurring, a collective state of vigilance (Fink 2002) or mindfulness (Weick and Sutcliffe 2001) is recommended. And this state must be one which not only makes sense of problems within an organization but also one that is capable of identifying problems as they emerge across the partnership networks which we discussed above. This is no mean feat for any public organization. Most PSOs still remain ill-equipped to horizon scan for threats in their environment and identifying potential threats from within an organization, as we have already stated, requires putting together many small pieces of a larger

mosaic of risk. On both counts, sense-making functions are more likely to be seen as a distraction from the achievement of core organizational goals rather than an essential concern. Problems can also arise, however, if systems that are put in place to manage crises create a sense of organizational complacency. In this regard, the 'normalization of risk' (Boin et al. 2005) can mean that public managers adopt a 'we have got this covered' attitude to potential threats and stop looking for, and thinking about, worst-case scenarios. Sensing risks and crisis is a perpetual process which should not stop once a system or policy has been put in place.

In their study of high reliability organizations (HROs) such as aircraft carriers, nuclear power plants and fire-fighting crews, Weick and Sutcliffe (2001) found that these organizations were able to maintain reliable performance because of certain key characteristics. They describe these as:

- Preoccupation with failure – treating any lapse as a symptom that something is wrong with the system, encouraging reporting of errors, learning lessons from near misses and being wary of complacency.
- Reluctance to simplify interpretations – knowing that the world is complex, unstable and unpredictable, they encourage individuals to look beyond their own boundaries and to be sceptical of received wisdom.
- Sensitivity to operations – scrutinizing normal operations in order to reveal deficiencies in supervision, safety procedures and training, hazard identification, etc. and encouraging continuous adjustments that will prevent errors from accumulating and enlarging, encouraging people to speak out about their concerns.
- Commitment to resilience – developing capabilities not only to detect problems but also to be able to continue working when things go wrong.
- Deference to expertise – decisions are delegated to those on the front-line and with the most expertise (not necessarily the most experience) in that field.

(Adapted from Weick and Sutcliffe 2001: 10–17)

All organizations, whether they are HROs or PSOs, develop their own cultural beliefs about the world in which they operate. They create rules, regulations and procedures based on a set of expectations, which may or may not be met. When unexpected events occur, they may be so small that they are hardly noticed, or their potential for damage may not be fully realized. A recurring source of misperception lies in the temptation to define an unexpected event as unproblematic in order to preserve the original expectation (Weick and Sutcliffe 2001: 49), such as defining a water contamination episode as a unique 'one-off' set of circumstances rather than symptomatic of an underlying vulnerability in the capacity to produce safe drinking water.

Key factors in any sense-making process are the ability to learn from what has happened in the immediate past, listen to worst-case predictions and listen to a range of voices in the organizations that will be affected in a crisis. In 2010, the Australian

Meteorology Bureau predicted that a La Niña weather pattern in the Indian Ocean would result in high weather pressure. If this was coupled with a large monsoonal rainfall, it would create a high risk of flooding throughout Australia. Between July and December of that year Australia experienced its wettest period on record and as a consequence many parts of the country, particularly in the state of Queensland, suffered flooding throughout 2010. These events, however, were a minor prelude to the major flash flooding that occurred between December 2010 and January 2011 across Queensland, in which the scale and severity far exceeded the earlier flood events. A total of thirty-eight people were killed, over 13,000 households were completely flooded and the cost of reconstruction was counted in billions of dollars

Amidst this tragedy were a few success stories relating to sense-making and crisis preparation. In the rural region of Banana Shire, located in the hinterlands of north Queensland, residents who had suffered from flooding in the months prior to the 'big one' had lobbied their local government for increased crisis management measures in anticipation of future floods. Sensing the risk, and keen to respond to local electorate concerns, the local council put in place a number of devolved crisis management units within isolated communities in preparation for any future event. When the floods returned, these localized units managed to coordinate local evacuations and other emergency response measures effectively, leading to calls from the official inquiry for their model to be replicated across the state (Stark and Taylor 2014). This instance of sense-making, which proceeded through a local authority willing to listen to its public, stands in stark contrast to other stories of local government performance pre-flood, which were all too often characterized by neglect of crisis management measures and a lack of awareness of the growing threat caused by the monsoonal rainfall. What this case shows is that participatory forms of governance, which allow citizens to air concerns and voice grievances about the risks they face, can perform a crucial role in horizon scanning, sense-making and crisis management preparation (Stark and Taylor 2014).

CONCLUSION

The pressures on organizations to address issues of risk and crisis management are increasing. Such pressures emanate partly from the internal operations of the organization and the need to maximize efficiency and quality in service delivery, and partly because of the requirement to comply with government and the expectations of citizens, insurers and others. Compliance, on its own, is not enough if an organization is to address the broad range of risks it faces as it attempts to achieve its corporate objectives and fulfil its role in the community. A belief in the wider benefits to be gained from attempting to manage risk in a holistic, enterprise-wide manner, and the development of plans to deal with a crisis situation, is now gaining ground. Although the impetus for addressing risk issues in many organizations has come through the adoption of codes of corporate governance, there is now a greater awareness that governance has

to be balanced with performance if the enterprise is to be successful. Awareness and management of risk are essential elements in achieving the desired performance outputs.

When crises occur, it is usually due to a combination of factors relating to human, technological, management and governmental interactions. While crises always have the capacity to come as 'bolts from the blue', we do have some capacity to identify potential crises as they incubate. Sensitive organizations, with the capacity to collate and assess a range of data about threats, will be able to see some (although not all) crises coming before they wreak havoc. Later in this book, we will examine how organizations can better prepare themselves to deal with crises in other ways (Chapter 5), and learn lessons from such events (Chapter 7). However, in the following chapter, we will start to explore some of the techniques that can be applied to identify and assess risks, and consider issues of public perception and willingness to tolerate situations that bring both societal benefits and pose potential threats.

EXERCISE 2.1 LEARNING LESSONS FROM A CRISIS

Choose an example of a crisis situation within a public service organization and consider the following issues:

1. What factors contributed to the development of the crisis?
2. Could action have been taken to: a) identify the crisis as it emerged; b) deal with the crisis while it was happening?
3. What damage or loss resulted?
4. What lessons were learned?

DISCUSSION QUESTIONS

1. Based on your own experience in a public service organization, or on your general knowledge of this sector, what do you believe is the most powerful justification for risk and crisis management, and why?
2. Can a private sector approach such as enterprise risk management be successfully transferred to a public service organization? Give reasons.
3. What are the key pieces of legislation that are driving risk and crisis management in your organization?
4. How would you scan the horizon for potential crises? Would you use existing organizational tools or create unique processes to perform 'sense-making' functions?

REFERENCES

Alink, F., Boin, A. and 't Hart, P. (2001) 'Institutional Crises and Reforms in Policy Sectors: The Case of Asylum Policy in Europe', *Journal of European Public Policy*, 8: 71–91.

Ansell, C., Boin, A. and Keller, A. (2010) 'Managing Transboundary Crises: Identifying the Building Blocks of an Effective Response System', *Journal of Contingencies and Crisis Management*, 18(4): 195–207.

Auditor-General (2010) *Home Insulation Program*, Audit Report no. 12 2010–11. Canberra: Australian National Audit Office.

Ayres, I. and Braithwaite, J. (1992) *Responsive Regulation: Transcending the Deregulation Debate*, New York: Oxford University Press.

Bell, S. and Hindmoor, A. (2009) *Rethinking Governance: The Centrality of the State in Modern Society*, Melbourne: Cambridge University Press.

Boin, A., 't Hart, P., Stern, E. and Sundelius, B. (2005) *The Politics of Crisis Management: Understanding Public Leadership under Pressure*, London: Cambridge University Press.

Boin, A. and 't Hart, P. (2003) 'Public Leadership in Times of Crisis: Mission Impossible?' *Public Administration Review*, 63: 544–53.

Bovens M. and 't Hart, P. (1996) *Understanding Policy Fiascos*, Edison, NJ: Transaction Publishers.

Brändström, A. and Kuipers, S. (2003) 'From "Normal Incidents" to Political Crises: Understanding the Selective Politicization of Policy Failures', *Government and Opposition*, 38(3): 279–305.

Chapman, C. and Ward, S. (1997) *Project Risk Management: Processes, Techniques and Insights*, Chichester: John Wiley & Sons.

Cottam, M.B., Dieter-Uhler, E., Mastors, E. and Preston, T. (2004) *Introduction to Political Psychology,* Mahwah, NJ: Lawrence Erlbaum Associates.

Culp, C.L. (2001) *The Risk Management Process: Business Strategy and Tactics*, New York: John Wiley & Sons.

DeLoach, J.W. (2000) *Enterprise-Wide Risk Management,* London: Financial Times, Prentice Hall.

Financial Reporting Council (2005) *Internal Control: Revised Guidance for Directors on the Combined Code*, London: Financial Reporting Council.

Fink, S. (2002) *Crisis Management: Planning for the Inevitable*, Lincoln, NE: iUniverse.

Fraser, J. and Simkins, B.J. (eds) (2010) *Enterprise Risk Management: Today's Leading Research and Best Practices for Tomorrow's Executives*, Hoboken, NJ: John Wiley & Sons.

't Hart, P. (1994) *Groupthink in Government: A Study of Small Groups and Policy Failure*, Baltimore, MD: Johns Hopkins Press.

't Hart, P. (2010) 'Political Psychology', in D. Marsh and G. Stoker (eds), *Theory and Methods in Political Science*, 3rd edition, Basingstoke: Palgrave.

HC 296 (2000) *The Road Haulage Industry, Fifteenth Report of the Environment, Transport and Regional Affairs Committee*, Session 1999–2000, London: Stationery Office.

Hill, M. and Hupe, P. (2009) *Implementing Public Policy*, Thousand Oaks, CA: Sage.

Independent Commission on Good Governance in Public Services (2004) *The Good Governance Standard for Public Services,* London: OPM and CIPFA.

Janis, I . (1982). *Group-Think*, Boston: Little Brown.

Jennings, W. (2012) 'Mega-Events and Risk Colonisation: Risk Management and the Olympics', Centre for Analysis of Risk and Regulation, Discussion Paper 71.

Jennings, W. and Lodge, M. (2011) 'Governing Mega-Events: Tools of Security Risk Management for the London 2012 Olympic Games and FIFA 2006 World Cup in Germany', *Government and Opposition*, 46(2): 192–222.

Kirkbride, J. and Letza, S. (2003) 'Corporate Governance and Gatekeeper Liability: The Lessons from Public Authorities', *Corporate Governance*, 11(3): 262–71.

La Porte, T.R. and Consolini P.M. (1991). 'Working in Practice, But Not in Theory: Theoretical Challenges of High Reliability Organizations', *Journal of Public Administration Research and Theory*, 1: 19–47.

Lam, J. (2003) *Enterprise Risk Management: From Incentives to Controls*, Hoboken, NJ: John Wiley.

Landau, M. and Chisholm, D. (1995). 'The Arrogance of Optimism: Notes on Failure-Avoidance Management', *Journal of Contingencies and Crisis Management*, 4: 67–80.

Lewis, C. (2012) 'A Recent Scandal: The Home Insulation Program', in K. Dowding, and C. Lewis (eds), *Ministerial Careers and Accountability in the Australian Government*, Canberra: ANU E Press.

McPhee, I. (2005) Risk and Risk Management in the Public Sector, a Speech to the Public Sector Governance and Risk Forum, Australian Institute of Company Directors in conjunction with the Institute of Internal Auditors Australia. Available at: <http://www.anao.gov.au/~/media/Uploads/Documents/risk_and_risk_management_in_the_public_sector.pdf> (accessed 3 June 2014).

Moynihan, D.P. (2009). 'The Network Governance of Crisis Response: Case Studies of Incident Command Systems', *Journal of Public Administration Research and Theory*, 19(4): 895–915.

National Audit Office [NAO] (2011) *Managing Risks in Government*. Available at: <http://www.nao.org.uk/wpcontent/uploads/2011/06/managing_risks_in_government.pdf> (accessed 18 May 2014).

Office of Government Commerce [OGC] (2004) *Management of Risk: Guidance for Practitioners*, London: HMSO.

Parker, C. (2002) 'Regulating Self-Regulation: The ACCC, ASIC, Competition Policy and Corporate Regulation', in S. Bell (ed.), *Economic Governance and Institutional Dynamics*, Melbourne: Oxford University Press.

Power, M. (2008) *Organized Uncertainty: Designing a World of Risk Management*, Oxford: Oxford University Press.

Preston, T. (2008) 'Weathering the Politics of Responsibility and Blame: The Bush Administration and its Response to Hurricane Katrina', in Boin, A., A. McConnell and P. 't Hart (eds), *Governing after Crises: The Politics of Investigation, Accountability and Learning*, Cambridge: Cambridge University Press

Rhodes, R.A.W, Wanna, J. and Weller, P. (2009) *Comparing Westminster*, Oxford: Oxford University Press.

Perrow, C. (1999) *Normal Accidents: Living with High-Risk Technologies*, Princeton, NJ: Princeton University Press.

Reason, J. (1997) *Managing the Risks of Organizational Accidents*, Aldershot: Ashgate.

Robinson, N. (2002) 'The Politics of the Fuel Protests: Towards a Multi-Dimensional Explanation', *Political Quarterly*, 73(1): 58–66.

Rothstein, H., Huber, M. and Gaskell, G. (2006) 'A Theory of Risk Colonization: The Spiralling Regulatory Logics of Societal and Institutional Risk', *Economy and Society*, 35 (1): 91–112.

Sagan, S.D. (1993) *The Limits of Safety: Organizations, Accidents and Nuclear Weapons*, Princeton, NJ: Princeton University Press.

Starbuck, W.H. and Farjoun, M. (2005) *Organization at the Limit: Lessons from the Columbia Disaster*, Malden: Blackwell Publishing.

Stark, A. (2010) 'A New Perspective on Constituency Representation: British Parliamentarians and the "Management" of Crises', *Journal of Legislative Studies*, 16(4): 495–514.

Stark, A. (2014) 'Bureaucratic Values and Resilience: An Exploration of Crisis Management Adaptation', *Public Administration*, 92(3): 692–706.

Stark, A. and Taylor, M. (2014) 'Citizen Participation, Community Resilience and Crisis-Management Policy', *Journal of Australian Political Science*, 49(2): 300–315.

Stevenson, A. (2013) *The Public Sector: Managing the Unmanageable*, London: Kogan Page.

Stewart, J. (2009) *Public Policy Values*, Basingstoke: Palgrave Macmillan.

Toft, B. and Reynolds S. (1997) *Learning from Disasters: A Management Approach*, 2nd edition, Leicester: Perpetuity Press.

Turner, B.A. (1978) *Man-Made Disasters*, London: Wykeham.

Waugh Jr, W.L. and Streib, G. (2006) 'Collaboration and Leadership for Effective Emergency Management', *Public Administration Review*, 66: 131–40.

Weick, K.E. and Sutcliffe, K.M. (2001) *Managing the Unexpected: Assuring High Performance in an Age of Complexity*, San Francisco: Jossey-Bass.

Wisner, B., Blaikie, P., Cannon T. and Davis, I. (2004) *At Risk: Natural Hazards, People's Vulnerability and Disasters*, London: Routledge.

FURTHER READING

Fone, M. and Young, P.C. (2005) *Managing Risks in Public Organizations,* Leicester: Perpetuity Press.

For an in-depth analysis of public sector risk, this book is an essential read. The authors explore conceptual issues relating to risk, uncertainty and the management of public risk, before proposing an organizational framework that enables the alignment of risk management with the organization's goals and objectives. Written for both academics and practitioners, the book also provides an insight into the political, economic, legal and other environments in which public sector organizations operate, and gives practical guidance on key risk management issues.

Bovaird, T. and Löffler, E. (eds) (2003) *Public Management and Governance,* Abingdon: Routledge.

This edited book covers a range of topics relating to the management and performance of public service organizations. Part III of the book focuses on governance as an emerging trend in the public sector and includes chapters on ethics and standards of conduct.

Toft, B. and Reynolds, S. (2005) *Learning from Disasters: A Management Approach*, 3rd edition, Leicester: Perpetuity Press.

First published in 1999 and now in its third edition, this book demonstrates how organizations can learn from mistakes and failures. Disasters are examined as systems failures and the authors show how a failure of hindsight, i.e. an inability to learn from one's own and from others' experience, can lead to catastrophic situations. Well-illustrated with numerous case studies, this is an essential read for any student of risk or crisis management.

Chapter 7

After the crisis

Evaluation, learning and accountability

LEARNING OBJECTIVES

By *the end of this chapter you should:*

- be aware that what happens 'after' the crisis is a significant factor in crisis management;
- be aware that post-crisis stages are characterized by learning and accountability dynamics which often conflict;
- have developed a solid understanding of the problems and processes associated with evaluating crisis management performance;
- have developed a clear understanding of the nature of post-crisis inquiries and the problems associated with learning through inquiries; and
- be aware that the aftermath of each crisis is different and that the institutional, political, economic and social contexts are important in terms of shaping post-crisis outcomes.

KEY POINTS OF THIS CHAPTER

- Evaluations of crisis management policy have to overcome a series of complex methodological problems in order to define successes and failures.
- Efforts to learn after crises often result in small-scale changes because reforms are constrained by institutional legacies and intransigent public policies.
- Crises are socially constructed in the aftermath period through interactions which 'frame' their nature and the performance of key actors and organizations.

- There is a range of outcomes in the post-crisis stage which may be political and policy oriented, and success in one category does not automatically mean success in the other.
- Post-crisis outcomes are shaped by many factors, particularly the nature and salience of the crisis, the timing of the event(s), party politics, the affected policy area and the degree of symbolism attached to the threat.

KEY TERMS

- **Evaluation** – may come in a variety of formats but is generally an investigation into the circumstances surrounding 'what went wrong', and what lessons can be learned.
- **Post-crisis accountability** – processes and issues relating to ensuring that crisis managers (from elected politicians through to public officials) are answerable for their roles/decisions in causing and managing crisis, with the possibility of sanctions being applied where necessary.
- **Post-crisis learning** – processes and issues related to ensuring that policies/institutions and procedures/values are able to adapt or reform after a crisis, in order that mistakes are not repeated and that society is better prepared should a similar crisis arise again.

POST-CRISIS EVALUATION: LEARNING AND ACCOUNTABILITY IN CONTEXT

At this stage in the crisis management cycle, emergency management issues cede to other concerns around policy evaluation, learning and accountability. What were the causes? Could it have been avoided? Is anyone to blame? Could it have been better managed? What lessons can be learned? Such questioning emanates from political executives, political parties, media, ordinary citizens victims and their families, lawyers, and more.

This period might be slower paced than the acute stage in terms of the demands made on public managers but it would be a mistake to describe the aftermath of a crisis as prosaic. In fact, these periods can be very dramatic because efforts to account for what happened can stimulate extreme emotions, prompt radical change and electrify political relationships. For this reason analysts have begun to recognize that this stage of the management cycle is a point in the life of a crisis that can actually be more problematic than the emergency that preceded it (Rosenthal 2003: 132). This is because the shift to recovery issues often means that 'what began as an accident or series of incidents turns into a story about power, competence, leadership and legitimacy (or lack of it)' (Boin et al. 2005: 100).

In broad terms, we need to come to grips with two closely entwined dynamics if we wish to understand this stage. These relate to *learning* and *accountability*. In the aftermath of a crisis 'lesson learning' is certainly encouraged, if not demanded. As Wildavsky (1988: 245) notes about the recovery period, 'learning is a golden concept: everybody is for it'. Indeed, the literature on post-event learning is often characterized by an assumption that crises will lead to rational policy evaluations, clear-headed lessons and organizational improvements which will enhance future crisis management efforts. In this sense, post-crisis learning is very much about looking forward in positive ways to a new and safer future (Boin et al. 2008). However, public managers need to ask why it is that public sector organizations continue to repeat the mistakes of the past, despite their engagement in lesson learning processes?

To a large extent, the answer to this question can be found in the concept of accountability or, more accurately, in the political reality of accountability as it plays out in public sector systems. Unlike learning, accountability is very much about looking back so that that an account of what happened can be constructed (Boin et al. 2008). In these accounts, individuals and organizations involved in decision-making need to explain and answer for their actions (explanatory accountability) and they also have to make commitments to change what went wrong (amendatory accountability). This is the essence of accountability; explaining and changing problematic policy pathologies (Pyper 1996).

However, the search for proper accountability can easily become a search for someone or something to (unfairly) blame, a means of self-promotion or an exercise in political manoeuvring through which culpable actors escape censure. In such contexts, clear-headed evaluations are replaced with political machinations which prejudice meaningful change. We must be careful, therefore, not to assume that lessons will be learned from a crisis because in many instances 'the more we know about a crisis, the less likely we are to learn from it. This is the case, because in the politics of blaming, information is tailored to be ammunition . . . data are selected and moulded to construct winning arguments in a battle for political-bureaucratic survival' ('t Hart and Boin 2001: 184).

Central to both accountability and learning is the issue of *evaluation*. If we are to hold decision-makers to account or put in place 'lessons learned' insights, we need to have a clear idea of what success and failure means in crisis management terms. What worked and what did not? This seemingly simple question is made complex by a range of problems which are inherent to any evaluation of policy. The most important of these is the simple fact that one person's policy success is another person's policy failure. Unfortunately, this issue of subjectivity creates a grey area in which political interpretations of success and failure can flourish.

Finally, it is again important to understand that evaluative processes do not exist in a vacuum. They too have to be understood in *context*. This means locating them within (at least) three environments:

- the larger systemic environment in terms of the democratic, public sector and crisis management system relevant to the crisis;
- the historical or chronological environment, which takes into account the timing at which the crisis arrives in terms of the pertinent organizations; and
- the crisis itself in terms of its threat, inconceivability and impact.

Each of these contexts will have an important bearing on the nature of accountability and learning at this stage.

We begin this chapter by tackling the thorny issue of crisis management evaluation in the hope that having a clearer set of prescriptions about 'good' and 'bad' crisis management might curb detrimental post-crisis politics. We then move onto discussing learning and accountability and we conclude by drawing attention to the contextual factors that can influence the quality of both. In each area we wish to show the importance of performing post-crisis functions correctly. Decisions at this stage can have profound effects when the next threat arrives. If there is too much blame, crisis leaders may act as timid followers of procedure next time rather than real decision-makers. If there is insufficient accountability, the credibility of future crisis managers may be damaged by sceptical public opinion. And if no learning takes place at all in these periods, then future crises and crisis management mistakes become inevitable.

THE CHALLENGE OF EVALUATION: WHAT CONSTITUTES A SUCCESSFUL CRISIS RESPONSE?

More often than not crises enter into folklore as high-profile failures of some sort. Levees fail to prevent floods and presidents fail to respond; nuclear meltdowns and space shuttle explosions are said to be caused by failed safety cultures; and global financial crises emerge out of the failures of financial regulation. However, crisis management successes do exist but they are under-reported. In Australia, government responses to asylum crises, terrorist attacks and floods have been defined as successful either in terms of the effectiveness of crisis management policy or the political gains that came with strong leadership (Dyrenfurth 2005; Paul 2005; Arklay 2012). Similarly, in Europe, responses to the HIV-in-the-blood-supply crisis of the 1980s and 1990s have been defined as successful on programmatic and political terms (Albæk 2001). In the United States, the reassuring actions of Tylenol after their stock was poisoned with cyanide has become a classic case study in effective crisis communications (Argenti and Druckenmiller 2004), and in South America community responses to natural disasters have been lauded (Maskrey 1994). The key question when reviewing these cases is what actually constitutes success and failure when it comes to crisis management?

It would be something of an understatement to claim that there are methodological problems associated with this question. McConnell (2011), for example, draws

attention to no fewer than seven significant problems in the evaluation of crisis management efforts:

1. *Perceptions* – success and failure cannot be considered indisputable facts but rather the result of subjective perceptions. Facts can tell a story of success or failure but they are always interpreted by evaluators differently depending on their values and aims.
2. *Benchmarks* – there is no definitive set of performance indicators for crisis management although some, such as the SPHERE targets for international humanitarian responses, have gained popularity. Despite this, using one set of benchmarks risks privileging one set of values above others. For example, privileging policy effectiveness targets may overlook the importance of protecting human dignity and democratic rights during a crisis.
3. *Winners and losers* – crisis management can be a zero-sum game, which means that the interests of some have to be compromised so that the crisis is ended. The managing of the threat of the volcanic ash cloud that travelled across Europe in 2008 is a good example. While the grounding of flights across Europe allowed aviation authorities to claim success in terms of safety, thousands of disgruntled tourists stranded around Europe questioned why the decision was taken without solid scientific evidence.
4. *Boundaries of evaluation* – where do we 'draw the line' in terms of evaluation? Political opportunists may either wish to narrow the evaluation process so that it focuses on a blameworthy individual or, conversely, they may seek to broaden out the analysis to examine a whole system or sector as a potential failure. The nature of the evaluation is another politically loaded issue: should a technical inquiry explore managerial issues or should a broader inquiry examine political and social cultures too?
5. *Time* – following on from the above, the question of time is also an evaluative issue. Short-term, medium-term or long-term analyses will lead to different results. For example, consider a crisis such as the 2001 foot and mouth epidemic in the United Kingdom. In this case, many acute-stage failures were evident but in the longer term those failures prompted many substantive improvements in crisis management policy. A short-term analysis would lead to a verdict of failure but a longer-term evaluation would have to consider lesson-learning successes.
6. *Goals* – stable policies have clear goals but in the turmoil of a crisis goals can be fluid, contradictory and contingent on events. And in a context of high uncertainty, information deficits and unintended consequences can mean that defining any goal can be problematic.
7. *Alternatives* – how can we possibly know what would have happened if decision X had not been taken or been taken in a different way? Although some crisis analysts have addressed this question by building alternative scenarios to what actually happened

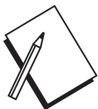
> in real crises (Rosenthal and Pijnenberg 1991), we are still some distance from being able to use counterfactuals to evaluate performance. (See Box 7.1.)

Consideration of these issues is absolutely crucial but we do not wish to present an image of the policy evaluation process as an insurmountable task. Public managers can engage in crisis management evaluations. Below we present one pathway through which an evaluation can be tackled, developed by McConnell (2010, 2011). This model instructs evaluators to focus upon *process*, *decisions* and *politics* and its key strength is that it provides clear definitions of crisis management success and failure based on these three areas. Let us begin with the definition of success:

> A crisis management initiative is successful if it follows pre-anticipated and/or relevant processes and involves the taking of decisions which have the effect of minimising loss of life/damage, restoring order and achieving political goals, while attracting universal or near universal support and/no or virtually no opposition.
>
> (McConnell 2011: 68)

And the definition of failure represents something of a negative mirror image of the above:

> A crisis management initiative fails if it follows unanticipated and/or non-relevant processes and involves taking of decisions which have the effect of



BOX 7.1 POTENTIAL BENCHMARKS FOR CRISIS EVALUATION

- Stated objectives of crisis managers
- Benefit to individuals/groups/localities under threat
- Level and speed of improvement
- Adherence to industry standards, e.g. risk management standards, crisis management protocols
- Adherence to appropriate laws
- Adherence to contingency plans
- Comparison with the crisis experience of another jurisdiction
- Level of expert/political/public support for the initiatives
- Benefits outweighing costs
- Degree of innovation adopted
- Preservation or enhancement of moral/ethical principles

Source: Derived from McConnell (2011).

> heightening loss of life/damage, acting as a barrier to the restoration of order and damaging political goals, while attracting universal or near universal opposition and/no or virtually no support.
>
> (McConnell 2011: 70)

In both definitions we can see the importance of process, decisions and politics:

- *Process* – there are three aspects to an evaluation of process. The first relates to the following of 'pre-anticipated processes'. This means adherence to the plans, procedures and frameworks created during pre-crisis stages. When crisis managers execute contingency plans perfectly, replicate scenario training in real situations or adhere to a set of established preparedness principles, they might be able to claim some degree of success. The second aspect relates to the phrase 'relevant processes' which is designed to capture the fact that 'sticking' to plans and procedures as *the* route to crisis management success can be problematic. Hence, a second measure of success might be found in the ability of crisis managers to engage in ad hoc attempts to make plans, procedures and policies more relevant by amending them or even abandoning them altogether. What matters in this evaluation is the extent to which a process matches the reality of the crisis. The third aspect of evaluating process relates to the degree of support it attracts. Processes which have little support can rarely be considered successful. For example, a contingency plan which is only supported by a small percentage of a crisis management network will have little effect.
- *Decisions* – these are primarily evaluated in terms of their effects on the crisis response. In general, three categories exist in this aspect of an evaluation: minimizing loss, restoring order and achieving political goals. In this last aspect, decisions can be evaluated like processes in that they should attract support and credibility. However, it is vital to see decisions as analytically distinct from agreed-upon processes. They are distinct because they represent separate interventions often requiring initiative or intuition. For this reason they do not relate to actions which implement pre-prepared processes. For example, the 1999 evacuation of Florida residents in anticipation of Hurricane Floyd proved overly problematic because decision-makers chose to publicize a very vague definition of households at risk. The result was that many thousands were evacuated who did not need to be. Returning to our earlier points, this could be seen as effective or ineffective – a decision which was either 'overkill' or precautionary. The important *analytical* point here, however, is that it has to be evaluated as a contingent decision that was distinct from pre-crisis planning processes.
- *Politics* – as the previous two sections have intimated, political successes are primarily measured in terms of enhancements in political support, credibility and legitimacy. A basic yardstick in this regard can be found in opinion poll 'bounces' for leaders in the wake of their crisis leadership. In the wake of 9/11,

for example, approval ratings for George W. Bush rose exponentially. A second way of measuring success is to review the absence of critical voices or public anger, particularly if a crisis has been mismanaged. At a broader level, the ability of a political leader or organization to maintain its policy agenda or maintain its broader ideological or political values in the face of a crisis can also be considered a measure of success. For example, in the face of the global financial crisis, the United Kingdom's Liberal Democrats, operating in a coalition with the Conservative Party, have been forced to compromise a number of their election promises and party values in order to support public sector cuts designed to reduce the government's debt. These actions, widely viewed as compromises of their intrinsic values rather than crisis management measures, have led to public criticism of the party's leaders.

This framework (see Table 7.1) certainly advances the evaluation of crisis management behaviour significantly, not least because it allows an evaluator to plot out degrees of success and failure across a spectrum. Despite their use in everyday language, success and failure are not absolute terms. Crises can simply not be categorized definitively into one box or another. Therefore evaluators need to develop a spectrum upon which their evaluations can be better gauged. In doing so there is a greater chance that meaningful lessons can be learned from a crisis.

This framework, however, is not without its problems, particularly if the focus of analysis is on a public sector organization or political institution rather than a policy (Stark 2011). There is a complexity issue involved as a public sector organization might perform a specific function which spans all three evaluative dimensions simultaneously. Hence one organizational function could be the subject of a complicated and overlapping series of evaluations which could fall victim to hindsight bias. In addressing this issue, Stark (2011) suggests a simple two-stage evaluative process through which an institution's functions are first defined and then linked to the expectations of key actors in a crisis.

This type of evaluation focuses much more on the political reality of this stage of the crisis process and recognizes that specific groups will evaluate the same organization differently, depending on their specific interests. It is therefore an attempt to understand how evaluation works in a subjective political world. The question for an evaluator is: how did an organization frustrate or facilitate these expectations? The answers that emerge represent an evaluation that is more appreciative of politics and the fact that fully objective forms of analysis are an impossible target in a political context (see Box 7.2).

POST-CRISIS POLICY REFORM AND LEARNING

In theory, crises create not only enormous potential for policy reform, but also for learning. The word learning evokes positive images, taking reform beyond mere policy

Table 7.1 *Success and failure in crisis management*

Processes		
Success	Failure	Types of evidence used to assess
Adherence to processes relevant to resolving crisis in hand, e.g. as specified in contingency plans OR considered 'good practice' in the crisis management field (such as bringing stakeholders and responders together) OR improvised because of their relevance OR bypassing the contingency plan in order to save lives/restore order	Adheres to processes which are not relevant to resolving the crisis in hand, i.e. specified in contingency plans OR considered 'good practice' in the crisis management field OR improvised because of their relevance OR bypassing the contingency plan in order to save lives/order	Inquiry reports, witness testimonies, contingency plans, expert briefings, stakeholder briefings, best practice documents
Utilizing processes which have constitutional and/or stakeholder legitimacy/support	Utilizing processes which do not have constitutional and/or stakeholder legitimacy/support	Inquiry reports, witness testimonies, expert briefings, stakeholder briefings, opinion polls, party statements, media reports and commentary
Attracting universal or near universal support for processes and/no or virtually no opposition	Attracting universal or near universal opposition for processes and/no or virtually no support	Inquiry reports, witness testimonies, stakeholder briefings, opinion polls, party statements, legislative debates, media reports and commentary, internet forums

(Continued)

Table 7.1 *(Continued)*

Decisions

Success	Failure	Types of evidence used to assess
Decisions which help contain or eradicate threats	Decisions which do not contain threats, allowing them to escalate	Inquiry reports, witness testimonies, contingency plans, expert briefings, stakeholder briefings, best practice documents
Decisions which help minimize damage to people, property and any actors or institutions affected by the crisis	Decisions which damage people, property and any actors or institutions affected by the crisis	Inquiry reports, witness testimonies, stakeholder briefings, opinion polls, party statements, media reports and commentary
Decisions which help restore order and stability	Decisions which prevent the restoration of order and stability	Inquiry reports, witness testimonies, stakeholder briefings, expert briefings, opinion polls, party statements, media reports and commentary
Attracting universal or near universal support for decisions and/no or virtually no opposition	Attracting universal or near universal opposition for decisions and/no or virtually no support	Inquiry reports, witness testimonies, stakeholder briefings, opinion polls, party statements, media reports and commentary, legislative debates, internet forums

Politics		
Success	Failure	Types of evidence used to assess
Enhancing reputation and/or electoral prospects for leaders' parties and governments	Damaging reputation and/or electoral prospects for leaders' parties and governments	Opinion polls, media reports and commentary, party statements, legislative debates, internet forums
Easing the business of governing by making the issue manageable	Detrimental to the business of governing because the issue is unmanageable	Government briefings, opinion polls, media reports and commentary, party statements, legislative debates, internet forums
Maintaining government's desired policy agendas, either the status quo or policy change	Knocks off course government's desired policy agendas, either through the status quo or policy change	Government briefings, opinion polls, media reports and commentary, party statements, legislative debates
Maintaining government's broad governance agenda and promotion of values, either through conservation or reform	Knocks off course government's broad governance agenda and promotion of values, either through blocking desired conservation or creating an otherwise undesired reform momentum	Government briefings, opinion polls, media reports and commentary, party statements, legislative debates
Attracting universal or near universal support for political implications and/no or virtually no opposition	Attracting universal or near universal opposition for political implications and/no or virtually no support	Inquiry reports, witness testimonies, stakeholder briefings, opinion polls, party statements, legislative debates, media reports and commentary, internet forums

Source: McConnell (2011).

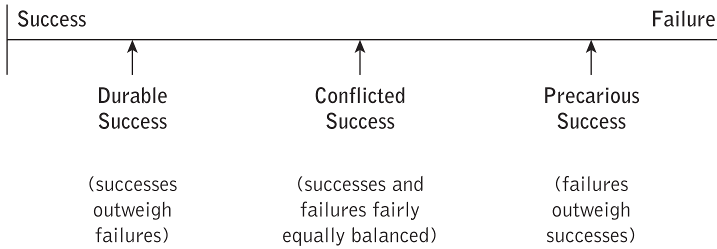
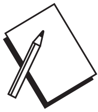


Figure 7.1 *A crisis management success/failure spectrum*

Source: McConnell (2011).



BOX 7.2 MATCHING EXPECTATIONS TO ORGANIZATIONAL OUTPUTS

The process through which this evaluation operates is relatively simple. Certain crisis actors will have specific expectations about how public organizations should operate in relation to their interests. The larger the gap between these expectations and the actual outputs of an organization, the greater the likelihood of accusations of failure. This process therefore requires that research takes place into what a range of actors wants from crisis management responses. Stark (2011) defines three broad categories of crisis actor.

- *Crisis manager expectations* – these are actors 'inside' the machinery of a government-led response who share some common features. Hence front-line responders, local and central bureaucrats, appointed members of an executive, and elected political leaders can all be classified under the term crisis manager. Two features unite this group. Crisis resolution will be their primary objective with a subsidiary goal being to come out of the crisis cleanly, free from association with blame and the threat of reforms.
- *Citizen expectations* – citizens will have different expectations of a crisis response depending on their proximity to the effects of disruption. While crisis managers and citizens will be united by their desire to resolve the crisis, the directly affected are far more likely to want a crisis response that is cognizant of their views. Such expectations can easily conflict with the wishes of crisis managers who may want to be insulated from citizen demands or engage in more authoritarian forms of crisis management.
- *Opportunistic expectations* – numerous actors gravitate towards the politics of a crisis, even if not directly affected or required for the purposes of resolution. These actors are labelled opportunistic here as they are united by their exploitative motivations. Opportunistic actors can include individual or

groups of elected representatives, journalists, shunned crisis management agencies or even organizations from other governance tiers (e.g. at the local or supranational levels) that have been excluded from a crisis response. Unlike crisis managers and affected citizens, public concessions from opportunistic actors about the need to end the crisis quickly may mask the fact that the escalation, exacerbation or politicization of events may better serve their interests.

Source: Stark (2011).

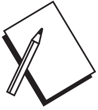
changes into the language of societal improvement. However, once we try and dissect the meaning of this universal 'cure all', we realize that it is both complex and contested. Some see the term as entirely relative to individual perceptions, while others exhibit varying degrees of positivism, specifying certain conditions for learning to have taken place: the rectification of deficiencies, or the correction of a mismatch between intentions and outcomes.

For our purposes, it is useful to recognize a relative congruence, despite differences in language between a number of approaches which differentiate between alterations and improvements to technical aspects of organizations/policy, and changes in core beliefs. We should be aware here of the distinction between 'shallow' and 'deep' types of learning in analyses which focus upon 'double-loop' and 'single-loop' learning (Argyris and Schön 1996; Argyris 1999). Single-loop learning is the most common after crises. It refers to 'the correction of practices within the existing policy paths and organizational frameworks. It is learning to deal with manifest problems without having to change core beliefs and fundamental rules of the game' (Boin et al. 2005: 121). Many would argue, however, that single-loop reforms deal with symptoms rather than causes and that they entrench rather than reform problems in the status quo. Double-loop learning refers to learning around the larger context within which technical operations occur – cultures, paradigms, the organizational foundations of an institution (Argyris and Schön 1996). Learning here is not simply connected to strategies for effective performance but to the very cultures that define effective performance. However, double-loop learning tends to receive the least attention from public managers because it is costly in time and effort and is unlikely to provide actors with short-term reciprocal forms of 'pay-back' (Korac-Kakabadse et al. 2002).

The shallow and the deep dimensions of learning can also be seen in the similarities shared by a number of typologies of public policy, which differentiate between (1) alterations and improvements to aspects of organizations/policy, and (2) changes in core beliefs and goals (Hall 1993; Sabatier and Jenkins-Smith 1993; Rose and Davies 1994). This congruence between studies has led Boin et al. (2008: 16–17) to typify three broad forms of post-crisis learning and reform:

- *Fine-tuning* – this involves small-scale and incremental 'tweaks' to pre-existing policies. For example, after the *Challenger* disaster, NASA implemented a series of technical single-loop reforms but failed to address its risk philosophy and risk culture in any significant manner (Boin 2008: 250–1).
- *Policy reform* – this involves the reform of policy principles and institutional values. In the aftermath of the 2001 foot and mouth crisis, for example, a slow process of adaptation sought to shift the farming sector away from the principles of intensive farming, which were based around excessive levels of production, to a more sustainable style of farming based upon environmental principles.
- *Paradigm shift* – this is the most significant type of change when the consensus around the values, ideas and goals which underpin a policy sector organization or society are changed. The changes in foreign policy and government structure introduced after 9/11 around the concept of 'homeland security' are arguably one example, although it could equally be argued that these reforms helped solidify a fundamental ideological continuity. Currently, debates about the reforms that have emerged after the global financial crisis suggest that despite the massive shocks caused over recent years, a paradigm shift has not taken place. Post financial crisis, it is 'business as usual' for many (see Box 7.3).

Keeping in mind the spectrum of reform responses outlined above, we can say that post-event periods tend to be characterized by fine-tuning and limited policy reforms rather than substantive paradigm shifts. One of the major reasons for this relates to the strength of pre-existing institutions, policies and ideas. A wealth of literature exists that argues and illustrates that the past profoundly shapes the future in terms of public management. Public policy is said to be largely 'path dependent' in these accounts, which means that previous decisions create what are known as 'self-reinforcing mechanisms' (Pierson 2005; Streeck and Thelen 2005; Kay 2005). If change is to be engineered after a crisis, these mechanisms have to be 'loosened'. Severe crises that bring trauma, drama and future uncertainty can provide the necessary shock to shake policies out of their normal trajectories but this is not always the case. Reinforcing mechanisms can be strong and immutable and they come in many forms: well-established policy frameworks can generate inertia if they are institutionalized within an organization for a long period of time; stakeholders who benefit from policy outcomes can be intransigent, encouraging the status quo and resisting change; and the politics surrounding a policy may benefit political elites and powerful interests who may seek to keep reform off the agenda. The crucial point to be made for crisis situations is twofold: (1) past decisions can restrict large-scale change even after a crisis has exposed them as problematic; (2) the extent of change will depend on the nature of the crisis in relation to the strength of the self-reinforcing mechanisms that are resistant to change. However, not all organizations are the same. Some agencies seem to exhibit an ability to break free from the past in order to promote learning and change. For present purposes, it seems useful to get a brief sense of two broad 'ideal' types of institution at opposite ends of the spectrum.



BOX 7.3 WAS THE 'CREDIT CRUNCH' REALLY A CRISIS?

There can be no doubt that the events which have come to be labelled respectively as the 'credit crunch' and the 'global financial crisis' were catastrophic. The narrative alone is dazzling: banks liquidated, nationalized and merged; governments defaulting on debt and being downgraded on credit ratings; and anti-capitalism protests and international financial institutions fighting over the sovereignty of nations. How could these events not be considered anything but a monumental crisis?

One rather controversial argument, presented by Professor Colin Hay, suggests that we should not use the term 'crisis' in this context, because policy-makers have failed to reform the 'boom and bust' economic system that led to the credit crunch in the first place. Hay defines crises 'as moments of decisive intervention' which are characterized by the inevitability of reform. This allows him to make his case that these events were not a crisis because no meaningful intervention has been found to reform the status quo. However, Hay's concern is not to downplay the catastrophes that occurred between 2007 and 2012. Instead, his real claim is that deepseated crisis tendencies remain in the economic system, yet no substantive reform agendas have been put on the table to fix them.

While we might disagree with Hay's limited definition of a crisis, it is difficult to disagree with the argument that the kind of large-scale reform needed to prevent a reoccurrence of the credit crunch has not taken place. As house prices slowly rise again, investment bankers return to trading deals and governments seek to animate private markets by reducing public sector 'waste', we might ask: what have we learned from this crisis and what has really changed? If the answer is 'not much' then maybe Hay is right to question whether we can use the term global financial *crisis*.

Source: Hay (2011).

The most conducive to reform would be high-reliability organizations (HROs), such as air traffic control systems and firefighting bodies, where matters of safety are of paramount importance because they are at the heart of what the organization is set up to do (Weick and Sutcliffe 2001). Their systems and cultures are ingrained with an understanding of the need to anticipate errors, make systemic adaptations, learn in the event of failure and engage in deeper 'deuterolearning', i.e. learning how to learn (Argyris and Schön 1996). Therefore, they have the capacities to 'puzzle' (work out what went wrong and what is needed to fix it) as well as the capacities to 'power' (bring

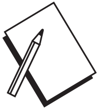
about the requisite change) (Boin et al. 2005). Some non-HRO, risk regulators in particular (Hood et al. 2003), will tend in principle towards high-reliability values. However, most departments of state, public sector functional agencies and so on may not give such a high priority to safety (although rhetorically they may do). Nevertheless, they may possess some characteristics which assist learning and reform. This would include leadership willingness to use a combination of persuasion and muscle in order to bring about change. There would also be a critical mass of financial resources, technology and staffing devoted to 'puzzling' and 'powering'. Such institutions might also have previous experiences of crises, which indicate the dangers of not learning lessons.

At the opposite end of the spectrum, there is a broad institutional type with limited institutional capacity for learning and reform. Typical public sector type organizations would tilt more towards this model. Issues to do with disaster readiness, safety, crisis management and risk management have to compete against core and powerful goals of organizations which are established to deal with other matters. Such institutions would tend to lack extensive experience of crises but are nevertheless vulnerable to their effects in the future. This vulnerability may play out in 'threat rigidity' (denial of risks and refusal to engage in adaptive behaviour) or through forms of institutional leadership that focus more on insulating the organization from costly learning and reform dynamics. Of course, each institution needs to be considered on a case-by-case basis, and it is very probable that the vast bulk of institutions will be positioned somewhere between the two poles – but lean more towards the non-HRO element.

ACCOUNTABILITY AND BLAME GAMES

A second reason for the abundance of fine-tuning reform and the absence of larger paradigm shifts post-crisis can be found in the nature of public accountability. Generally speaking, the dynamics of accountability operate on two broad levels. First, accountability is discussed outside formal governmental processes in the realms of the media and popular debate. It would be inconceivable, in the age of social media, for a crisis to be devoid of such scrutiny. Second, there is the more formal area of official inquiries and investigations. As indicated in Box 7.4, inquiries come in a variety of forms.

In principle, crisis investigations are meant to get to the heart of 'what went wrong' and 'what should be done'. Information is gathered, evidence is heard, witnesses are spoken to, experts are consulted, reports are written and recommendations are produced. The outcome is intended to be an impartial, convincing and authoritative 'solving' of the questions, uncertainties and debates surrounding the crisis. Policy-makers then consider the recommendations, weigh up other factors such as finance and possible conflicts of interest with other policies, and then take appropriate action. If followed, this process would almost certainly lead to double-loop forms of learning and reform but we know that such ideals translate less easily into practice.



BOX 7.4 FORMS OF POST-CRISIS/DISASTER INQUIRY

- *'Blue Ribbon' inquiries, Presidential Commissions and Royal Commissions* – executive initiated (in whole or in part) and wide-ranging in their investigation of an event or events of national or sub-national significance (e.g. 2002–4 National Commission on Terrorist Attacks upon the United States; 2010–11 National Commission on the BP Deepwater Horizon Oil Spill and Offshore Drilling; 2011–12 New Zealand Canterbury Earthquakes Royal Commission; 2013–14 Australian Royal Commission into Institutional Responses to Child Sexual Abuse).
- *Executive Statutory inquiries* – where ministers and/or legislatures use specific statutory powers to set up an inquiry, although establishing an inquiry is still discretionary (e.g. 2003–5 Special Commission of Inquiry into the Waterfall Rail Crash, New South Wales, Australia, under the Special Commission of Inquiry Act 1983; 2011–12 UK Leveson Inquiry into the Culture, Practice and Ethics of the Press, under the Inquiries Act 2005).
- *Executive ad hoc inquiries* – where establishing an inquiry is discretionary and without recourse to specific legislation (e.g. 1997–2000 Phillips Inquiry into BSE in the United Kingdom; 2001–2 Lessons Learned inquiry into foot and mouth in the United Kingdom; 2006 Tasmanian State Government inquiry into the Beaconsfield mining disaster).
- *Legislative inquiries* – initiated at the discretion of legislatures as a whole or a specific committee within the legislature, or occasionally an informal coalition of legislative members (e.g. 1999–2000 Belgian Parliamentary inquiry into the dioxin contamination of foodstuffs; 1997–8 UK House of Commons Defence Select Committee into the Chinook helicopter crash; 2010–11 Inquiry of the Canadian Parliamentary Coalition to Combat Antisemitism).
- *Internal departmental/agency inquiry* – where the initiative comes from the specific organization responsible for the relevant policy area (e.g. 1998–2001 UK Department of Health 'Bristol Babies' inquiry in the cardiac services and the death of young children undergoing complex heart surgery; 2012–13 New Zealand Ministry of Innovation, Business and Employment Independent Investigation into the role of officials in the Pike River tragedy.
- *Accident board inquiry* – where the inquiry is conducted by a body which is charged solely with the purpose of accident investigation (e.g. 2002–4 Bahamas Maritime Authority inquiry in the sinking of the Prestige oil tanker off the coast of Spain; 2003 Space Shuttle Columbia Accident Investigation Board; 2014 UK Marine Accident Investigation Branch Investigation Report into the Eshcol accident.

One of the first factors that can compromise an accountability process can be seen in the format and remit of a post-crisis inquiry. Accountability mechanisms come in a variety of formats but the vast majority are at the discretion of political executives who have considerable freedom to shape the nature of the investigative process. Inquiries may have a number of limitations (actual and/or perceived) in terms of learning. They include:

- a struggle to be established at all because of resistance from political executives and/or the authorities requiring investigation;
- chairperson/members appointed with predisposed views that may produce a bias in the inquiry process and outcomes;
- restriction of the committee terms of reference;
- witnesses unwilling/unable to appear;
- political interference in the investigative process;
- lack of resources (time, personnel or finance) to complete a thorough investigation;
- bi-partisan membership of parliamentary/legislative inquiries can lead to accusations of political bias in the investigation and outcomes; and
- the closed nature of some inquiries may lead to accusations of 'cover up'.

A second issue that can compromise accountability processes arises out of the socially constructed nature of crises. All crises and disasters are, to some extent, social constructs. They are a mixture of objective events and the perceptions of those events that are held by groups of actors. Depending on the specific crisis, events can be a complex interaction of technological, institutional, political, economic and geophysical elements. And in turn these objective elements of a crisis are then perceived and understood by different groups depending on their values. A simple example of a crisis being socially constructed can be seen in evaluations of wars and theatres of conflict. Once they are resolved the 'winners' get to define which side was 'right' and 'wrong', which side committed atrocities and which side acted ethically. These are social constructions – widely disseminated views about what has occurred which become conventional wisdom.

As a consequence, crisis inquiries and their outcomes are subject to a variety of different interpretations and are fought over by different interests. Following on from our previous chapter we use the term 'framing' as a shorthand label for these contests, which can occur on a number of levels. In some inquiries, the conflict can be around the nature of the knowledge being generated. Inquiries tend to look to 'science' and the 'law' as the benchmarks against which to judge the actions of crisis managers (Snider 2004). In reality, however, science and the law are just as contested as the social sciences, which is one reason why we often see political protests about inquiry findings, despite their 'scientific' impartiality. The most common contests, however, are not about the scientific nature of inquiries. They are instead fights for survival; to avoid blame and frame

the culpability of others. Actors will use a variety of strategies to argue their case and apportion blame. At the level of ideas, they may attempt to frame post-crisis debates in particular ways. This is particularly evident in the burgeoning literature on the 'blame game' (Hood 2002; Brändström and Kuipers 2003). Actors may seek to frame a crisis in terms of:

- *Severity* – the extent or otherwise to which core values have been violated. For example, playing down a crisis involves framing events as 'disturbances' or 'incidents'. The implication is that those responsible are not responsible for significant failings.
- *Causes* – whether the crisis is 'stand-alone' or something which is embedded in a deeper system-wide or policy failure. For example, a set of circumstances portrayed as isolated and ad hoc implies that 'blame' lies with particular decision-maker/operator failures.
- *Responsibility* – whether blame is concentrated with a single actor or is dispersed among many actors. For instance, the levying of blame at one individual means that an individual has the propensity to be made a scapegoat.

Framing contests are exacerbated by various decisions. In the (common) event of multiple inquiries – typically making different and sometimes conflicting recommendations – framing contrests can run wild as there is no definitive account of events. Paradoxically, therefore, the existence of several inquiries can impede 'learning' because it allows competing interests to coalesce and champion the particular investigation which suits their views/interpretation. In the aftermath of the 1989 Exxon Valdez oil spill, for example, the disaster was the subject of over fifteen different investigations. A second factor here is that the growth throughout the Western world of agencies/quangos/non-departmental bodies which are at arm's length of government generally makes it easier for political elites to pass responsibility on to more localized chief executives/departmental heads. For instance, during the Scottish exams crisis of 2000, Scottish Executive ministers successfully 'passed the buck' to the quasi-independent Scottish Qualifications Authority (Clarence 2002). Similarly, the Blair government was highly effective in avoiding the backlash from the crisis of funding surrounding London's Millennium Dome by deflecting responsibility onto the Millennium Commission and the New Millennium Experience Company (Gray 2003).

If we examine accountability mechanisms as political processes rather than a means of learning, we can see a number of different outcomes. The outcomes may be so 'explosive' that they prove difficult for crisis managers to survive, or they may be 'damp squibs', allowing those in positions of formal political or administrative power to continue with little or no challenge to their authority. However, despite such intense pressures for due accountability for 'what went wrong', outcomes do not normally involve the career slaughter of those in positions of authority. There are broadly three types of outcomes (Boin et al. 2009):

- *Hero* – a crisis may bolster leadership fortunes because the threat is perceived to be well handled, such as in the cases of Mayor Rudolph Giuliani after 9/11 and Queensland Premier Anna Bligh after the Queensland floods. A variant on this theme is where mistakes are made, but leaders accept responsibility and enhance their credibility and legitimacy on the part of a sufficient coalition of popular, media, stakeholder and party political opinion.
- *Villain* – a crisis may be instrumental in a downturn in career fortunes or maybe even a complete downfall. This latter fate befell Spanish Prime Minster José Maria Aznar after the Madrid bombings, Belgian Prime Minister Jean-Luc Dehaene after the dioxin scandal, and Icelandic Prime Minister Geir Haarde after the global financial crisis.
- *Escapologist* – a crisis makes only marginal difference or no difference at all, blending into and being overtaken by newer issues considered to be of greater political significance. A case in point is what happened to Australian Prime Minister John Howard. In particular, during his second and third terms of office, he managed to survive with little or no electoral damage from a series of crises related to his government's policies on detention centres, immigration and refugees.

We can also return to the three types of learning and reform we set out previously in the chapter and draw out the political outcomes in relation to each type. At one extreme, inquiries may be little more than political fixes, designed to protect key interests and those benefiting from the current policy regime. The outcome of such events is likely to be very modest fine-tuning or ideally no change whatsoever. Some inquires have been the subject of considerable flak in this vein: the congressional and White House investigations into the Katrina crisis response represent one such example. On the congressional side, the decision not to investigate the president's actions (taken by a Republican Congress in relation to a Republican president) led to the withdrawal of every Democrat member of the committee. Unsurprisingly, this investigation and the one performed by the White House both allowed the president to escape censure for his failures in crisis leadership (Preston 2008). A further type has the symbolism of change – a form of palliative – but little or nothing changes in terms of policy/practices. The collapse of Jerusalem's Versailles banquet hall in Israel in 2001 during a wedding party (captured on video and widely distributed throughout news networks) produced virtually no change to building regulations or their monitoring in a society where the policy agenda is dominated by security issues (Schwartz and McConnell 2008). Another is instrumental adaptation, where recommendations are taken on board by policy-makers in a pragmatic way (reluctantly or because they genuinely recognize that something needs to change in order to reduce vulnerabilities for the future). The final and most progressive format is where inquiries act as genuine driving forces for innovative policy change. The O'Connor Report into the Walkerton water contamination crisis in Ontario, for example, was highly influential in reforming the 'hands-off' approach to water regulation that had been characteristic of Ontario's neoliberal government (Snider 2004).

FACTORS INFLUENCING THE CRISIS AFTERMATH

A key theme throughout our previous chapters has been that crisis management actions need to be seen as part of a larger social, political and policy-oriented universe. We make this argument so that we can discuss the larger factors that affect crisis behaviour. Therefore, we need now to ask: what are the contextual issues that are relevant to evaluation, learning and accountability? Five issues seem particularly pertinent.

The nature of the crisis

The intrinsic nature of each particular crisis may have the potential to destroy the fortunes of crisis decision-makers or assist in their salvation. And the type of crisis will have a significant bearing on the ability of reformers to learn and implement change.

All things being equal, what we might call a classic crisis (unexpected, sudden, severe damage) is the type of crisis most liable to have a detrimental impact on the fortunes of senior decision-makers via accountability dynamics. Why didn't they see it coming? Why weren't they better prepared? Were they culpable? Many careers have foundered amidst the drama and turmoil of the unexpected – especially when there is significant loss of life, damage to property, or damage to key interests. One example is Michael Brown, the head of the US Federal Emergency Management Agency, who resigned amid the widespread perception (and pressure from the Bush administration) that his agency had failed to be properly prepared for, and been unable to show capability in coping with, the devastation that was wreaked by Hurricane Katrina. By contrast, slow-burning crises such as climate change are less liable to make or break political/bureaucratic fortunes. There are no unforeseen, dramatic focusing events (sudden loss of life, damage to property and so on) to concentrate the minds of the general public, media, stakeholder and political opinion. There may be warnings of cataclysmic focusing events in the future (such as floods as a consequence of global warming) but this is rarely sufficient to prompt a dramatic change in the fortunes of senior figures.

If we turn to learning dynamics with the same comparison, we can also claim that an unexpected crisis is more liable to act as a catalyst for policy change than the crisis of the slow-burning variety such as climate change. The shock of the unexpected can make policy-makers stumble into reform promises which shape the agenda for debate and rapidly attract support from policy entrepreneurs/stakeholders and public opinion. It then becomes hard to undo this commitment, even if it were feasible. In the United Kingdom, for example, Margaret Thatcher responded to a local property tax crisis by committing the government to abolishing a 400-year-old tax, despite British history being littered with failed attempts to find a suitable alternative. This set in motion a policy process that would lead to the ill-fated poll tax (McConnell 1995). By contrast, the threats posed by creeping crises are less inclined to produce reform. Longer-term issues have to compete for 'policy space' against short-term policy-making based to a large extent on electoral cycles, stakeholder power, political fixes, sudden crises and

so on. Policy reform in the face of creeping crises is of course possible, and change through incremental steps is a key feature of modern societies. However, policy entrepreneurs regularly seek to portray creeping crises in much more focused terms because they realize that such moves are more liable to be effective. This is the reason why advocates of significant adaptation in the face of climate change are always searching for hard-hitting statistics and potentially shocking stories. They need to 'manufacture' the conditions that are created naturally by sudden crises so that citizens and policy-makers have a sympathetic ear to their concerns.

Another issue in this area relates to the scope and depth of the crisis. In large-scale crises involving national trauma, such as the Breivik shootings in Norway, there is less inclination to 'play politics'. Solidarity and recovery are the order of the day. These events can be contrasted with policy disasters and fiascos, where the crisis is more about a scandal than a national trauma. In these instances, opportunities exist to use accountability mechanisms for political purposes. We also need to consider the extent to which a crisis has a detrimental effect on powerful interests. Political scientists have much debated the relative powers of citizens, special interests and bureaucrats. Such debates aside, we detect a simple tendency. The more powerful the interests affected by the crisis, the more likely it is that their view will prevail over less powerful interests in the post-crisis period. One example is the power of the US food and drink industries in effectively blocking long-term plans by the World Health Organization to learn from the ongoing obesity crisis through enhanced public education campaigns in relation to diet, health and physical activity. The opposite also applies. Many crises and disasters in particular have left devastating impacts on vulnerable peoples and groups, but little happens after the crises because these groups are not in the position to exert influence on longer-term policy reforms (Wisner et al. 2004). In recent years, however, the voices of some survivors and families of victims have been strengthened through well-articulated campaigns, the use of websites, and effective interaction with a media that is increasingly interested in the newsworthiness of post-crisis battles against officialdom. The 2001 Walkerton water contamination crisis is a good example of such influence – citizens were represented by the Canadian Environmental Law Association, which had a considerable influence over the recommendations of the official inquiry – the O'Connor Report. Family groups were also influential in pressurising the Bush administration to opt for an 'independent' and broad-ranging 9/11 Commission (as opposed to a congressional inquiry). However, such campaigns are not guaranteed to be successful. The families of the 7/7 London bombings in London, for example, failed to obtain a public inquiry into the events.

Timing

The timing of a crisis is crucial. In policy terms, John Kingdon (2003: 1) neatly captured the importance of timing when he wrote simply of 'an idea whose time has come'. We might say something similar about the fortunes of crisis decision-makers. The timing

may be so significant that it destroys careers, or helps provide good fortune for those leaders who would otherwise be exposed to the winds of societal change. For example, it may happen in the wake of other similar crises and so there is a predisposed momentum for leadership change. In effect, the rhetoric is that of 'one crisis too many'. For example, UK Home Office failures surrounding foreign prisoners being released from jail (rather than considered for deportation) escalated over 2005 and 2006 to the point that Home Secretary Charles Clarke was sacked. Alternatively, crisis may hit at a crucial point in the electoral cycle – notably after an election when a new leader is enjoying a 'honeymoon' period – and so the momentum for change is blunted. There is no scientific formula that would allow us to calculate optimum times, because other factors come into play such as luck. Yet electoral fortunes are certainly important. If a governing party is weak (and growing weaker) in terms of popular support, a crisis may cause further damage to the fortunes of party leaders, because the crisis raises further and serious questions about their capacities to govern. At the time of the SARS outbreak in Hong Kong in 2003, the administration was already weak and the target of large-scale demonstrations. Its crisis response was also subject to heavy criticism in an inquiry by the Hong Kong Legislative Council. This led to the resignation of Health Minister Yeoh Eng-kiong – a move which many within the government hoped would ease public discontent. By contrast, if a crisis hits when a party is buoyed by strong popular support, party leaders are liable to have a fairly high degree of inherited support/sympathy for their crisis response

Party politics

In the Western world, members of political executives are almost exclusively members of political parties. In the case of prime minsters, presidents, chancellors and others at the apex of government hierarchies, they are also party leaders – operating in a variety of constitutional contexts. This gives rise to a number of factors that may strengthen and/or weaken the position of crisis decision-makers in the aftermath of crises.

Internal party politics can be a critical factor in shaping whether or not a political leader will survive. If a leader's position is precarious, the arrival of a crisis will often provide party critics with the opportunity to challenge his/her leadership credentials. The European sovereign debt crisis and subsequent pressures for austerity measures across many nations, saw an end to the career of Irish Taoiseach Brian Cowen in 2011, when he lost support from with the coalition government headed by his party Fianna Fáil. Correspondingly, a leader with strong internal party support is less liable to come under attack as a consequence of crisis – even if many within the party have reservations about the handling of the crisis. For many years until his eventual resignation in 2011, Italian Prime Minister Silvio Berlusconi remained a largely popular figure within Forza Italia and latterly the People of Freedom Party, surviving innumerable sex and corruption scandals

There is also the relationship between government and opposition to consider. If a government does not have the support of the main opposition party or parties on a particular crisis issue, this opposition helps contribute to any broad coalition seeking to damage the government and its leaders. Correspondingly, when government has opposition support on a crisis issue, the fortunes of government figures are more liable to be strong and secure. This is particularly (but not exclusively) the case in major threats to national security, where bipartisan support is common.

There are also a number of party political factors which can help promote reform and learning. First, a leader with strong support in his/her party is generally well placed to command the political legitimacy needed to proceed with reform (if so desired). Second, a leader whose party has strong popular support in elections/opinion polls is better able claim a broad representative mandate for reforms. Third, and crucially, policy change is facilitated when government has a strong working majority in the legislature – this is almost certain in parliamentary systems but much less so in semi-presidential and presidential systems. If political elites can garner the requisite number of votes, they have enormous practical power to introduce new legislation, even though others may disagree. An example of all three conditions is John Major succeeding Margaret Thatcher and placing abolition of the disastrous poll tax at the top of his leadership campaign and his agenda (Butler et al. 1994). The Conservative Party rallied round its new leader, there was overwhelming public support for abolishing the poll tax and the Conservatives had a comfortable majority in the House of Commons.

The opposite also applies. Reforms may never get off the ground (or may flounder if they do) for many reasons. While a leader with precarious support in his/her party may try and seize on post-crisis reform as a last-ditch attempt to galvanize support, weak leaders are more liable to defend the status quo after a crisis. To do otherwise is high risk, with the possibility of a further slide in support. This tendency towards the status quo is heightened further if a majority in the legislature is small and weak (especially in parliamentary systems) or non-existent (especially in semi-presidential and presidential systems). The most powerful barrier to post-crisis policy reform is the conservative-minded leader with strong party and popular support – particularly (but not exclusively) in parliamentary systems.

Some policy sectors are riskier than others

Policies cover a wide range of spheres such as health, education, criminal justice, national security, transport, tourism and the economy. As a consequence, there is variance in the actors, institutions, stakeholders and policy instruments operating in each sphere. When any particular policy area is hit by ‘crisis’ and the threats typically associated with it, the impact on those leaders who are responsible/accountable for these policy areas may vary. Potentially, there are many aspects of ‘policy’ that are relevant to post-crisis situations. For example, the fortunes of some actors may be helped because dealing with crisis is a fairly routine part of his/her portfolio (e.g.

national security and home affairs). In such cases, post-crisis scrutiny and attacks on performance may be so regularized (they come with the job) that criticism needs to reach higher levels to be capable of doing real damage to political fortunes. However, there is one particular aspect of 'policy' that, we would suggest, is particularly important in influencing political fortunes in the wake of a crisis. We can most usefully outline this by drawing on the distinction between policy communities and issue networks.

The key factor here is the degree of consensus within the particular policy community/issue network. Rhodes and Marsh (1992) differentiate between issue networks (where there is a large number of participants, holding widely disparate views) and policy communities (where there is a much smaller number of participants who operate on the basis of a broadly shared consensus). Our contention is that as we move towards the issue network end of the spectrum where we find high fragmentation in numbers and political views, leaders in post-crisis situations are more liable to find themselves surrounded by those who call for their resignation. The contaminated blood scandal in France is a case in point (Steffen 2001). Health Minister Edmund Hervé was an eventual casualty of a crisis that escalated because a fragmented network of tension-ridden agencies and associations did not rally behind the government's explanations of its role. The opposite also applies. The greater the degree of consensus in a policy community, the less likely it is for leaders to see their fortunes slide, because there is a consensus-based community to rally round. The Swedish experience of contaminated blood stands in stark contrast to that of the French (Albæk 2001). One reason why there were no political/administrative casualties as a consequence of the Swedish crisis is that there was already a high degree of corporatist-style consensus in this area of health policy, and this continued into the inquiry which was representative of virtually all major interests.

Overall, our simple point is that 'policy' matters. It is a further piece in the jigsaw which helps us explain the conditions which, to varying degrees, render crisis decision-makers vulnerable to a slide in their careers after a crisis.

Crisis symbolism

Finally, there is the symbolic potential of the crisis. This refers to the capacity of the crisis to transcend the immediate circumstances on the ground. More specifically, some crises can 'hit a nerve' and expose wider social vulnerabilities and fears. This in turn can raise deep questions about fitness for office or fitness to govern, and may assist demands for a change of leaders or change of regime. One example is the 2005 riots in France which hit many cities including Paris, Dijon and Strasbourg. These raised deeper questions not only about racism and immigration in France, but also the government's hard-line attitude to perpetrators. The riots led to intense pressure for the resignation of Interior Minister Nicolas Sarkozy. Correspondingly, the symbolic potential of some crises may be much weaker, localized and confined to a fairly narrow area of policy competence. Examples include coastal erosion in Southwest Washington and a shortage

of social workers in Scotland. Such crises are less liable to end careers or spread to other key political/administrative decision-makers in government.

CONCLUSION

What we often observe in the post-crisis period are three intertwined ideals – clear evaluation, democratic accountability and reflexive learning and reform – that are compromised by the realities of policy and politics. Evaluation is compromised by the subjectivity that is inherent in any definition of success or failure. Accountability is compromised when framing and blaming dynamics obfuscate explanations of what occurred. And learning and reform can be compromised by the intransigence of policies, institutions and actors which cannot be shaken from their path dependencies. There is no doubt that we need to hold leaders and agencies to account in the wake of a crisis. Victims demand answers, communities need to air grievances and democratic principles require that those who exercise authority explain themselves to a national audience. However, we need carefully to consider the effects that are created when we pursue accountability because it is the process of blaming that injects the political into attempts to evaluate, learn and change to prevent future crises.

DISCUSSION QUESTIONS

1. Evaluate a crisis response of your choosing. Was it a success or a failure in your eyes? How did you come to this conclusion and might it be possible for others to disagree?
2. Examine the summary findings of a post-crisis inquiry. Would you describe the recommendations as examples of an attempt at fine-tuning, policy reform or paradigm shifting?
3. Do you believe that accountability gets in the way of learning? If so, should we really hold people and organizations to account post-crisis?
4. How can we make sure that public sector organizations reform effectively in the aftermath of a crisis?

REFERENCES

Albæk, E. (2001) 'Protecting the Swedish Blood Supply Against HIV: Crisis Management Without Scandal', in M. Bovens, P. 't Hart and B.G. Peters (eds), *Success and Failure in Public Governance*, Cheltenham: Edward Elgar.

Argenti, P. and Druckenmiller, B. (2004) 'Reputation and the Corporate Brand', *Corporate Reputation Review*, 6(4): 368–74.

Argyris, C. (1999) *On Organizational Learning*, 2nd edition, Oxford: Blackwell.

Argyris, C. and Schön, D.A. (1996) *Organizational Learning II*, Reading: Addison-Wesley.

Arklay, T.M (2012) 'Queensland's State Disaster Management Group: An All Agency Response to Unprecedented Natural Disaster', *Journal of Emergency Management*, 27(3): 9–19.

Boin, A. (2008) 'Learning from Crisis: NASA and the *Challenger* Disaster', in Boin, A., A. McConnell and P. 't Hart (eds), *Governing after Crisis*, New York: Cambridge University Press, pp. 232–54.

Boin, A., 't Hart, P. and McConnell, A. (2009) 'Towards a Theory of Crisis Exploitation: Political and Policy Impacts of Framing Contests and Blame Games', *Journal of European Public Policy*, 16(1): 81–106.

Boin, A., McConnell, A. and 't Hart P. (eds) (2008) *Governing after Crisis.* Cambridge: Cambridge University Press.

Boin, A., 't Hart, P., Stern, E. and Sundelius, B. (2005) *The Politics of Crisis Management: Public Leadership Under Pressure*, Cambridge: Cambridge University Press.

Brändström, A. and Kuipers, S. (2003) 'From "Normal Incidents" to Political Crises: Understanding the Selective Politicization of Policy Failures', *Government and Opposition*, 38(3): 279–305.

Butler, D., Adonis, A. and Travers, T. (1994) *Failure in British Government: The Politics of the Poll Tax*, Oxford: Oxford University Press.

Clarence, E. (2002) 'Ministerial Accountability and the Scottish Qualifications Agency', *Public Administration*, 80(4): 791–803.

Dyrenfurth, N. (2005) 'The Language of Australian Citizenship', *Australian Journal of Political Science*, 40(1): 87–109.

Gray, C. (2003) 'The Millennium Dome: "Falling From Grace"', *Parliamentary Affairs*, 56(3): 441–55.

Hall, P. (1993) 'Policy Paradigms, Social Learning and the State: The Case of Economic Policy Making in Britain', *Comparative Politics*, 25(3): 275–96.

't Hart, P. and Boin, A. (2001) 'Between Crisis and Normalcy: The Long Shadow of Post-Crisis Politics', in U. Rosenthal, A. Boin and L.K. Comfort (eds), *Managing Crises: Threats, Dilemmas, Opportunities*, Springfield, IL: Charles C. Thomas, pp. 28–46.

Hay, C. (2011) 'Pathology without Crisis? The Strange Demise of the Anglo-Liberal Growth Model', *Government and Opposition*, 46 (1): 1–31.

Hood, C. (2002) 'The Risk Game and the Blame Game', *Government and Opposition*, 37(1): 15–37.

Hood, C., Rothstein, H. and Baldwin, R. (2003) *The Government of Risk: Understanding Risk Regulation Regimes*, Oxford: Oxford University Press.

Kay, A. (2005) 'A Critique of the Use of Path Dependency in Policy Studies', *Public Administration*, 83(3): 553–71.

Kingdon, J. (2003) *Agendas, Alternatives and Public Policies*, 2nd edition, New York: Longman.

Korac-Kakabadse, N., Kouzmin, A. and Kakabadse, A. (2002) 'Revisiting Crises from a Resource-Distribution Perspective: Learning for Local Government?', *Local Governance*, 28(1): 35–61.

McConnell, A. (1995), State Policy Formation and the Origins of the Poll Tax, Dartmouth: Aldershot.

McConnell, A. (2010) *Understanding Policy Success: Rethinking Public Policy*, Basingstoke: Palgrave Macmillan.

McConnell, A. (2011) 'Success? Failure? Something In-Between? A Framework for Evaluating Crisis Management', *Policy and Society*, 30(2): 63–76.

Maskrey, A. (1994) 'Disaster Mitigation as a Crisis of Paradigms: Reconstructing after the Alto Mayo Earthquake', in A. Varley (ed.), *Disasters, Development and Environment*, New York: John Wiley & Sons.

Paul, L. (2005) 'New Levels of Responsiveness – Joining Up Government in Response to the Bali Bombings', *Australian Journal of Public Administration*, 64(2): 31–33.

Pierson, P. (2005) *Politics in Time: History, Institutions, and Social Analysis,* Princeton, NJ: Princeton University Press.

Preston, T. (2008) 'Weathering the Politics of Responsibility and Blame: The Bush Administration and its Response to Hurricane Katrina', in Boin, A., A. McConnell and P. 't Hart (eds), *Governing after Crisis*, Cambridge: Cambridge University Press, pp. 33–61.

Pyper, R. (ed.) (1996) *Aspects of Accountability in the British System of Government*, Wirral: Tudor.

Rhodes, R. and Marsh, D. (eds) (1992) *Policy Networks in British Government*, Oxford: Clarendon Press.

Rose, R. and Davies, P.L. (1994) *Inheritance in Public Policy: Change without Choice in Britain*, New Haven, CT: Yale University Press.

Rosenthal, U. (2003) 'September 11: Public Administration and the Study of Crises and Crisis Management', *Administration and Society*, 35: 129–43.

Rosenthal, U. and Pijnenberg, B. (1991) *Crisis Management and Decision Making: Simulation Oriented Scenarios*, Dordecht: Kluwer.

Sabatier, P.A. and Jenkins-Smith, H. (eds) (1993) *Policy Change and Learning: An Advocacy Coalition Approach*, Boulder, CO: Westview Press.

Schwartz, R. and McConnell, A. (2008) 'The Walkerton Water Tragedy and the Jerusalem Banquet Hall Collapse: Regulatory Failure and Policy Change', inBoin, A., A. McConnell and P. 't Hart (eds), *Governing after Crisis*, Cambridge: Cambridge University Press, pp. 208–31.

Snider, L. (2004) 'Resisting Neo-Liberalism: The Poisoned Water Disaster in Walkerton Ontario', *Socio and Legal Studies*, 13(2): 265–89.

Stark, A. (2011) 'Legislatures: Help or Hindrance in Achieving Successful Crisis Management?' *Policy and Society*, 30(2): 115–27.

Steffen, M. (2001) 'Crisis Governance in France: The End of Social Corporatism?', in M. Bovens, P. 't Hart and B.G. Peters (eds), *Success and Failure in Public Governance*, Cheltenham: Edward Elgar, pp. 470–88.

Streeck, W. and Thelen, K. (eds) (2005) *Beyond Continuity: Institutional Change in Advanced Political Economies*, New York: Oxford University Press.

Weick, K.E. and Sutcliffe, K. (2001) *Managing the Unexpected: Assuring High Performance in an Age of Complexity*, San Francisco: Jossey-Bass.

Wildavsky, A. (1988) *Searching for Safety*, New Brunswick, NJ: Transaction.

Wisner, B., Blaikie, P., Cannon, T., and Davis, I. (2004) *At Risk: Natural Hazards, People's Vulnerability and Disasters*, London: Routledge.

FURTHER READING

The aftermath of crises/disasters is the most understudied of all the phases of crisis management. For the potential of crises to bring about change, see Birkland, T.A. (1997), *After*

Disaster: Agenda Setting, Public Policy, and Focusing Events, Washington DC: Georgetown University Press. Much can be gained by exploring some of the public literature on policy change and learning. We particularly recommend the (now) classic work Sabatier, P.A. and Jenkins-Smith, H.C. (eds) (1993) *Policy Change and Learning: An Advocacy Coalition Approach*, Boulder, CO: Westview Press. A more organizational perspective on learning comes from Argyris, C. and Schön, D. (1996) *Organizational Learning II*, Reading, MA: Addison-Wesley. A managerially focused approach which is highly recommended for its specific focus on disasters is Toft, B. and Reynolds, S. (2005) *Learning from Disasters: A Management Approach*, 3rd edition, Leicester: Perpetuity Press. It is particularly useful in examining the connections and potential for learning across many apparently disparate disasters. Boin et al. (2005) *The Politics of Crisis Management: Public Leadership Under Pressure*, Cambridge: Cambridge University Press, provides an astute overview of the post-crisis tension between the need to consolidate and the need to reform. Boin et al. (2007) also provide the first book devoted to post-crisis inquiries, accountability and learning. It is entitled *Crisis and After: Case Studies in the Politics of Investigation, Accountability and Learning.* It includes case studies on the aftermath of 9/11, the Madrid bombings, the boxing day tsunami, Space Shuttles Challenger and Columbia, and Hurricane Katrina.

The recovery period for disasters is not covered in this chapter, but readers would be advised to acquaint themselves with some of this literature. A useful starting point is Schneider, S.K. (2011) *Dealing with Disaster: Public Management in Crisis Situations*, 2nd edition, Armonk, NY: M.E. Sharpe. Its particular strength is in focusing on how the debate ensuing in the aftermath of disasters is linked to our expectations before the disaster. An excellent overview of some of the issues to be addressed and the problems that are likely to ensue in the recovery period is provided by Emergency Management Australia in their (2002) document *Recovery*, which is part of a larger series on various aspects of disaster management. It can be accessed at <http://www.ema.gov.au/> by following the link to the Australian Emergency Manuals Series. Urban areas, where there is a concentration of population, economic activity, social problems and intense politics, are often the site of modern disasters. For an excellent introduction to the symbolic and structural aspects of recovery, see Vale, L.J. and Campanella, T.J. (eds) (2005) *The Resilient City: How Modern Cities Recover from Disaster*, New York: Oxford University Press. See also the practitioner-oriented Phillips, B.D. (2009) *Disaster Recovery*, Boca Raton, FL: CRC Press.