

4. WHAT DID WE LEARN?

INTEGRATING HIGH RELIABILITY ORGANIZING PRINCIPLES

INITIAL IMPRESSIONS FROM THE OKEFENOKEE CASE STUDY FIELD VISIT



HIGH RELIABILITY ORGANIZING IMPRESSIONS AND A LEARNING ORGANIZATION CONTROVERSY

The morning after the Case Study field visit, Dr. Karl Weick and Dr. Kathleen Sutcliffe shared their initial impressions of how they perceived High Reliability Organizing principles had surfaced during the Okefenokee Swamp tour with the various fire agencies.

This chapter summarizes their observations, as well as participant observations. In addition, this chapter illuminates a significant potential “organizational learning” conflict/controversy that occurred at the end of the previous day.

In doing so, the chapter attempts to provide the reader of this report:

- ❖ An accurate account of the controversial verbal interaction that transpired during the Case Study field visit.
- ❖ The subsequent important organizational learning/High Reliability Organizing discussion of how this incident was interpreted and deliberated during the following day’s integration phase.

“You can now work on being conscious of these High Reliability principles so that they also become a part of your routines and activities.”

Dr. Karl Weick

KARL WEICK: TWO HRO KEY POINTS

1. MAKING HIGH RELIABILITY PRINCIPLES A PART OF YOUR ROUTINE

Think of these principles of High Reliability Organizing as a language that can help you: label, understand, think about, and redo the things that you are already working on [back on your home units].

Fred Wetzel [U.S. Fish and Wildlife Service’s Fire Management Officer on the Okefenokee Wildlife Refuge] gave us a perfect example of this yesterday [on the case study field visit].

Remember when he said that they were doing *‘fire use’* fires without having a name for it? Then, when they got the name *‘fire use’* they could think about this more explicitly. They could do more about it.

That’s exactly the way you want to be working with some of these High Reliability ideas.

I’m sure a lot of you have been doing some of these High Reliability Organizing principles but didn’t realize it. So now that you *can* put a name on it, you can start to work on it—and you can realize that you can do better at these principles.

You can now work on being conscious of these High Reliability principles so that they also become a part of your routines and activities. So that you’re constantly doing a thorough scan of situations—a continual updating of these things that go along with mindfulness and High Reliability.

2. PROCESSING IN A ‘MINDFUL’ FASHION

It’s easy to get caught in the trap of saying to yourself: *‘by Reliability, I need to be doing the same thing automatically over and over’*. But, that’s missing the point. The point is you want to do the same kind of scanning of a situation.

You want to keep looking at things and processing them in a mindful fashion. But you also want to keep as much flexibility in your activities as you possibly can.

In this way, you can deal with the unexpected events that come up.

Dr. Karl Weick

“If you’ve got an inflexible, hierarchical kind of planning process, it may lead to more mindlessness—not mindfulness.”

Dr. Kathleen Sutcliffe

KATHLEEN SUTCLIFFE: TWO HRO KEY POINTS

1. BEWARE: PLANNING CAN LEAD TO MORE MINDLESSNESS

Plans, of course, are very important. But they can also make us more mind~~less~~. Plans cannot manage the unexpected. And plans cannot handle what they don’t expect.

Planning is a process of practices and principles that have to be continually enacted over and over. Some organizations do mindful planning; some do mindless planning. Mindless planning would be just having a checklist and going down it without doing a very rich discussion, or having a planning process that takes into account a lot of different views and different stakeholders.

Yesterday we heard Fred Wetzel and others talking about a planning process that involved many different stakeholders in that [GOAL] process who were trying to figure out what could possibly go wrong. There was a richness to that process that really gave them a sense of the kinds of things that could come up. There was a lot of input into that [GOAL] plan.

But, on the other hand, if you’ve got an inflexible, hierarchical kind of planning process, it may lead to more mindlessness—not mindfulness.

2. HIGH RELIABILITY IS ABOUT DESIGN - NOT RESOURCES

Some people have said that if their organization had as many resources as some of the organizations that Karl and I have benchmarked, then they could also be more of a High Reliability Organization. This isn’t necessarily so.

High Reliability is about *design*. It is not necessarily about resources—in the traditional way in which we think of resources, in terms of money. . . . If High Reliability *is* about resources, it is about cognitive attention and time resources.

It is about the time that it takes to build the rich network of communications like we heard about yesterday [GOAL]. Fred Wetzel and the others talked about constructing this rich communication network and a respectful interaction. Both of these take a lot of time and a lot of forethought—which is more of a design issue.

Establishing normative routines for analyzing the small and large failures that have gone on, and reexamining your procedures to incorporate new learning, is also an issue of design.

Dr. Kathleen Sutcliffe

WORKSHOP PARTICIPANT COMMENTS AND OBSERVATIONS



IMPRESSED WITH COLLABORATION

“We’ve been chided for years to do field trips or staff rides on a successful operation. I think that’s what we did yesterday. I was very impressed with the collaboration and the obvious pride that is exhibited by these people in the GOAL organization.”

ECOSYSTEM—NOT POLITICAL—BOUNDARIES

“What impressed me most yesterday was the comment that was made that GOAL was doing ‘what was best for the land.’ It became apparent to me that they were looking at ecosystem boundaries not political boundaries. Prior to a wildfire or prescribed fire, everyone—all the stakeholders within the ecosystem—were coming to the table with common threads that were linking them together, and they were working out issues and getting on the same boat together.”

A DEFERENCE TO THE LOCAL FOLKS’ EXPERTISE

“A thread I noticed running through the conversations yesterday was a deference to expertise and a reliance on expertise. There’s a lot of stock placed [by GOAL] in the expertise of the local folks. This is one of the aspects that has developed trust over the years. I think a lot of the controversy through the 1980s when the outside Incident Management Teams were brought in, was their failure to recognize and rely upon this local expertise. The Friendly Fire was not all that friendly, largely for that reason. The local folks were not brought into the fold.

Kathleen [Sutcliffe] made a good point earlier about the inclusiveness of the [GOAL’s] current planning process and its respect and reliance upon the local land owners for their expertise. Their knowledge of the land and of the road system and of the bearing capacity of the soils—what equipment you can put where, and where you can build line and where you can’t.”

THE AFTER ACTION REVIEW PART 1

Toward the end of the all-day case study field visit, during the question and answer period, the following discussion occurred. (Part 2, insights into the organizational learning process that this interchange inspired, are summarized on the following page.)

WORKSHOP PARTICIPANT:

“As an organization, does GOAL do After Action Reviews?”

SKIPPY REEVES, MANAGER, OKEFENOKEE REFUGE, (JOKINGLY):

“Say that in English?”

WORKSHOP PARTICIPANT:

“Do you guys—GOAL, as an organization—talk about what went right and what went wrong?”

SKIPPY REEVES:

“We’ll do it informally. I don’t know if we’ve ever had a formal debriefing.”

FRED WETZEL, FMO, OKEFENOKEE REFUGE:

“After the Black Jack Bay Complex Fire we pulled in all the partners and we actually sat down and we reviewed everything that had happened. . . We did all those things that you normally do. We really looked at all that had happened and how we could improve. The best part about it was that we couldn’t find much that we could improve upon. We had one fatality and that was a skunk on the road. We had one man slip and bruise his hip.



“We couldn’t find much

that we could improve upon.”

We had one person in town who was spreading rumors about how much he was getting from the government to make us lunches. And that was it for a year—those were the only three things that we dealt with.”

SKIPPY REEVES:

“At a planning level or at a steering committee level, I don’t know that the eight of us on the steering committee have ever really sat down and said: ‘Hey, how can we make this organization better?’ We’re together a lot. We talk a lot on the phone. It’s informal as we ride around in the car and we adjust as we go through the incident. I don’t know that we would need the eight of us to sit down, or that anything would be accomplished by bureaucratic meetings—[he smiles] unless we were going to go eat barbeque somewhere.”



FOLLOW-UP: THE AFTER ACTION REVIEW PART 2

During the follow-up discussion the next day—in reference to the prior After Action Review question and response—the following conversations occurred.

WORKSHOP PARTICIPANT (ALAN DOZIER, CHIEF OF FOREST PROTECTION, GEORGIA STATE FORESTRY COMMISSION):

“One of the questions yesterday hit me pretty hard—me being a part of the presenting group. And I got to thinking about it a lot last night. Somebody asked the question: ‘*Do you do After Action Reviews?*’ And I was standing out there and I thought: *Oh my gosh, here we are, we’ve got this nice organization here and they’re going to find out that we don’t do After Action Reviews.* [He smiles. Everyone laughs.] But then Skippy Reeves’ answer had something to do with barbeques and with lunch. And I got to thinking that I think what’s going on here is that they go around and do their After Action Reviews one person at a time—over lunch. And they do this with intent; they do this consciously. Their steering committee members go around and do that. And then they gather that information. They don’t publish any actual After Action Reviews. But when they do have a gathering—somehow or another—those issues are brought up. And that’s how they’re doing those reviews.”

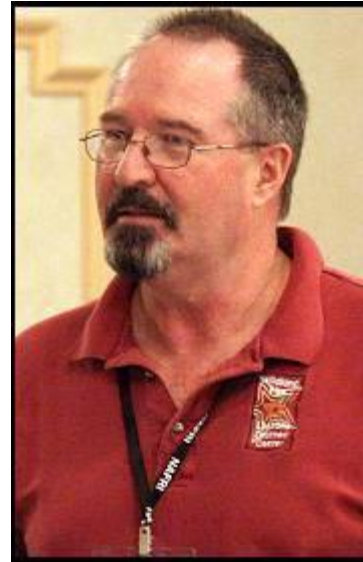
DR. KATHLEEN SUTCLIFFE:

“I know they’re doing this informally among themselves. But I guess the question for me is: are they taking from what they learn from these ‘After Action Reviews’ and somehow building this back into the plan or the planning process? One of our questions (for organizations) is: *Where are they vulnerable?* And one place where GOAL might be vulnerable is building and incorporating what they’ve learned back into the process. But, maybe they do have a process for this?”

WORKSHOP PARTICIPANT (ALAN DOZIER):

“Yes, a real loose process—and I think that’s one of things that makes it work down here with this bunch.”

DAVE CHRISTENSON, ASSISTANT MANAGER, WILDLAND LESSONS LEARNED CENTER:



Dave Christenson

“Toward the end of the day yesterday they talked about an annual After Action Review—and that’s good. But then during the year, throughout the projects that you’re doing—if not daily, at certain points—you need to take the time to reflect and to reintroduce the things that you’re learning and not wait until the end of the year. And the other comment yesterday that really concerned me, was that there were only three things that came up. I hear this over and over again with Incident Management Teams: *No one got killed, we only had one slight injury, and one other small thing that came up as*

the result of an After Action Review. And this leads me to wonder, how rich are these After Action Reviews?”

There’s a tendency to use as a metric for success: *Did we kill anybody? Did everybody get home healthy?* To think that if we accomplished this, then we were totally successful. But I don’t think we want to get into this mindset. We need to keep looking at ourselves to see how we can keep getting better and better. We want to build onto our strengths and to admit our vulnerabilities—to admit that, yes, there are things we need to be working on. We now have the process in place to do this—the After Action Review.”

WE HAVE HAD FAILURES - WE TEND TO CALL THEM 'ANOMALIES'

FRED WETZEL, FMO, OKEFENOKEE NATIONAL WILDLIFE REFUGE:

“Sitting down and eating with folks bridges a lot of barriers that you can’t bridge any other way. To take the time to be with them, where they live, eat the food they eat, and just be somebody. That helps a whole lot.

. . . The thing that impressed me most about the hallmark of the High Reliability Organizing process—it’s a great mechanism to generate discussion. . . . To get you looking at things in a new way. To use new words for old things to bring them up to another new level. And then to apply those new concepts to what you’re going to do tomorrow or the next day.

We are trying to build within our organization a competence to do the job that we’ve been tasked with. We want to move from that point to an even higher level as we grow together as a group. . . . One of our greatest fears and challenges is preparing for personnel change. When we replace our refuge manager, there will be a GOAL member and a Forest Service rep on that selection board. Believe it or not, the same is true when the Forest Service here

hires a new district ranger. The Fish and Wildlife and GOAL representatives sit in on the selection committee and help weed through folks. We want to try to bring in people who could have the skills and mindset that we feel are very important to us. We want new ideas. But we also want people who are exhibiting the ‘extroverted’ type of mentality.

I also heard, in the negative, about preoccupation with failure today. We are talking about accountability; people making decisions that don’t go well. . . . In terms of preoccupation with failure, if you spread out the decision making process to more than just yourself and your organization, and then ‘it’ hits the fan, you won’t be standing alone.

We have had failures, or at least what people would call failures. We tend to call them ‘anomalies.’ We know they’re going to occur. They happen. And because of them, and the way in which we deal with them, the group is made stronger.”

BEWARE OF COMPLACENCY AND OF NORMALIZING 'ANOMALIES'

DR. KARL WEICK:

“Let me say a little bit about failure. A big problem is complacency. Like after NASA had success after success after success, they got complacent. They started to take things for granted, and they cut their margins of safety. As a result, they worked too close to the edge and trouble happened. So the preoccupation with failure point is a big red flag against these processes of complacency that can easily overwhelm a lot of other things that you are doing. . . . There is also this process whereby people start normalizing what Fred called ‘anomalies’ over a period of time. Those things start to build up. And those are the places where you get these early warning signs that things are going to go haywire. Like when you stumble onto something like a system that is missing the 1,000-hour fuel moisture—is the system

missing other things? Are you missing these early symptoms—these weak signals—that can grow into something larger? You need to be looking closely at these early markers that maybe things are going to unfold.

. . . The problem with a phrase like ‘Preoccupation with Failure’ is that it means a lot of things. Including the notion that I don’t want to screw up, or I can’t afford to screw up any more, and what are the consequences of this to me. That’s one meaning of failure. . . . If you look at the way you do a lot of your fire investigations, you never describe culture, or the situation that the people were put into . . . For our purposes, when we talk about failure, it is the little clues or symptoms of how the system is doing.”