

## **Critical Command: In One Ear and Out the Other**

By Grant M. Coffey

Tempered by 30 years of emergency service - 24 of those as a command level officer - I watched the devastation of Hurricane Katrina and ached silently for the many people that have lost and endured so much in the Gulf Coast natural disasters. At the same time, I experienced frustration at the Monday morning prophets, know-it-alls and armchair analysts that came out of the woodwork to jump on the blame-game bandwagon. Why are there so many questions about the adequacy of the response to this overwhelming event? What does this say about our ability or inability to respond to future incidents, whether natural or human caused? What are the answers, and are we even listening if there are? After years of emergency response and disaster preparedness service, I'm certain I don't have all of the answers, but I am also certain that we must develop a better solution to the nagging question: Why do good people sometimes produce bad results? As G.K. Chesterton said in *Scandal of Father Brown* (1935), "It isn't that they can't see the solution, it's that they can't see the problem."

### **Back To Square One**

In order to fashion a solution to a problem, one must first identify the problem. Regarding response to recent disasters and overwhelming emergency incidents, many people formulate opinions about problems with prevention, mitigation and recovery. One concern is that we are dealing with issues that tend to repeat themselves over and over throughout history with one critical commonality: the human element. It is my opinion that we can glean insights from analysis of actions at past incidents and if done correctly, integrate lessons learned into our "toolbox" of improved response techniques and decision making. The main question is: How do we do this effectively? It is critical to properly assess the dysfunctions and craft systemic change, because if one fails to diagnose the key pieces of the puzzle, the risk becomes one of a Rube Goldberg solution rather than a simple yet effective one.

A common fix-it methodology can produce a complicated, seemingly scholarly plan, but when the crisis hits, it ends up as fodder for the office document shredder. A key point to recognize here is that simpler can often be better, and complexity can mask the true roots of the problem. After the spate of recent large scale natural and human-caused incidents, will leaders ever experience an epiphany that will guide them to a solution for more effective handling of key decisions in crunch time? This is problematic in that these events occur infrequently and therefore lessons learned are rarely integrated effectively into response to future events. I heard it stated recently that, "Experience is something you get after you need it." This prompted me to dig with increased vigor into current research and what my experience at numerous emergencies tells me about the true nature of crisis decision making, or what I call, "critical command". Steven Mink of Crisis Management says, "Remember that managing a crisis is managing your decisions."

### **Flying by the Seat of Your Pants**

Just how do we go about better management of the decision making process – especially under extreme pressure? Remember that the specific type of crisis event by itself isn't as much an issue (e.g., terrorist events, civil disturbances, major storms/floods or a subduction earthquake) as is the associated components to these events – large, overwhelming, non-linear events that are unpredictable, and chaotic

which therefore affects the application of “normal” decision making and response measures. As such, the use of a rational, cognitive approach may fail because of the interaction of inherent stressors at the event with predictable reactions resulting from typical human response. In simple terms, there’s a regression to more intuitive or gut level responses that in the hands of inexperienced managers can be risky at best.

A natural consequence of this in the face of an infrequent but high stakes event is the common response of even experienced commanders to jettison any pre-plans or written standard operating procedures (SOP’s) in the command vehicle and make decisions on the fly. Additionally, this approach courts disaster because under extreme stress, the typical human response is to freeze up, tunnel focus, refuse input and estimate situations poorly. This leads to compartmentalization of the leader’s thinking and potential breakup of the organizational response units that are under his/her direction. In 1990, Weick wrote, “Stress, fear and panic predictably lead to the collapse of clear thinking and organizational structure.”

After a career of hundreds of emergency responses and countless incident reviews, I can tell you that the plans are not the problem. As previously stated, even the best plans can come apart due to the nature of a disaster and the critical decisions that must be decided in a short time frame. The noted fire service guru Chief Alan Brunacini put it succinctly when he stated, “The first 10 minutes are worth the next 10 hours.” Stated simply, this means that the mistakes you make early on, have profound ramifications - positive or negative - farther down the line. For example, imagine a seemingly minor mistake with your golf swing and its magnification to the trajectory of the golf ball’s path farther down range as it breaks the clubhouse window. The problem is a human one, and as such, the solution, however seemingly difficult to decipher, is very solvable with the correct approach.

### **It Takes One to Know One**

Because of the infrequency of crisis events and the dichotomy of decision making at the office versus while in the hot seat, there is a pressing need for an approach that creates a learning environment by simulating these conditions so that leaders can learn to be better crisis managers. This approach must apply lessons learned from experts in the field who have actually been in difficult situations; not just military, fire, police and other responders, but those knowledgeable in human psychology, safety engineering, organizational management and other related fields. In this post-911 world, diverse disciplines must work together and, in fact, can help each other strengthen the decision making process. Much like the frog that experiences small, incremental changes in conditions and soon is boiled to death, I have witnessed an organizational “tactical anesthesia” or the tendency to become lulled to sleep and miss all of the deadly clues. Because much of the time novices or organizational “outsiders” can bring a fresh new outlook, it may become easier to break the organizational paradigms. One can easily memorize and rehearse SOP’s at tabletop simulations and walkthroughs like a talking parrot, but the key is in how people perform and react when faced with the pressures of an atypical event in real time. Such scenarios cause the average manager to jettison SOP’s long practiced but not easily adaptable to a dynamic, chaotic scene. Some events can shift from predictable and linear to unpredictable and non-linear in a heartbeat, but can your leaders shift too? Shinseki claims that, “Managing transitions is the key to winning decisively.”

Properly designed and guided scenarios refine leader’s abilities under fire and teach them to avoid candle moth and tunnel vision behaviors, as well as the ability to catch the “cues and clues”: Those vital pieces of information that guide us when faced with a decision fork in the road. When faced with repeated scenarios, hot washes and guided group learning sessions, leaders can learn new behaviors and break the cycle of ingrained and often subconscious habits. If the ingrained habit is a negative one, the “under

stress, we regress” principle causes the leader under pressure to make a quick decision, reverting to the last, best-learned behavior even if it is a poor choice. These choices, when multiplied several-fold, can end in disaster. In *Friendly Fire*, Snook writes, “It normally isn’t an isolated event which causes an accident. There is a chain of events or circumstances which come together and lead to a tragic outcome.”

### **Making Ends Meet**

Although the “big one” may come once in a blue moon, it carries such overwhelming implications that we must strive to break the cycle of poor crisis decision making. Are we doomed to repeat our failures endlessly? Are we too mired in the political and ideological morass to actually reinvent our approach to disaster response?

Let’s become students again and with the help of committed professionals from diverse response and scholastic fields, unlock the secret to human response to difficult events.  
This effort should include:

- Intuitive models like Recognition Primed Decision Making, where one looks for patterns and clues and then devises a plan that is adaptable.
- Subject students to situational stress not normally experienced in the everyday workplace.
- Cross train with other disciplines that must learn to work together in a crisis.
- Promote team building personnel dynamics and human interaction skills.
- Integrate lessons learned from past incidents and reward correct, safe behavior.

As James Reason said, “Group dynamics before a crisis affect survival during a crisis.”

### *About the Author*

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