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## The New Orleans Disaster and HRO Theory

*Why didn't Mayor Nagin of New Orleans use city buses to evacuate residents before flood waters rose?*

*Why didn't Governor Blanco send in the Louisiana National Guard sooner?*

*Why didn't FEMA react more quickly?*

In the next days and months there are going to be plenty of words written with regard to the above and related questions – unfortunately, almost all will be politically tinged and not very reliable.

Over the past several years we've written several times about Highly Reliable Organizations (e.g., aircraft carriers, emergency rooms, and – in its finer moments – NASA), and what we can learn about improving organizational performance from these entities.

While New Orleans is still very early in the remediation stage, it seems worthwhile to advance some hypotheses about the terrible events there and what HRO theory says about how to avoid – or at least seriously mitigate – the impact of such disasters in the future (whether they be acts of nature or acts of terrorists).

A couple of caveats. First, we're focusing on New Orleans and its surrounding area only because so far the most has been written about what happened there. As the story unfolds, we will learn much more about the extent to which the New Orleans experience was replicated elsewhere. Second, we emphasize that these are *hypotheses* – it's always dangerous to assume too much from imperfect, incomplete, and unfolding information (a very good example was the first report right after Katrina passed that the Superdome was "structurally sound," followed within four days by the report that "it probably will have to be completely rebuilt"). Finally, this is not meant to be a political treatise: Like many of you, I've seen the incompetence of Federal Emergency Management Administration (FEMA) in Republican and Democratic Administrations and Congresses alike!

Having said the above, as we develop a better understanding, it will be interesting to see the extent to which the hypotheses below speak to learning we must create if such disasters are to be mitigated in the future.

First, was the environment here a "highly fragile process" environment, the kind that HROs typically operate in?

These environments tend to be composed of complex interactions and to have "tight couplings" within those interactions. Response to a hurricane, particularly one with flooding as a highly likely parallel or subsequent event seem to fit this definition:

- There are many "moving parts" in terms of process (interactions among at least three levels of government, across parishes, and across entities – police, fire, National Guard, FEMA, volunteers)
- These entities operate with complex procedures and process rules
- There is a "tight coupling" within the processes
  - They are time dependent
  - A rigid set of sequences is necessary for successful production
  - There is very little "slack" in the system

Second, successful "highly reliable organizations" tend to exhibit the following behaviors:

- Preoccupation with failure
- Reluctance to simplify interpretations
- Sensitivity to operations
- Commitment to resilience
- Deference to expertise (as opposed to authority)\*

Let's look at what happened in New Orleans against each of these behaviors, and see what we think we know so far:

#### Preoccupation with Failure

The best of these organizations relentlessly and imaginatively ask the question, "What can go wrong?" They don't rely on past experience, since our environment changes constantly (as Karl Weick says with regard to safety, in HRO terms it is "a dynamic non-event" – the same might be said of disaster avoidance)

So how did those in charge of dealing with Katrina do here? We really don't know. We know that the Director of FEMA said, "We train all the time for this kind of disaster," but it seems strange that all that training resulted in as feeble an effort as was seen. We have seen little to suggest there was pervasive questioning about what could go wrong at the city, state, and federal level. In fact, one account said that the disaster plan for New Orleans was to rely on personal transportation for most evacuation, and city buses for the balance. Only the former seemed to have happened.

#### Reluctance to Simplify Interpretation

The conduct of those at all levels seems somewhat in question here: The dikes were reinforced for no more than a Category Three hurricane (it was actually between a Four and Five), so it was reasonable to expect that one or more dikes would fail. When you look at this fact, and combine it with the above and the effect known as seiche (basically, the sloshing back and forth of bodies of water after having been disturbed by a hurricane or earthquake, an effect that can easily last for days), you'd have to say that if the alarm bell was raised, it wasn't heard at any level (that is, the Mayor could have started employing buses for evacuation before the hurricane struck, the Governor could have mobilized National Guard troops to arrive immediately after the hurricane, FEMA could have mobilized troops and rescue teams before the hurricane).

#### Sensitivity to Operations

Simply put, in the context of Katrina, this means forgetting about procedures, policies, and regulations, and focusing first on saving lives. In other words, decide to *beg for forgiveness after the fact rather than ask for permission*. At this early stage, it would seem that no one at any level of authority was willing to do this. In fact, the lack of action was so pervasive that, the quote of the president of Jefferson Parish to the effect that, "Bureaucracy murdered people in New Orleans," is probably

correct. What this may suggest is that we have to devise a system where people will not be penalized for doing what they think is the right thing, as a sort of "Good Samaritan Rule" for leaders.

#### Commitment to Resilience

There have been some suggestions that the Mayor and the Governor basically lost hope and became non-factors as decision makers as the tragedy deepened. Certainly the New Orleans police force, with two suicides and a hundred or more officers simply walking away, demonstrated a lack of resilience. Contrast this to the situation in 9/11, where there were incredible accounts of fire and police continuing to stream *toward* the collapsing World Trade Towers. Some serious thought must be given to how to recruit, train, and reward this behavior in a way that yields a high probability of critical decision-makers and organizations remaining effective as these type of situations deteriorate.

#### Deference to Expertise

Again, it is difficult to sort this one out. The Mayor certainly warned of the potential size of the tragedy, from before the hurricane struck, to the day of this writing (during which he repeated his earlier statement, "It is not outside the realm of possibility that 10,000 people are dead in New Orleans"). And the Governor is quoted as saying that she could not get Homeland Security or FEMA itself to recognize the potential magnitude of the tragedy. On the other hand, did either of these officials act with regard to those things that they *could* control? It seems not.

So what does this very preliminary analysis suggest?

- *That brave leadership is in short supply in catastrophic events – and we may want to think about how to identify, recruit, and retain such leaders*
- *That the nature of bureaucracy is not consistent with the operating rhythm required in catastrophic events, and thus, some type of bureaucratic "martial law" may be required to give leaders more freedom of action in such events*
- *That the debate that will surely follow in the months ahead needs to focus more on how to abstract and apply the lessons we learn, rather than castigate and condemn the guilty – we are already paying for our mistakes as a society here, let's try to extract the benefit of making those payments*

\*See Weick, Karl and Sutcliffe, Kathleen "Managing the Unexpected," 2001, from which these behaviors have been adapted

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