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A word from Anne and her team...

How to manage the longer-term aftermath of a crisis

Hello and welcome to our latest newsletter. I continue to be delighted with the responses and feedback I receive to our publications. If you didn't have a chance to read the last one, which focused on the importance of being prepared for a crisis and how to react, you can find it by clicking here. I was also very pleased to see so many of you at my recent seminar where I looked at the topics covered in some of my latest communications.

In this newsletter I will conclude my overall crisis theme by looking at how businesses and their boardrooms should manage the longer-term aftermath of such an event. We'll cover how the establishment of practices, procedures and detailed reporting can help organisations truly learn from past incidents and help prevent future occurrences, as well as manage the longer-term effects. At the same time, we'll focus on how doing this is a crucial step in preparing for any potential investigation/prosecution (by the relevant authority) that often comes months, and sometimes years, after the actual incident occurs.

In my role, I regularly spend time with businesses who have suffered incidents and accidents that can potentially have a considerably detrimental effect to their organisation. I'm often asked what my most important piece of advice would be, and it is, with a few exceptions, always the same.

Maintain a sense of vulnerability

There is a natural instinct that when an organisation feels like it is through the worst of a crisis it relaxes, breathes a collective sigh of relief and gets back to business as usual. You've spent a considerable amount of time investigating, crafting responses, building evidence and creating reports and you feel comfortable that you are now in a good place.

Whilst, of course, we all have businesses to run, this can be a risky approach. As much as the initial storm may have abated, there is often still much to do. A potential prosecution may be some way off and there is always the chance that, through no fault of your own, the story may appear on the news cycle again. If, for example, another business has a similar incident you may well be mentioned as part of the reporting on that incident.

Maintaining a clear focus on your actions and preparation for a prosecution is critical. It is common to hear the phrase "we must learn lessons from this" and, as such, one may think that learning lessons and changing is an inbuilt function in both people and organisations. But, all too often, it isn't. In their publication "Guidance on Learning from Incidents, Accidents and Events", the Institute of Chemical Engineers make this very point. Yet, the key here is that this phrase can mean different things to different businesses. For example, it could mean any of the following:

a. That the team of investigators has understood how and why an incident occurred.
b. That several people in an organisation now know how to prevent it happening again.
c. That an organisation has implemented a set of changes (for example in equipment and personnel behaviours) which will prevent this event happening again.
d. That an organisation has implemented a set of changes which will prevent this event, and similar events, happening again and even learnt about its processes for Learning from Incidents (LFI) as a result of an incident investigation.

As you can see, those are a fairly broad range of interpretations. It goes without saying, that I'm in favour of using the last definition as the one that businesses adopt. This would lead to a significantly larger risk reduction than if a business followed the first example. It's also the best approach to take when you think about the potential prosecution. Making significant change and implementing detailed processes and reporting will help when it comes to this stage. Remembering that making changes is not tantamount to admitting guilt.

Learning from incidents

In order to provide a relevant and implementable example for businesses, I have included a downloadable PDF from the Energy Institute on the process of "Learning from Incidents" (LFI). It looks at how businesses can adopt the very best approach to learning and why it is so important.

LFI offers a framework for organisations to gather knowledge and change working practices to prevent future incidents. Typically, there are seven phases to the process which I will briefly summarise here:

Reporting

Every incident or near miss must be reported. It raises awareness of potential problems and provides the starting point for LFI. Reporting must be systematic and every single event that could jeopardise safety should be noted.

Investigating

During an investigation, specific incidents are analysed to identify the causes. Ideally, immediate, underlying and root causes should surface through the investigation process. Root causes take time to be established but are far more valuable learning tools than the immediate causes.

Developing Incident Alerts

Sharing information with colleagues is a critical part in learning and preventing future incidents. Alerts can take many forms,

such as written bulletins or videos, but they should include data about the context in which the incident occurred and the causes that led to it. The purpose is to help people understand what to do to prevent similar incidents happening again. It may be necessary to take legal advice on how these alerts can be communicated, whilst, at the same time, ensuring that any investigation remains covered by "litigation privilege".

Communicating

Following on, incident alerts should be communicated to everyone who might benefit from them. A degree of pragmatism will help. There is a balance to be struck between communicating all incident alerts and targeting specific groups of people. It's something for the team who develop the alerts to spend some time thinking about. In particular, the team should not just consider the facts, but consider the underlying themes. An incident which involves traffic management may have underlying issues such as failure in supervision, which is not unique to traffic management but reflecting of the business as a whole. Hence the communication needs to emphasise that although the incident arose in traffic management, the failings are much wider.

Reflecting

We all need to be given time to reflect, and it's no different when it comes to incidents. People need to think about the relevance of the incident to their work and be offered the chance to feedback and offer input into the wider company approach. There may well be a first-class recommendation from junior members of the team that, if implemented, makes a big difference. And, of course, wider engagement is just sensible business practice.

Implementing actions

During this phase, people select actions to implement into their own work to help avoid similar incidents. LFI must result in positive change in an organisation's processes or behaviour, leading to an increase in safety. Because, with very few exceptions, without a change in organisational processes, practices or behaviour, learning simply cannot have taken place.

Change in behaviour or processes

This can be as simple as updating a procedure or as complex as redefining the culture of a business. What is clear though is that there must be evidence of a change. Again, this can be as simple as maintaining a log of all changes and then recording when they have been implemented. Other mechanisms could include audits, staff surveys, site visits or externally commissioned reports.

The last point is crucial when it comes to thinking about dealing with authorities and potential litigation. As an example, if the incident resulted in a fatality, there will be an inquest and the coroner will want to hear not only about the incident, but also how it will be avoided in the future. They will need more than reassuring words. They'll want specific detail, a log of actions you have taken and proof that implementation has occurred. If they are unsatisfied that an organisation has not learnt lessons, they may well issue a report to prevent future deaths.

If there is a prosecution, the court will want to know what has been done to avoid a repeat of the incident and will look more favourably on businesses that have truly implemented change for the better. And, frequently, the Health and Safety Executive (HSE) will undertake a visit at some point to check that whatever changes were to take place have been implemented. It's a statement of the obvious, but one that I like to reinforce: if you say you are going to do something, then you must ensure you do it.

An example of LFI in action

I think it helps to briefly show an example of how LFI can work well. The locomotive division of SNCF, the French National Railway Operator, maintains a database of all events called Cecile. It was created in 1980 and includes a classification of all reportable events, of which, on average, there are 550 every day. The database has 2,500 users at the national level and data and statistics are generated regularly at the national, regional and site level. It allows deep analysis of correlations according to event type, severity, location, hour of the day, level of driver experience and driver working hours. It allows for detailed analysis and helps with the prevention of future incidents. Whilst this is undoubtedly at the extreme end of the scale, it proves the power of data and systematic recording of everything.

Maintaining Corporate Memory

It's incredibly important for the board to ensure that quick fixes that follow an incident do not lapse and go full circle back to the normalisation of deviation. My experience has shown that it is very easy to be extra vigilant after an incident and implement change, but that corporate memory soon fades.

Only through the implementation of rigorous and detailed regular reporting can the incident remain where it should be; front of mind. The issue of maintaining a sense of importance and delivering a cultural change is hard. Often, the team who has dealt with the immediate aftermath of an incident are exhausted and, quite understandably, need a break from it. Whilst at first glance, and reading what we have said so far, this may seem like a bad idea, it probably isn't.

A change of leadership?

Often, when I help businesses with their responses to incidents, I come across a group of tired people who have spent many waking hours knee deep in their responses and managing their corporate reputation. I find there is often an effective way to deal with this – create a new team focused on embedding change. I'm not advocating this as a blanket approach, because it is all very situational, but sometimes it works well.

What a new team does, is create a renewed sense of vigour to respond to the challenges and also sends a powerful cultural message to every single colleague. If people see a new team created specifically for implementing change, they will understand just how seriously the organisation takes its responsibilities.

Fresh eyes and fresh perspective cannot be underestimated. It's also incredibly important because it acts as a knowledge transfer exercise to other people in the organisation.

In conclusion

Whilst incidents and accidents are not something any business wants to happen; they are invariably a part of corporate life. The crucial part is how you deal with them, both in the short and longer-term. Don't let actions drift; ensure you put the right processes, procedures and measurements in place to show you are learning from them. And understand that the way you deal with them and how you maintain a ruthlessly watchful eye can often be the difference between a healthy and thriving business, and one that is consigned to the pages of history.

If you'd like to talk about this and understand how I can help you be prepared, please do get in touch.

With my very best wishes

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