Crisis Management

Aligning scripts and actors:

Strengthening crisis response capabilities by

minimising process deviation

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A thesis submitted in fulfilment of the requirements for the degree

of Doctor of Philosophy - Business

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Dedication

This thesis work is dedicated to my wife Sue and our sons Steve and Matt. They have been a constant source of support, patience and encouragement during the challenges of managing the complex balancing act of working, studying and maintaining a personal life. I am truly thankful for having them in my life.
Acknowledgements

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- My wife Sue, for her love and tireless emotional support together with her editorial guidance, which kept me focused, and without which I would not have been able to complete this research.
Statement of Authentication

The work presented in this thesis is, to the best of my knowledge and belief, original work except as acknowledged in the text.

I hereby declare that I have not submitted this material, either in full or in part, for a degree at this or any other institution.

.................................................................

Gerold C. Knight
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<td>CCE</td>
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</tr>
<tr>
<td>CCEP</td>
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</tr>
<tr>
<td>CCHBC</td>
<td>Coca-Cola HBC AG – Franchise Bottling Partner to TCCC</td>
</tr>
<tr>
<td>CMP</td>
<td>Crisis Management Plan</td>
</tr>
<tr>
<td>CMT</td>
<td>Crisis Management Team</td>
</tr>
<tr>
<td>ERM</td>
<td>Enterprise Risk Management</td>
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<td>FMCG</td>
<td>Fast Moving Consumer Goods</td>
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<td>IMCR</td>
<td>Incident Management and Crisis Resolution – the acronym for the crisis management program utilised within the Coca-Cola System</td>
</tr>
<tr>
<td>PA&amp;C</td>
<td>Public Affairs and Communications Department</td>
</tr>
<tr>
<td>QSE</td>
<td>Quality Safety and Environment</td>
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<tr>
<td>SME</td>
<td>Subject Matter Expert</td>
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<tr>
<td>TCCC</td>
<td>The Coca-Cola Company</td>
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Abstract

Crisis Management

Aligning scripts and actors: Strengthening crisis response capabilities by minimising process deviation

The present business resilience paradigm has expanded to embrace the processes and routines employed by a business to remain viable, sustain growth and recover (if required) in what for many people has become a complex global operating environment. Sutcliffe (2003, p. 2) defines resilience as “the maintenance of positive adjustment under challenging conditions” and the combination of proactive routines such as enterprise risk management and reactive routines such as crisis management create the overarching umbrella of business resilience. Whether they are proactive or reactive, ostensive routines form the framework and script from which organisations operate and strive for such ‘positive adjustment’. The business challenge, particularly in crisis management, is to ensure the effective interpretation and performance of ostensive routines during events that have the potential to play out on the world stage.

This research examines an observed phenomenon in business, which is the deviation between ostensive and performative routines during crisis management responses. Human nature is such that there will often be a difference between the script and the performance. In crisis management, issues are created when the gap between the performance and ostensive routine grows too large, or, following an acting metaphor, where actors forget what they have practiced in rehearsals and create their own script. Such deviation has been observed repeatedly and most critically in the first 24 to 48 hours of a response when it is arguably the most important period in which to follow the script and apply the correct routines. The aetiology of deviations between a crisis management script and its production is the focus of this research. This addresses a gap in the crisis management literature which, while spread across multiple streams including leadership and teams, is at times
incoherent. Utilising a case study approach focusing on the fast-moving consumer goods (FMCG) sector, this research analyses the potential causes of process deviation. In evaluating two specific dynamics the research collected empirical data to address the question of how ostensive and performative routines interact in a crisis management situation and what factors contribute to deviations from ostensive routines. By answering this question, a theory is developed to explain the deviation.

The first dynamic focused on reviewing the tools and routines and sought to establish if deviation is due to routines being ineffective, and whether this is combined with a lack of process maintenance and updating, after an actual crisis. That is, essentially: are routines and artefacts the cause of the deviation?

The second dynamic evaluated whether the deviation is human-related. It analysed whether deviation is driven by the casting and experience of the team members or the actions of the crisis leader in directing the team. While this research focuses on the root cause of the deviation from an FMCG perspective it argues that the findings are applicable across industry sectors. The research confirms that the following theory applies:

“Ostensive crisis routines and their related artefacts are robust. The process deviation from the ostensive routines during a crisis response occurs due to human dynamics which incorporate the behaviours of the members of the crisis team and the crisis leader. The core causes of deviation are ineffective crisis leadership and weaknesses in the crisis team structure.”
Chapter 1 – INTRODUCTION

1.1. Business Resilience and Crisis Management

In recent years, business resilience has transformed as a concept into a renewed paradigm that embraces the processes and routines that are employed by a business to remain viable, sustain growth and recover when required, in a complex global operating environment. Conceptually, it is argued that business resilience now transcends traditional theory that saw it largely focused on business recovery. Today it embraces broader dynamics that include both preventative and responsive routines, which when fully adopted enable businesses to remain resilient and grow.

The importance of business resilience stems from the fact that multi-national companies in the 21st century operate in an environment influenced by volatility, uncertainty, complexity and ambiguity (Dobbs, Manyika, & Woetzel, 2015). Today, businesses need to do certain things well to manage this complexity. These activities are clustered into five streams. Businesses need to:

- understand their risks and opportunities and proactively adapt to changing circumstances;
- utilise an exceptional internal and external risk radar to detect changes in their operational environment;
- build strong internal and external functional collaboration networks;
- work proactively to minimise exposures and leverage opportunity; and
- be able to respond rapidly and decisively to a crisis.
Resilience as a concept is difficult to define and can depend on the stream being studied. Sutcliffe and Vogus (2003 p.2) define resilience as “the maintenance of positive adjustment under challenging conditions” and it is a combination of proactive and reactive routines that creates the overarching umbrella of business resilience. The concept is intertwined with risk management as a process for managing uncertainty in a proactive manner. Hence, the concept extends beyond one of simple recovery, as positive adjustment is arguably both a preventative and a responsive routine. Routines form the foundation of the supporting capabilities and exist to guide the process, whether their focus is on proactive elements such as risk management or on reactive elements such as the execution of business continuity plans.

Within the business resilience model resides a core response element: crisis management. Crisis is also a complex term to describe but at its essence crises are the “unforeseen challenges that come from outside the normal course of business to threaten the health, and even the survival, of the firm. Crises such as product recalls, environmental accidents and natural disasters have challenged corporations and their crisis management teams since the first commercial enterprise opened its door” (Coghlan, 2017, p. 3). Therefore, in a business context, effective crisis management requires that crisis management teams follow process, procedures and routines to deliver the most appropriate and efficient management of the response. To do otherwise can result in a variety of consequences. In a worst case this could include the death of employees or members of the public; destruction of property and assets; significant reputational damage; and financial impacts either through the loss of business or stemming through fines or class actions.

Furthermore, an effective and consistent approach is essential since a crisis can evoke multiple emotions across stakeholders, distract leadership from the core business, and potentially irreversibly damage the reputation of a business. The four years during which the research projected in this thesis was undertaken, has seen an apparent escalation in the occurrences of crises (or at least their reporting), and during an organisation’s lifecycle many managers will be faced
with a crisis. In these instances, managers need to activate and apply ostensive crisis management routines to effectively respond to the situation. However, this is often easier said than done. This research project analyses a pattern of behaviour that has been observed on multiple occasions by the researcher, during eighteen years of crisis management experience in the private sector. This behaviour is where crisis teams fail to use, or incorrectly use, the ostensive routines and related artefacts during a crisis response. Specifically, where routines exist, and teams are trained to follow them, there is an observed propensity to deviate from the script and to neglect the existing artefacts that are designed to guide a crisis team to a conclusion that minimises negative impacts to the business. This leads to the core purpose of the research which is to examine how ostensive and performative routines interact in a crisis management situation within a business context and to understand what factors contribute to deviations from the routines.

From the outset, it is acknowledged that the extant literature on crisis management and routines addresses a variety of themes ranging from training to communication and leadership behaviour. However, the aetiology of deviation between script and production and associated team dynamics in a business crisis response scenario, where direct response observation have been made, coupled with the interviewing of subject matter experts, has not been the focus of previous work. This is linked to the observation that crisis management research and in particular research into the role of crisis leadership, is “often criticized for its lack of specificity” and “few scholars have considered the role of resource dependence in crisis situations” (Bundy, Pfarrer, Short, & Coombs, 2016, p. 1672 & 1682). This study addresses this gap in the existing narratives and targets the lack of specificity assessing crisis management deviation and leadership within an operational business context. These elements are critical areas for businesses, as they need to be prepared to respond to crisis in a world in which managing uncertainty is the new norm. This specific gap in knowledge further defined by extensive research in the field of crisis management has illustrated the existence of two main strands of literature (Bundy et al., 2016).
The first strand addresses internal organisational elements. For these scholars: “crisis management involved the coordination of complex technical and relational systems and the design of organizational structures to prevent the occurrence, reduce the impact and learn from a crisis” (Bundy et al., 2016, p. 1664). The second research strand addresses the external perspective, where the focus is on stakeholder management, which incorporates extensively the elements of external crisis communications. Bundy et al also analysed crisis research in respect of the leadership elements of crisis management. Interestingly, they found that the research focus has been on the classical elements of leadership with a focus on the tactical response, together with the interrelationships between pre-crisis and post crisis leadership versus the actual application of leadership in the crisis team during the management of the crisis. Research has also focused on the conditional factors such as the role of the board and the nature of the response by a CEO (Bundy et al., 2016, pp. 1670-1671). They went on to conclude that “the internal perspective suggests that leaders are critical to the crisis management process and that a number of factors influence their ability to lead. However, much like research on organizational preparedness, research on crisis leadership is often criticized for its lack of specificity” and “few scholars have considered the role of resource dependence in crisis situations.” Therefore, “research on specific actions and processes may also inform research on crisis management” (Bundy et al., 2016, p. 1672 & 1682).

The present research, into the aetiology of deviation during a crisis response by crisis teams is critical, as it addresses this gap in specific crisis management theory. It thereby responds to the concerns expressed by Bundy et al (Bundy et al., 2016) on the lack of specificity in respect to crisis leadership and response. Importantly, it also makes recommendations on additional areas of research focus, with the added benefit of having a practical application in the business environment. Ultimately the concepts of rapid, decisive and, most importantly, effective crisis management sit at the heart of this study, for the reality is that “bad things happen to good companies. Media decry mistakes, missteps and misdeeds. Stakeholders fear the performance of their investments. Customers
question loyalty … and in the end the outcomes are determined by how companies behave – by what they do, how they do it and when they do it” (Caywood & Englehart, 2003, p. 2). It is here, in the ‘heat of the battle’ that the performance of the crisis management team (CMT) can mean the difference between success and failure and enhancing performance and minimising process deviation can contribute to a positive outcome.

Table 1 – Key Definitions

| Business Resilience | The ability of a business to manage uncertainty and maintain positive adjustment under challenging conditions while enabling growth. This is achieved through the implementation of preparedness measures (e.g. ERM, security, training) and effective reactive measures (e.g. crisis management, business continuity, disaster recovery) that provide fundamental response mechanisms (Anderson, 2014; Prezelj & Doerfel, 2017; Sutcliffe & Vogus, 2003). |
| Crisis | A popular evocative word derived from the Greek word ‘krisis’. A crisis is not limited to circumstances of emergency and disaster but can refer to tensions that call for critical judgments, exercising critique, reflexivity that would inform decisions reached and actions taken (Antonacopoulou, 2014). |
| Routine | A routine is a repetitive, recognizable pattern of interdependent actions (Feldman & Pentland, 2003; Mante & Sydow, 2007; Pentland, Hærem, & Hillison, 2010). In its basic format “an organizational routine is not a single pattern but, rather, a set of possible patterns—enabled and constrained by a variety of organizational, social, physical, and cognitive structures—from which organizational members enact particular performances” (Pentland & Hueter, 1994, p. 461). |
1.2 A Theoretical Foundation

Driving the importance and relevance of the research is the fact that businesses are regularly confronted by crisis situations. Crises can cut across all sectors and therefore minimising the financial and reputational exposure is critical to ensuring that a business confronted with a crisis remains resilient. The cost of a crisis can be both tangible and intangible in nature. Table two illustrates the ubiquitous nature of crises by documenting several high-profile cases (both historical and recent) that transcend industry sectors. Their listing is not designed to be all encompassing, but rather it aims to present a context of the various forms that a crisis can take and to confirm that no industry or business is immune to this type of risk. As illustrated, brands are often at stake and while the nature of brand crises may vary, it is important to acknowledge that consumers rely on brands and that unethical, improper, and illegal actions may seriously damage that trust, while crises involving these distinctive attributes may be considered by stakeholders as even more serious in nature (Custance, Walley, & Jiang, 2012, pp. 19-20).

Therefore, as outlined earlier, with an identified gap existing in the extant literature on crisis management, this study proposes to examine the specifics of a business crisis management response with a focus on the ostensive routines, artefacts, capabilities, personalities, performative actions of the CMT together with the CMT’s leadership, thereby addressing this gap. This will create an understanding of the causes of deviation and enable identification of strategies to minimise the deviation and thereby mitigate adverse business impacts. The importance of minimising the gap between the ostensive and the performative routines is vital and can be attributed to several areas. In establishing the framework, it is noted that within the crisis management response the crisis management plan (CMP) and its components form the ostensive routine and associated artefacts, which become the script for the CMT to follow during the response to the event. In this regard, the value of a well-designed crisis response program is that it brings to a company the ability to prepare and respond to any contingency.
As Pourkomaillian (2013) notes, when an incident occurs, success results when the business can prevent panic and chaos, thereby stopping the incident from morphing into a crisis. The basic doctrine of crisis management is to ensure that effective planning exists through: establishing crisis processes and procedures; preparation and response, including an understanding of the problem at hand; and the sensitivities of the market which can influence the response. These sensitivities include the government’s position, as they are a specific stakeholder and play an influential role in the successful resolution of any crisis. In the food manufacturing category, for example, the CMT needs to be cognisant of the fact that consumers are faced with a wide range of competitively priced products of consistently high quality. Each item must be safe, aesthetically pleasing, good tasting, and consistent with the product image. Variations within the same batch or between batches of a product must be kept to a minimum since consumers interpret such variations as an indication of production faults. A further relevant factor, as the literature indicates, is that “overall, consumer attitudes towards food safety in general differ according to demographic and socio-economic factors such as gender, age, educational level and economic status” (Wilcock, Pun, Khanona, & Aung, 2006, p. 58).

Within the crisis response, the ostensive routine encapsulates the scripts and artefacts designed to guide the actions of the CMT, and the performative aspect incorporates the manner of the execution of the routines by the members of the CMT and includes the leadership approach. Theoretically, the script is ingrained into team member behaviour through frequent rehearsal. This can be described as the ongoing education, training and process validation that participants of the crisis team undergo to ensure that, during an actual crisis, their performance is aligned with the script. An inconsistency between the script, the rehearsals, and the actual performative routine leads to added complexity in the crisis response with potentially adverse consequences.
### Table 2 – Examples of Crises across Industry Sectors

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<td><strong>Pharmaceutical</strong></td>
<td>▪ The thalidomide disaster is one of the darkest episodes in pharmaceutical research history. The drug, licensed in 1956 for prescription free over the counter sale, was marketed as a mild sleeping pill safe even for pregnant women with an added ‘benefit’ of reducing morning sickness. However, it caused thousands of babies worldwide to be born with malformed limbs. The damage was revealed in 1962 (Plumb, 1962).&lt;br&gt;▪ The Tylenol cyanide contamination case in 1982 killed seven people, impacted 100 million consumers and reportedly cost the company US$150 million. It is often cited as a best practice crisis response (Davis, 2011; Dilenschneider, 2007; Stateman, 2008).</td>
</tr>
<tr>
<td><strong>FMCG</strong></td>
<td>▪ The 2009 baby formula scandal in China, which is noteworthy for its sheer magnitude and the scale of consequences: the extent of harm to consumers – with a total of 296,000 children falling ill after consuming milk products contaminated with melamine, including six fatalities (BBC News Report, 2009); and loss of some US$113 million by New Zealand based Fonterra, the world’s largest international trader of dairy products. Guilt by association was extensive (Gao, Knight, Zhang, &amp; Mather, 2013, p. 1045).&lt;br&gt;▪ In 2014, Wal-Mart and McDonalds in China were embroiled in scandals relating to the sale and consumption of meat products. This impacted sales growth as consumers lost faith and trust in their systems. (Jourdan, 2014)</td>
</tr>
<tr>
<td><strong>Motor Industry</strong></td>
<td>▪ The Ford Pinto case of the early 1970’s was based on Ford’s 1968 decision to introduce a subcompact car and produce it domestically. This crisis involved the explosion of multiple vehicles due to a defective fuel system design that Ford was aware of. The case led to the debate of many issues, most focussed on the use by Ford of a cost-benefit analysis and the ethics surrounding its decision not to upgrade the fuel system based on this analysis (Lee, 1998).&lt;br&gt;▪ The 2010 Toyota recall was linked to ineffective early warning analysis and poor crisis management, resulting in a cost of between US$2 billion and US$3 billion in addition to a regulatory fine of US$1.2 billion (Feng, 2010, p. 473; Kalb, 2012; Prez &amp; Prokupecz, 2014; Trudell &amp; Hagiwara, 2014).&lt;br&gt;▪ The 2015 VW emissions scandal, in which VW attempted to beat the regulatory testing system by installing a diesel-emissions ‘defeat device’ impacted over 11 million vehicles globally with the financial cost topping $30M USD with significant reputation damage also experienced. (Riley, 2017)</td>
</tr>
<tr>
<td><strong>Oil and Gas</strong></td>
<td>▪ In July 1988 an explosion occurred on the Piper Alpha oil and gas platform in the North Sea. Within seconds a major un-stabilised crude-oil fire resulted, and the lower parts of the platform were engulfed in smoke. The subsequent fire resulted in the loss of 167 lives in what was the world’s worst offshore accident (Drysdale &amp; Sylvester-Evans, 1998).&lt;br&gt;▪ The 2010 BP Deepwater Horizon disaster resulted in employee deaths and widespread environmental damage. It was linked to a culture that failed to adequately address safety risks, a poor crisis response lacking urgency, accuracy, empathy and honesty. The financial impact amounted to US$44 billion (Chazan, Faucon, &amp; Casselman, 2010; Gilbert &amp; Kent, 2015).</td>
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CMTs therefore, are trained to react in a specific way. Issues are created when the gap between the performative routine and the ostensive routine grows too large, or, following a theatrical metaphor, where the actors forget what they have practiced in rehearsals causing them to ad lib and create their own script.

Understanding the cause of the deviation will enable the identification of strategies to enhance CMT performance and avoid pitfalls that can cause a CMT to become either dysfunctional or misaligned in response. This has a flow-on effect of minimising the impact of the crisis, “with the outcome of potentially improving a company's reputation for honesty and accountability, exhibited through the nature of their response” (Morgan, 2012, p. 7). This in turn can contribute to the learning phase of crisis management to ensure that the warning signals that assist in preventing future crises are identified and not overlooked (Veil, 2011). This point is critical as the importance of learning has been closely linked to the ability of a business or organisation to prevent further crises (Smith, 1990; Turner, 1976; Turner, 1978) and thereby enhance their overall business resilience.

1.3 The Focus of the Empirical Data Collection

The aetiology of deviation between script and production forms the basis of this research. It sets out to address the question of how ostensive and performative routines interact in a crisis management situation and what factors contribute to deviations from the routines? This research adopted a case study approach and leverages empirical data collected from several sources, including:

- observations of both training simulations and live activations of CMTs;
- interviews with subject matter experts in crisis management across industry sectors; and
- analysis of the response to specific historical incidents through case review and analysis from created vignettes.
This combination of these varied data sources enabled the evaluation and the confirmation of the driving forces behind the occurrence of the deviation. That enabled the inquiry to evaluate if the deviation was due to factors such as having routines and artefacts (e.g. the CMP) but not maintaining and modifying the routines in response to lessons learned from an incident or, alternatively, whether it is the CMT members, their selection, leadership skills and team dynamics, that create the deviation. It is important to stress from the outset that the research focused on the behaviours and actions observed, rather than on the nature of the crisis incident per se, as the type of incident does not affect whether or not a deviation occurs. It examined the initial and ongoing team response and dynamics and discusses how script deviation, because of varying factors, can adversely impact the overall response.

While crisis management approaches across business are similar in construct, this research accessed and evaluated the crisis response routines adopted within TCCS, which incorporates The Coca-Cola Company (TCCC) and its franchise partners, following the Belgium crisis of 1999. This case is summarised in Table 3 with a full study of the crisis contained in appendix C. Coca-Cola is, of course, a major and high-profile international brand. That noted its approach to risk management and crisis management is typical of a major corporate. Hence, it is a representative case, and informative of the experiences of similar corporates (Yin, 2009, p. 48). Thus, it provided a compelling context for the present work. Further, it is arguable that, whilst the case is not necessarily ‘revelatory’, the depth of access afforded to the researcher remains comparatively rare in research of this nature, especially given the sensitive subject matter (Yin, 2009), further adding to the compelling context for this research. The project specifically focused on the components as implemented by TCCC’s franchise-bottling partner Coca-Cola Hellenic Bottling Company (CCHBC), and as aligned with the relevant TCCC Business Unit – Central and Eastern Europe. The detailed rationale for examining this system is laid out in the methodology, however at this point it can be noted that the global reach and scale of this business and the impact that a crisis can have on people, product, and reputation make this a compelling area on which to focus the research.
To establish the context of the business model, TCCC is the trademark owner of brands including Coca-Cola, Sprite, PowerAde and Minute Maid. TCCC operates under a bottling franchise arrangement and has operations in over 200 countries. In short, TCCC as the brand owner is the marketer of the brands and supplies the concentrate for the production of the products. The bottling partners are responsible for the manufacturing, sales and distribution of products to customers and ultimately to the consumer. As the brand owner, TCCC has developed the system-wide crisis response arrangements. This crisis response model is commonly referred to as Incident Management and Crisis Resolution (IMCR) and involves dual participation in the crisis team by members of TCCC and their bottling partners on either a country or a regional basis.

At the time of writing, CCHBC is TCCS’s third largest franchise-bottling partner operating in twenty-eight markets across Europe, Eastern Europe, Russia, and Africa. CCHBC is a FTSE 100 company and annually sells approximately two billion-unit cases of product. The company has nineteen CMTs covering the twenty-eight markets in which they operate. This is supplemented by a Group CMT of which the researcher is the chairperson and leader.

This research collected empirical data relating to process deviation during a crisis response and adopted a case study approach to address the question how do ostensive and performative routines interact in a crisis management situation in the business environment and what factors contribute to deviations from the routines? In answering this question, a theory was created and validated the reason(s) for this deviation. As part of theory development, the research examined the data to assess whether the deviation occurred because the crisis routines, artefacts and training are either considered inappropriate in their current form, so not fit for purpose, or are not modified and enhanced in response to lessons learned during a post-incident review.

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1 A unit case equals 5.678 litres or 24 servings of 8 US fluid ounces and is the typical volume measurement in TCCS.
Table 3 – The Coca-Cola Crisis of 1999

<table>
<thead>
<tr>
<th>FMCG Coca-Cola Specific</th>
<th>The Belgium Crisis of 1999 – Establishing a compelling context</th>
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<tr>
<td></td>
<td>Background:</td>
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<td></td>
<td>▪ The crisis commenced on the 8th of June 1999 when reports were</td>
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<td></td>
<td>received that several school children at a middle school in Belgium</td>
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<td></td>
<td>had fallen ill after consuming Coca-Cola. The problem was</td>
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<td></td>
<td>exacerbated two days later when school children in Bruges also</td>
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<td></td>
<td>reported illness after consuming Coca-Cola. The crisis for the</td>
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<td></td>
<td>companies involved expanded due to an ineffective initial response</td>
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<td></td>
<td>with the Governments from France and Spain accusing the</td>
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<td>companies of selling tainted product.</td>
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<td>Issues:</td>
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<td></td>
<td>▪ Critically, it was noted that TCCS focused on the wrong problem and</td>
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<td></td>
<td>failed to follow the basic doctrines of crisis management including a</td>
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<td></td>
<td>lack of: early warning indicators; crisis routines; preparation of the</td>
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<td></td>
<td>crisis teams; and understanding of local market sensitivities (Mitroff,</td>
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<td></td>
<td>2002, pp. 1 - 2). The companies were also criticised for a lack of</td>
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<td></td>
<td>acceptance of responsibility for the creation of the incident which</td>
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<td></td>
<td>impact consumer and public trust.</td>
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<td></td>
<td>Impact:</td>
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<td></td>
<td>▪ The cost of not getting this crisis response right from the outset was</td>
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<td>a product recall that saw approximately 17 million-unit cases of</td>
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<td></td>
<td>Coca-Cola and other soft drinks being recalled and destroyed. The</td>
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<td>estimated cost of the crisis was US$103 million (Nemery, Fischler,</td>
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<td>Lessons Learned</td>
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<td></td>
<td>▪ Crisis management processes and routines must be in place to guide</td>
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<td></td>
<td>the overarching crisis response. Importantly, these ostensive routines must be understood and followed.</td>
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<tr>
<td></td>
<td>▪ Crisis management teams need to undergo regular practice to ensure that they understand the routines and apply them effectively.</td>
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<td></td>
<td>▪ Understanding the perceptions and positions of the multiple stakeholders enables tailored responses to be developed.</td>
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Appendix A: Full Belgian case study

The research also evaluated whether the deviation is due to an ineffective approach to the structure, leadership and coordination of the CMT: that is, actors are not cast correctly, so that their behaviour and skill sets contribute to the deviation. Based on the findings from the triangulation analysis, which incorporated both manual and automated coding approaches, the research was able to answer the question posed and confirmed a theory to explain the
deviation, recommend specific courses of action to remediate the identified issues, and recommend avenues for additional courses of research.

The research concluded that the central cause of process deviation is linked to the team structure, its operating dynamics, and leadership. There are ample arguments and evidence that the ostensive routines and associated artefacts do not drive, nor actively contribute to, the process deviations. It will be shown that the subject matter experts specifically noted the value of the tools and their effectiveness in their current form. This does not mean that there is not an opportunity to revisit the routines and tools and enhance them as appropriate, rather this turns the focus to the human dynamic. Moreover, it firmly establishes the theory that process deviation is linked to human dynamics. That is, it is the actors and their casting as crisis team members, and the actions of the crisis leader, that are leading influences. The theory will illustrate that this is driven by various factors including experience, training, culture and personality type. Stemming from the answer to the question of how the ostensive and performative routines interact in a crisis management situation and what factors contribute to deviations from the routines, the theory notes that:

*Ostensive crisis routines and their related artefacts are robust. The process deviation from the ostensive routines during a crisis response occurs due to human dynamics which incorporate the behaviours of the members of the crisis team and the crisis leader. The core causes of deviation are ineffective crisis leadership and weaknesses in the crisis team structure.*

By leveraging the findings of this research, organisations have an opportunity, through the application of the remedial actions, to strengthen the capabilities of their crisis teams. The remedial actions discussed in this paper are already implemented in the day to day crisis management response in Coca-Cola HBC. In turn, they provide tangible business benefits through enhanced crisis management response capabilities. Additionally, there is a further benefit in that the research results can actively factor into the formal education process of
business leaders for as Fischbacher-Smith note “crisis management is generally underrepresented in the MBA curriculum and it is time to feature it more prominently” (Fischbacher-Smith & Fischbacher-Smith, 2012, p. 70). The research additionally validates that future studies, both in respect of understanding the cultural elements of the team structure and considering the personality type combination of a crisis team, would serve to further strengthen CMT responses and further contribute to the ongoing minimisation of process deviation.

1.4 Chapter Summary

This chapter introduced the conceptual foundations of the research within the business resilience stream and described that the research sets out to understand how ostensive and performative routines interact in a crisis management situation and what factors contribute to deviations from the routines. It commenced with an outline of the new business resilience paradigm. This paradigm has expanded its focus to preventative measures, integrating components such as enterprise risk management, and worked through the elements of the critical responsive mechanisms of crisis management. It reinforced the importance of crisis management and confirmed that crises can strike any industry, irrespective of sector, and there is a significant financial and reputational impact, and in some instances loss of life, when a crisis team does not get it right.

The research approach was outlined in that data would be obtained utilising a number of techniques including the observations of both training simulations and live activations of CMTs; interviews with subject matter experts in crisis management across industry sectors; and analysis of CMT responses to specific historical incidents through case review and analysis from created vignettes. In doing this the focus was on an examination of the processes, routines and
performance within the Coca-Cola system, a business model that is compelling due to its size, global reach and variety of brands.

Having established the context, the chapter moved to outline the specific focus of this research, that being the process deviation observed by crisis teams during their response to a situation. It established the point that this research is focused on answering the question of how the ostensive and performative routines interact in a crisis management situation and what factors contribute to deviations from the routines and is supported by theory development and creation, and that this is in contrast to the process of theory testing. Having established the causes of the process deviation, the research strived to identify strategies to minimise that process deviation. Overall crisis management capabilities would be strengthened through application of recommendations to minimise deviation.

Chapter 2 will examine the extant literature on the interrelated streams of crisis management, risk management, business resilience and the link to ostensive and performative routines and provide the theoretical framing for this research.
Chapter 2 – LITERATURE REVIEW AND THEORETICAL FRAMING

2.1 Introduction

This research specifically focuses on crisis management and the deviation in ostensive and performative routines that can exist during the management of a crisis. Its foundations lie in four interrelated research streams: crisis management; ostensive and performative routines; risk management and business resilience. While it can be argued that the streams of crisis management, risk management and business resilience, despite their interrelationship are divergent in nature, it is acknowledged that there exists a debate in respect of this divergence of streams.

Central to the debate is the relationship between risk and uncertainty (Fischbacher-Smith, 2016b). The debate incorporates the position that crises are essentially uncertain events where there is little or no predictive capability associated with their onset. Additionally, one view is that risk assessments, *per se*, are effective for predicting random failures in engineered systems but do not always help in dealing with the role of human actors in the process. The contrary view is that the risk management agenda has expanded from its roots in technical analysis to become a cornerstone of good governance (Fischbacher-Smith, 2011, 2016a; Power, 2009; Power, Scheytt, Soin, & Sahlin, 2009).

Arguments also exist that resilience can be seen to have three main perspectives, those outlined above, with the addition of business continuity.
framed as an element of crisis management that has an “incubation” phase (Turner, 1976), an operational phase and a crisis of legitimation (Smith, 1990). It is arguable that business continuity sits at the nexus of the operational crisis and the crisis of legitimation phase. Conversely in the debate, it can be argued that crises are not always uncertain events, but can be predicted through using risk management and responded to through activities such as proactive security mechanisms. These are just two proactive elements of business resilience through which crises can be avoided or more efficiently managed. Bringing into the discussion the role that ostensive and performative routines play for each of these core elements illustrates further the complexities that exist.

The complexity of the interrelated themes and the criticality of ensuring that process deviation is minimised effectively opens up multiple literature streams. To establish the contextual nature of the themes and validate the knowledge gap, the extant literature for these four streams is reviewed. This review focuses firstly on the literature as it relates to the field of crisis management. It is noted that much research has been conducted in this field starting with the early work of Turner (1976) and covers a diverse range of concepts and ideas. In this study the crisis management literature is examined from the perspective of the relevant processes and routines; crisis team composition; team leadership and dynamics; and preparation and training.

The discussion then turns to the second theme: the field of routines and their utilisation as scripts and guides as a component of the crisis management response. The review then examines the concepts of enterprise risk management (ERM) and business resilience. In totality, they provide the theoretical architecture in which crisis management exists, incorporating and possessing three distinct phases: the precipitation phase (in which the potential for a crisis is created), the operational phase of the crisis, and the post-crisis phase (Smith, 1990), with the observations from the review illustrating fragmentation in crisis management research and validating the relevance of the research.
2.2 Crisis Management

‘Crisis’ is a term used to cover a wide range of bad and unwelcome things (Waring, 2013, p. 71) and what constitutes a crisis differs between organisations. An organisational crisis is commonly defined as a low probability, high impact event that is perceived by key stakeholders to threaten an organisation’s viability (Alas & Gao, 2010; Carmeli & Schaubroeck, 2008; Pearson & Clair, 1998). Others see a crisis as an event that pushes a company to its limits.

“In other words a crisis should challenge the organisation’s abilities to cope with the task demands of the event within its existing resource and capability structures and without additional damage occurring” (Fischbacher-Smith, 2014b, p. 427).

Numerous events can trigger a crisis. They can emerge from an identified risk eventuating or from a system or process failure. Pearson and Sommer (2011, p. 27) observed that “organizational crises can seem to strike and disappear instantaneously, like a bolt of lightning, or they can build momentum and effect slowly, like a glacier.” They can arise through poor management as the actual cause (Turner, 1994) and there are also occasions when stakeholders consider a management response to a minor incident is inappropriate. This turns what might be a normal business issue into an institutional crisis.

The following subsections present the extant crisis management literature through the lens of processes and routines; crisis team composition; team leadership and dynamics; and preparation and training. The review confirms that while crisis management research is extensive and has focused on a variety of elements, past work has at time been described as fragmented (Bundy et al., 2016) and does not address the discrepancy between ostensive and performative routines during the activation of a CMT response within a business context.
2.2.1 Processes and Routines

Mitroff et al examined multiple crisis management responses and noted that

“crisis prepared companies develop plans to handle a larger number and wider variety of emergencies than they have faced in the past” (Mitroff & Alpaslan, 2003, p. 110), and

“through a deliberate set of integrated and interrelated series of actions, these organizations make major crises far less likely to occur” (Mitroff & Pauchant, 1990, p. 79).

These interrelated actions would arguably include ERM as a preventative element in avoiding or mitigating a potential crisis. Within this context, artefacts provide the framework for a structured response to situations that potentially impact the viability of a business. Without the routines and artefacts (preventative or reactive), a business can overrate its capabilities with response perceptions not matching reality (Ritchey, 2011). In the field of resilience preparedness, processes and routines provide structure as this “encompasses activities as diverse as risk and preparedness analysis, preparedness planning, resource allocation, training and exercising, deployment in real events and feedback” together with “early warning, evacuation, stocking equipment and establishing appropriate governance and coordination structures” (Staupe-Delgado & Kruke, 2017, p. 214). Arguments also exist as to whether it is a process and routine versus the result, which is more important, indicating that deviation can perhaps be tolerated in order to attain a result. This latter concept ignores the fact that “preparedness is a continuous phenomenon consisting of drills, exercises, adjustments of risk and preparedness analyses and preparedness plans” (Staupe-Delgado & Kruke, 2017, p. 215), which all require structure and are best served when processes and routines are followed.

Processes, routines and plans are therefore critical in guiding crisis management response and building capability, and the degree to which
institutions are encoded in an actors’ stock of practical knowledge can influence how they communicate, enact power, and determine what behaviours to sanction and reward (Barley & Tolbert, 1997, p. 98). That said, Smits and Ezzat (2003) argue that how well the action is implemented depends upon the quality of the plan and its support structures. Aligned to this is the readiness of the responsible parties to behave in accordance with the plan.

Research has also determined that the ostensive part of the routine is often conceptualised as narratives, or in effect stories, of how work is done, implying the connections between actors, actions, and understanding at different levels (Salvato & Rerup, 2011). Therefore, preparation and response strategies need to be multifaceted and to incorporate elements including routines that identify potential issues (ERM); processes and tools to help manage and resolve situations (e.g. emergency response); and a mechanism for post crisis evaluation that enables modifications to be made to the routines and/or behaviours. From this it is evident that to avoid crisis occurrences, businesses need the

“ability to focus on many issues at the same time, analysing and interpreting the complex, often contradictory information that arises. It is only by moving from attention stability to attention vividness that organizations can start to pick up early warning signals and transform those signals into preventive actions” (Rerup, 2012, p. 14).

Without these processes that traverse all aspects of the response, including such areas as media management, the response of a business may be perceived as slow, ineffective and potentially insincere. This was illustrated earlier in this thesis with reference to the Belgium incident (Table 3) and is reinforced in the inadequate crisis management arrangements activated by businesses during events such as the Chinese infant milk powder case in 2009 (Custance et al., 2012; Kim & Choi, 2014).

The artefacts linked to an ostensive routine enable a crisis team to avoid these pitfalls by providing the guidance, framework and lens on which to base
informed action. Rerup and Feldman (2011), in their examination of routines and their impact on organisational change, recognised the complexity of the relationship between routines and schemata and the role of trial and error learning processes. It could be deduced from this that trial and error in crisis management builds capability via experience. Hence, the longevity of CMT membership becomes important as it enhances trust and skills. Supporting the concept of team longevity is the tendency for the routines to improve over time both during performances and between performances. Within each performance or iteration of a pattern of action, every action is dependent on the prior actions (Pentland, Feldman, Becker, & Liu, 2012), which are linked to the interpretation of the routine.

Performance and practice are critical to ensuring effective utilisation and review of the routine. Spillane argued that practice creates and recreates the ostensive aspect “though Feldman and Pentland (2003) confined their discussion to organizational routines, ostensive and performative distinctions can be applied to other aspects of the situation, including structures and tools.” (Spillane, 2008, p. 148)

This again drives the focus towards team performance, dynamics, training and leadership in respect of the cause of deviation from routines.

2.2.2 Team Composition

A crisis team comprises “individuals who share interactions and experiences in decision making” (Sommer & Pearson, 2007, p. 1243). At the same time it is “an assembly of people - a chemically unstable mixture with its own personality, history and emotional dynamic” (Robert & Lajtha, 2002, p. 187). When operational, the CMT will probably find itself subjected to unusual levels of fear, stress and fatigue often working in a dynamic environment under suboptimal conditions” (Lapierre et al., 2015, p. 195). Ultimately "a crisis management team is a cross functional group of people within the organization who have been designated to handle the crisis" (King, 2002, p. 63) and bring it to a successful resolution. King (2002) further concluded that not all teams are effective, and
cohesion can be influenced by factors including time, information resources, procedural conflict, poor leadership, and prior interactions. All of these if not managed appropriately impact the level of trust. In many cases the team can be seen to comprise subject matter experts, and this increases pressure as the “experts are expected to successfully attain vaguely defined goals in the face of uncertainty, time pressure, high stakes, team and organizational constraints, and shifting conditions” (Kahneman & Klein, 2009, p. 516).

These are elements that are often present during a crisis response. Ensuring the correct team composition exists greatly assists the capability of the team to resolve the issue. It enables a team to avoid groupthink (Janis, 1972) while ensuring cohesiveness. This cohesiveness in a team is important as it has been found to exert considerable influence on the quality of the discussions (Callaway & Esser, 1984). A structured approach to compositions is required as often managers are simply thrust into a CMT role due to the position that they hold, rather than any specific experience in high-pressure crisis response situations. This can create issues as complex decisions will need to be made within the containment or damage control phase of a crisis response the manager will be required to make some of the “most chaotic, time-pressured, and critical decisions of the entire crisis life cycle” (Dionne, Gooty, Yammarino, & Sayama, 2018, p. 97). In this context crisis management experience becomes critical.

When considering the attributes of the managers who will comprise the team, Smits and Ezzat (2003) argue that the CMT members must be dependable, calm, self-confident and assertive, with personalities that have the ability to influence perception and decision-making. Further, Crandall et al (2014, p. 108) argue that the members must have the ability to work as a team; be able to work under pressure; have a tolerance of ambiguity; and possess good listening and verbal skills, which, when present and combined, strengthen the CMT’s capability.
Weick’s investigation (1993) into the 1949 Mann Gulch Disaster\(^2\) examined the role of decision making during a crisis where the actions and routines did not align in a high pressure situation to expectations, with devastating consequences. This was attributed to the thinking processes and the role of the crisis leader. It should be noted that while the role of the CMT is to think broadly the team needs to ensure that process is followed as “recovery lies not in thinking then doing, but in thinking while doing and in thinking by doing” (Weick, 2002). In respect of team composition, the role of ‘bricoleurs’ has been discussed, with Weick (1993) arguing that they are important in crisis management as they remain creative under pressure, precisely as they routinely act in chaotic conditions and attain order in chaos. They are also perceived as innovative in their approach. It could, however, be asked what role the bricoleur plays in the team: are they a member or a leader? Is a high level of innovation perhaps counterproductive to minimising process deviation, or can the two elements reside together? It could be argued that, as will be seen in this research, the latter applies.

The concept of sensemaking also enters the equation in respect to the team’s capabilities from a preventative and response perspective. Maitlis and Soneshein (2010, p. 554) support the argument of Weick that “enacted sensemaking can provide the basis of a crisis prevention and management ideology by leveraging a kind of human involvement in systems that is rooted in shared beliefs about self-control and voluntary cooperation”. This allows individuals in the view of Weick, to “think about crises in ways that highlight their own actions and decisions as determinants of the conditions they want to prevent” (Weick, 1988, p. 316) with this becoming a powerful way in which to support the management of a crisis. That said, it is argued that “collective

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\(^2\) The Mann Gulch Disaster occurred in 1949 and involved a wildfire in Montana in the United States. Fifteen smokejumpers parachuted into the area to fight the fire. Unexpected high wind changes caused a sudden expansion of the fire, cutting off the men’s route and resulting in the deaths of thirteen. The research examined routines, decisions and actions taken.
sensemaking in crisis is near impossible in the absence of social processes that lead to collective mindfulness, the enriched collective awareness that facilitates the ‘construction, discovery, and correction of unexpected events capable of escalation” (Maitlis & Sonenshein, 2010, p. 557).

Mallak (1998), in examining adaptive behaviour during crises and the importance of having individuals who respond quickly to change, confirmed the role of the bricoleur, as for them a crisis is a normal operating condition and they have the ability to react accordingly. A diverse range of ideas and information inputs is vital. Hence, the broader composition of the team is important as no one person can solve the problem alone (Barton & Sutcliffe, 2010). Here lies the importance of sense making, which is linked to contextual rationality. Leaders need to ensure that they develop resilient groups capable of four things: improvisation; wisdom; respectful interaction; and communication (Weick, 1996). The type of organisation can also influence the team composition; for example, in High Reliability Organisations (HROs) the environment can make a team vulnerable to error if their attention is scattered, distracted or unstable (La Porte, 1996; La Porte & Consolini, 1991). These negative traits can predispose people to estimate incorrectly, misunderstand, and mis-specify the nature of the situation that they face (Schulman, 2004). Additionally, their continuous exposure to potential crises means that, figuratively speaking, their next failure to meet aspirations could also be their last-ever action (Levinthal & Rerup, 2006).

These arguments reinforce the importance of getting the composition right and here the teams’ personalities and dynamics, together with the leadership displayed, play a key role.

2.2.3 Team Leadership and Dynamics

Leadership is a critical element of crisis management and this incorporates the business decision relating to the leader of the crisis team (Alas & Gao, 2010). The criticality stems from the fact that the “difference between triumph and tragedy hinges upon the ability to produce and revise (i.e. plausible, reasonable,
coherent, actionable, justifiable) assessments of highly unusual, ambiguous and dynamic situations” (Boin, 't Hart, Stern, & Sundelius, 2005, p. 19). From a leadership perspective, studies have examined a variety of aspects. These include the role that the company leader, be that Chairman or CEO, plays during a crisis response and why they may fail to provide the necessary leadership and prioritisation to prevent and prepare for a crisis (Caywood & Englehart, 2003; Cesta, Cortellessa, & De Benedictis, 2014; Halverson, Murphy, & Riggio, 2004; Jaques, 2012). The leadership theme incorporates understanding the attributes that create the environment in which leaders fail to identify the emerging risks that can lead to a crisis (Sheaffer & Brender-Ilan, 2014) and this can include the role that the hubris syndrome in a company’s CEO or senior leadership plays in leading to haphazard decision making (Owen & Davidson, 2009). Indeed Owen concluded that “collective hubris may well prove to be a contributing factor in the risk taking behind the explosion on the Deepwater Horizon drilling rig” (Owen, 2011) and at the Royal Bank of Scotland (RBS) under its chief executive prior to it having to be bailed out by the British taxpayer in 2008 (Owen, 2011). Therefore, hubris certainly is a leadership attribute to be avoided.

The literature also examined the nature of leader selection and how the unpredictability of a crisis, due to the number of risk components involved, requires different skill sets to day to day management. As Fischbacher-Smith proposed to their students when discussing crisis leadership, “do you think that those who manage well under conditions of steady state, but who are untested in conditions of crisis will cope when the crises arises?” (Fischbacher-Smith & Fischbacher-Smith, 2012, p. 63). This is an interesting point. Evaluating and understanding the individual leader is fundamental with factors such as a leaders’ openness to receive differing perspectives and allowing their team to voice their observations and ideas being an important theme (Martínez - Córcoles, 2018, p. 240).

In this vein, it can be argued “that both the qualities of the individual and environmental factors in which they operate are important elements in the leadership equation. Finally, leaders who are expected to perform as crisis
managers need to be trained and experienced in crisis management, and should not be placed into such positions without applicable training and assessment” (Surugiu & Surugiu, 2012, p. 305). This is a concept supported by Dionne who comments that “the importance of having active and engaged leaders during a crisis cannot be understated. Because proficient decision making is driven by expert or experience-based knowledge” (Dionne et al., 2018, p. 104).

Other researchers, such as Cesta et al (2014), focus on leadership, the impact on the decision-making process and the importance that training and rehearsals play in enhancing response capabilities. In his findings, King (2007) noted that a crisis leader must display a sense of confidence, while at the same time expressing empathy with those who were hurt or potentially harmed by the crisis. Conversely, Teo et al (Teo, Lee, & Lim, 2017, p. 136) presented the argument that “leadership is critical in an organizational crisis and is often conceptualized as the process of exercising social influence.” They contend that:

“during periods of high uncertainty, charismatic leadership behaviour, which communicates determination, provides mission and a vision while articulating high performance expectations, is predictive of organizational performance, compared to transactional leadership behaviour which focuses on setting goals and tasks and ensuring compliance.” (2017, p. 138)

What these themes assert is that the context of leadership will vary depending on the interpretation of the role. In many cases the leader of the organisation is the CEO and will be called on to be the spokesperson of the business, not the leader of the crisis team. The reality is that the operational crisis leader is a senior manager that is suitably trained and skilled, who is focused on the process, goals and completion of the associated tasks and who is pivotal in guiding the company spokesperson. This is supported by the findings of Dionne et al (2018, p. 117), who concluded that “the best person for addressing a crisis may not be a formal leader holding the highest position of authority, but rather a widely acknowledged expert in a specific type of crisis response or crisis management that has established critical relationships with several key
constituents”. What is required is a transformational leader who can motivate the team to exceed expectations rather than a passive leader who shirks the responsibility of nurturing the team (LePine, Buckman, Crawford, & Methot, 2011).

In a different vein, the literature also illustrates that the perspective of crisis management and the perception of who should be a crisis leader and the skills they should possess can be influenced by the nature of the businesses surveyed. By way of example, Mikušová & Čopíková’s research centred on understanding the expectations of small business owners (their survey pool) regarding the skills required by a crisis manager. The researchers emphasised that the managers surveyed often had no theoretical knowledge or practical experience with crisis management and therefore decided intuitively on the skills sets. This saw the skills categorised in managerial, functional and social streams and with performance expectations being centred against managerial competencies such as financial acumen. This showed an expectation that the crisis manager is a doer with managerial skills such as finance, rather than a leader (Mikušová & Čopíková, 2016, p. 174). So, while processes and routines exist to be managed, the critical leadership element was not seen as relevant to small business owners.

Research into team dynamics discusses a variety of areas relevant to the CMT structure. Roberts and O’Reilly (1974) discussed communication failures and pinpointed three potential culprits: trust; influence; and mobility. This is particularly relevant in the structure and response of the CMT, since they found that with “high trust groups there was less socially generated uncertainty and more efficient problem solving.” Weick (1988) explored the relevance of sense making by the team in crisis situations and argued that commitment, capacity and expectations affect sense making during a crisis and the manner of interpretation can impact the severity of the crisis itself. “Capacity and response repertoire affect crisis perception, because people see those events and they feel they have the capacity to do something about. As capacities change, so do perceptions and actions.” (Weick, 1988, p. 311) Additionally, due
to the lack of cognitive schema, some people must wait until a crisis occurs before they can diagnose a problem, rather than be in a position to detect a potential problem as part of early warning.

The team’s skills and dynamics also influence the approach adopted toward the issue at hand. Belbin (1993) discussed the importance of team dynamics, and identified a series of nine key roles in a team and argued that the balance between roles reflected in team composition is a factor in determining success. Studies have examined the potential that Belbin’s team roles can play in the composition of crisis teams (Smith, 2000) and the fact that some roles can actually undertake a primary and secondary role thereby reducing the size of the team (Fisher, Hunter, & Macrosson, 1998). While Belbin’s approach may have relevance in enhancing a team’s dynamics it is however noted, that the Belbin framework is not without criticism (Furnham, Steele, & Pendleton, 1993). In respect of the team membership it was observed that the relative influence of different members may change as a function of the tasks that they are performing or the demands that are directed toward the team. Additionally, while the adoption of Belbin’s approach in a ‘normal’ business context may have relevance, for a crisis team this is difficult as other factors influence CMT construct.

Mathieu et al (Mathieu, Tannenbaum, Donsbach, & Alliger, 2013, p. 146) commented that early in their lifecycle teams benefited from a composition that had low average but moderate variance in members’ uncertainty avoidance. Then later in the lifecycles, teams benefited more from a combination of high average and moderate variability of members’ relationship orientation, which illustrated the importance of relationships overtime as this translates to enhancing trust through experience. Weick and Sutcliffe (2006) contend that when individuals are paying attention to failure, simplification and resilience mindfulness occurs. Mindfulness, in turn, broadens environmental scanning, generates interpretations that are more context relevant, and produces decision behaviour that is more discriminating. They found that “those who manifest mindfulness engage in thought patterns that allow them to make a larger
number of currently relevant, more precise distinctions" (Weick & Sutcliffe, 2006, p. 516), which are critical in the team’s evaluation of information. This poses a question as to which personality traits most effectively enable the application of mindfulness, which in turn may mitigate process deviation?

Building on this, Yin and Jing (2014) note that the broader the nature of a crisis, the more complex and dynamic the environmental pressure becomes, and that this can impact the team by dissuading them from careful thinking, communication and judgement. "When coordination ties deteriorate, people must make their own sense of what is occurring. The collapse of collective awareness causes a chain reaction, further disturbing regularities and rendering individual rational thinking and efforts useless at best, and counterproductive at worst" (Yin & Jing, 2014, p. 102).

Sommer and Pearson (2007) provide further insight into the complexities faced by a CMT identifying that often, in a crisis, conventional decision making no longer suffices. The team may need to not only follow process and routines but to do so by applying creative and novel decisions. A creative decision is defined as a decision that is both a novel contribution and of operational value. A novel decision is unusual, uncommon, unconventional, or different from past decisions (Sommer & Pearson, 2007). Pearson (2002), in studying blueprinting for crisis management, canvassed the themes relating to crisis prepared organisations, including the role of training and response capabilities, and with Claire (1997) outlined the enduring interest in the role of leadership within a CMT. The studies concluded that leadership within the context of team operations was a critical area of future study and suggested that further research might focus on whether the leadership skills, strategies and approaches required during a crisis mirror those that are effective during normal operations. That aligns to the current area of study, which examines the role of team composition and leadership as it relates to the issue of process deviation by a CMT. It also raised a specific question in respect of the personality types that are best suited to perform not only the crisis response role but also the critical role of the crisis leader. Ultimately, it is difficult to
dispute the impact of weak leadership and its translation to ineffective team performance within a crisis context (Owen, 2008, 2011; Smith, 1990, 2000; Turner, 1976). That said, it is not the only factor that contributes to the cause of process deviation (Fischbacher-Smith, 2016a; Fischbacher-Smith, 2017) with the following section delving into the role that planning, preparation and training can play.

2.2.4 Planning, Preparation and Training

As the business environment has been rendered more complex, the need to focus on crisis management readiness has heightened. These are trends that will continue. Carmeli and Schaubroeck (2008, p. 178) argue that in order “to have and maintain an advantageous position in a complex and high-velocity environment, the top management team (TMT) needs to build up a repertoire of responses that will ensure the organisation’s viability under all plausible circumstances”. Labas (2017, p. 78) notes that “organizational crisis preparedness has strategic importance and significant influence on business, which is mainly the result of an adequate existing crisis preparedness culture and firm’s values.” He concludes:

“lots of firms are crisis prone and a few are truly crisis prepared. The results obtained stress the importance of adequately implementing organizational crisis preparedness, while also outlining that firms should take action. Accordingly, in order to succeed, the implementation of organizational crisis preparedness should be top managers’ strategic responsibility and they, in turn, should be able to train and motivate their employees” (Labas, 2017, p. 78).

The existence of threats to competitiveness and business survival however, may or may not be sufficient stimuli to cause business leaders to ‘think the unthinkable’. That said, it is acknowledged that preparation is the backbone of a solid response program. Robert and Latjtha (2002, p. 187) support this and argue that:
“the key to effective crisis management lies not so much with the writing of detailed manuals...as with structured and continuous learning processes designed to equip key managers with the capabilities, flexibility and confidence to deal with sudden and unexpected problems/events”.

Additionally, they contended that plans and routines should be subject to ongoing review to ensure that they remain relevant. This updating should be enriched with feedback from experience and through simulation exercises. Organisational learning is critical to the review process and Bundy et al (2016, p. 1678) note that, while research remains equivocal on the ability of organisations to learn from a crisis, there is evidence that learning is highly conditional and driven by multi-level phenomenon. Irrespective of the complexity, post crisis learning is a core activity and is a “rather straightforward process: the causes of the crisis event are revealed through evaluation, after which flaws are addressed by the implementation of changes” (Broekema, Kleef, & Steen, 2017, p. 328). Broekema et al (2017, p. 329) also noted that sensemaking is a central part of returning to normality and the “shared understanding of the causes of events and what changes should be made to prevent future crises might facilitate the effective implementation of crisis lessons”.

The importance of the routine of learning post a crisis can be traced back to the work of Turner. He noted that “when the immediate effects [of a disaster] have subsided, it becomes possible to move toward something like a full cultural readjustment...of beliefs, norms and precautions, making them compatible with the newly gained understanding of the world” (Turner, 1976 p. 382). The importance rests in the fact that a crisis creates an environment that challenges existing routines and management thinking. It provides the opportunity for reflection however it is observed that full cultural review and readjustment is an ideal that is rarely achieved (Smith & Elliott, 2007). The barriers to post crisis learning are varied and can include a belief that catastrophic events are unique in nature and restricted in both space and time. Additionally, the organisations learning culture may give rise to single loop learning and in this scenario while some learning occurs “it tends to occur within the dominant
organizational paradigm which may well have given rise to the conditions for
the failure in the first place” (Smith & Elliott, 2007, p. 532).

Acknowledging the importance of learning, it is critical that facilitated learning
exists within the structured processes and routines. Here again the crisis leader
plays the pivotal role in ensuring that team members are engaged and take part
in the learning process. In this post “crisis revision stage, when normality has
been restored, there is time for reflection and more structural changes can be
implemented, such as changes in protocols” (Broekema et al., 2017, p. 335).
When conducting the learning, it is critical to ensure the correct climate exists.
This is because during a crisis things go wrong and therefore post crisis “the
learning climate should lead workers to feel accepted and respected rather than
fearing blame, punishment or ridicule engaging workers in a process of self-
diagnoses” (Margaryan, Littlejohn, & Lukic, 2018, p. 59).

Building on the themes discussed, in the planning and preparation stage the
importance of the plan and the artefacts becomes clear since they provide
structure for those who are working under duress. Training and rehearsals
through simulations are the keys to ensuring that a CMT is prepared to manage
a crisis, as the team gains awareness of decision strategies that enhance the
response to potential crises and their associated pressure (Roberts, 1990;
Sommer & Pearson, 2007). While practice does not necessarily make perfect, “it
does seem to lead to clearer thinking and smoother action under duress”
(Pearson et al., 1997, p. 53). In respect of the ostensive routines and the role of
plans, it has been contended that “the purpose of crisis management is not to
produce a set of plans, it is to prepare the organization to think creatively”
(Pearson & Mitroff, 1993, p. 59). The practice of the ostensive routine and the
delivery of the required performance in times of pressure therefore becomes
critical, hence the importance of training.

Research does examine deviation in training, yet only in the context of
preparation; that is, how companies actually prepare and why they deviate from
best practice in this space (Kovoor-Misra, Zammuto, & Mitroff, 2000). The study
by Kovoor-Misra et al (2000) did not extend to an evaluation of CMT
performance or the failure to utilise the artefacts created to support the
ostensive routine. Acknowledging that the crisis management plan and its
components form the artefacts supporting the ostensive routine, their use must
become ingrained into team member behaviour through regular rehearsal. This
is ongoing education, training and process validation that participants on the
crisis team undergo in order to ensure that, during a crisis, their performance is
aligned to the script.

In the area of planning and preparation Pearson and Mitroff (1993) highlighted
the need for proactive (e.g. signal detection) and reactive (e.g. containment
strategies) components of crisis management. Signal detection ensures that
signs of danger are identified (Rerup, 2006), for – irrespective of how weak the
signals may be – there are often processes that can be enacted to aid in the
detection of the event (Rerup, 2012), and “through a deliberate set of integrated
and interrelated series of actions...these organizations make major crisis far less
likely to occur” (Mitroff & Pauchant, 1990, p. 79).

While Elsubbaugh et al (2004) agree that training is at the core of preparation,
they challenge Mitroff’s focus on the importance of early warning indicators.
They argue that this position fails to acknowledge the importance of the
interrelationship between risk, resilience and crisis management and associated
preventative strategies that can stop a crisis from eventuating. Counter
research, though, has reinforced the importance of signals detection. This
includes such elements as indicators of consumer safety, and how this
complements strategies to ensure that managers are well prepared, with the
skills and practice to act effectively (Pearson, 2002, 2012). Additionally it
discusses culture as a concept specifically linked to the role of enabling,
enacting and elaborating to drive cultural change and imbed practices (Vogus,
Sutcliffe, & Weick, 2010).
2.3 Ostensive and Performative Routines

This research examined the interaction of ostensive and performative routines in a crisis response and the factors contributing to deviation. With this establishing the context at the outset it is observed that the relevance of pre-determined routines and plans in crisis response is an issue that has been debated within the literature. In the context of complexity, the potential for systems emergence is high (Goldstein, 1999; Gribbin, 2005; Holland, 2000) and it is therefore the ability of the crisis management team to adapt that is critical. This is also influenced by the complexity and dynamics of the operational environment and the socio-technical system that comprise the location of the crisis. Within this context it is still pertinent to examine the extant literature regarding ostensive and performative routines and discuss this within the context of the crisis response.

Feldman and Pentland (2003) first raised the concept of ostensive and performative aspects in the creation and execution of routines. Ostensive refers to the abstract pattern of actions, whilst performative refers to the specific instances of action, actors, time and place. It is arguable that the ostensive and performative aspects are not part of the definition of routines, as a routine is defined by repetitive, recognisable patterns of interdependent actions (Feldman & Pentland, 2003; Mante & Sydow, 2007; Pentland et al., 2010). While routines are a fundamental part of how organisations go about accomplishing their objectives, it is the actual behavioural patterns that constitute routines, rather than the managerially desired patterns of behaviour. As Feldman and Pentland (2003, p. 102) note “the ostensive aspect of the routine is the idea; the performative aspect, the enactment. Both aspects are necessary to constitute what we understand to be the routine.” Additionally, they argue that the:

“ostensive aspect of a routine can serve as a template for behaviour... and is why routines are sometimes likened to scripts. But it serves only as a guide; it cannot specify the details of the performance, which people must choose.” (2003, p. 106)
Howard-Grenville (2005, p. 618) built on this theme, arguing that:

“the ostensive aspect acts as a guide for what actions should be taken in performing a routine and can also account for actions already taken. It signifies what is distinctive about a set of activities that can be called a routine. Conversely, the performance of a routine recreates, maintains, and may modify the ostensive aspect of the routine.”

Additionally, it has been argued that the actual processes generate performance outcomes, with Becker et al (2005) positioning Feldman and Pentland’s (2003) argument that the abstract understandings and the specific performances, as well as artefacts, are rarely precisely aligned; rather, they are interrelated in complex ways. For instance, the performative and ostensive aspects of routines are mutually constitutive, with the ostensive guiding the performance but not determining the result. The performative aspect of routines can be best understood as inherently improvisational, thus it is impossible to specify routines in a complete way (Becker et al., 2005, p. 781). As Aggerholm et al (2014) argue, the performative aspect is essential for the creation and recreation of the ostensive aspect, while the ostensive aspect constrains and enables the performative. Power and position of the different inter-dependent occupational groups are influential regarding organisational resilience: the actors improvise, adapt and redefine roles as members of an occupational group to defend their occupational territory and their expertise (Tillement, 2009). It is also argued that one cannot assume that the processes as designed have been objectively created and fit for purpose. It is argued that by definition the routines will not be designed to deal with emergent conditions that are by definition, unforeseen or alternatively they can contain and reflect latent errors that have been embedded by those who designed the response (Reason, 1990, 1997; Smith, 2005).

On the topic of deviation, the literature confirms that human nature is such that performative deviation from the documented routine can occur and there is extensive research theorising the rationale for deviation (Feldman, 2000;
Feldman & Pentland, 2003). For example Feldman (2000) studied why individuals do not always carry out routines as they are intended. She concluded that people changed their enactment of routines in the day-to-day application because the routine was not achieving as intended or the outcome wished for; it was producing unintended or undesirable outcomes; or because outcomes revealed new possibilities. In each case, people either sought to repair a routine, or strove to improve it to match their aspirations. Beyond simple trial-and-error learning and adjustment, Feldman (2000) further argued, such changes could lead to ongoing, continuous change in how the routine is used across an organisation (Parmigiani & Howard-Grenville, 2011 p.435).

Deviation from a routine therefore may not in itself be a negative but can create positive benefits when improvements in the routine eventuate. This is the critical criterion: improvements in the ostensive routines must occur. Additionally, deviation can be also referred to as improvised behaviour and as Martinez concluded in his study on crisis leadership “improvised behaviour will only reveal its appropriateness in its aftermath. Improvisation could be defined as the unplanned, just-in-time behavior used to achieve the best possible result” (Martínez - Córcoles, 2018, p. 241). This research adopts elements of a theatrical metaphor as it delves into aspects of business life in terms of how activities are carried out and ordered with organisational members enacting roles, interpreting scripts and working to respond to scenes and plots (Cornelissen & Werner, 2014, p. 715). The relevance is that “in the case of the ‘organization as theatre’ metaphor, the aspectual or structural similarity that is constructed between the concepts of ‘organization’ and ‘theatre’ in their respective domains is that within both entities activities are carried out and statements are made that have a performative quality” (Cornelissen & Werner, 2014, p. 714). In their work, Barley and Tolbert defined scripts as "observable, recurrent activities and patterns of interaction characteristic of a particular setting" (Barley & Tolbert, 1997, p. 100) that mediate between the level of the field and the level of action. When actors perform the script by playing their roles within a plot, their behavior elicits reciprocal scripted behavior from others and this pattern of interaction confirms the organizational routine. If
actors vary from the script, the routine is disrupted and may change. Barley argues that the "actors' behaviors and interpretations give life to these abstractions...but since acts of communication, power, and moral sanction necessarily entail the vagaries of interaction, some slippage will occur between the institutional template and the exigencies of daily life" (Barley, 1986, p. 80).

It is evident that the routines are critical for providing a framework, script and lens for the actors and that the institution is reliant on the actors interpretation. Barley et al (1997, p. 102) determined that actions created deviation and “in many cases, however, enactment does not involve awareness or intentionality: actors simply behave according to their perception of the way things are.” This is particularly relevant where an individual lacks knowledge or experience, or both, since it enables ‘thinking before acting’ rather than ‘acting before thinking’. There are obviously individual characteristics associated with a propensity to individual action in crisis situations, where the actors may lack knowledge or experience, or both, or fail to enter into dialogue or follow process when their habits and routines are interrupted (Vera, Crossan, Rerup, & Werner, 2014).

Howard-Grenville (2005) also analysed the intentions of the actors and the manner in which activities are performed in order to understand the way in which intentions can influence the routines and the way that routines can be changed over time. The process “conceptualizes routines as ongoing accomplishments, and it extends it by identifying how actors and contexts shape both individual performances of routines and contribute to their persistence or change over time” (Howard-Grenville, 2005, p. 618). The focus though becomes the importance of deviation and its ultimate impact for it has been argued that “while idiosyncratic deviations from script occur, perhaps even with some frequency, such random deviations are apt to have only passing impact on social arrangements” (Barley & Tolbert, 1997, p. 102). However, while valid in respect to innovation through script alterations this position does not address the importance of potential negative consequences of this immediate response.
Conversely, Iannacci and Hatzaras (2012) contend that the actors have the option of altering the script. They argue that studies by Feldman and Pentland had a major shortcoming, as the work forced scholars to accept a single level of reality which is ‘flat’ and ‘horizontal’, thus diminishing the existence of emergent properties. Therefore, while the ostensive aspects of routines fall within the realm of the actual, the performative aspects fall into an empirical domain. While participants may use the ostensive aspect to guide actions and account for what they are doing, and to refer to patterns of activity that would otherwise be incomprehensible, the performative aspect creates, maintains and modifies the ostensive aspect in practice (Dionysiou & Tsoukas, 2013). The reactions of the participants are therefore situated in institutional, organisational and personal contexts. Their actions are motivated by will and intention with the organisational routine created through a reciprocal interactional relationship between the performative and ostensive aspects. Sonenshein (2016), in his study on the utilisations of routines in a retail chain, discussed the relationship of creativity (a form of deviation) and routines for “although scholars typically view creativity and routines as opposing concepts, a routine dynamics perspective helps recast these concepts as a duality. Recognizing their mutual constitution, and theorizing the dynamics and mechanisms that explain their relationship, illustrates how creativity is as much a part of routines as routines are a part of creativity” (Sonenshein, 2016, p. 756). Therefore, if deviation is a form of creativity Sonenshein argues that “adopting a dynamic ontology of routines allows scholars to notice and elaborate on how routines and creativity are not inherently contradictory because creativity is endogenous to and an outcome of routine performances” (2016, p. 753).

While creativity can play a role, and indeed is important in managing through complex scenarios, other scholars argue the importance of the relationship between role switching and adaption. For example Rosales (2014) argued that routines are upheld and underpinned through two main practices: role switching and role adaptation. By changing roles, individuals manage to maintain routines through the fulfilment of activities that correspond to others. Adjusting role actions enables individuals to perform the routine while taking
situational factors into account. The present research suggests that looking at organisational routines from a role-based perspective could enhance our understanding of the micro-foundations of organisational routines. In turn, routine theory has brought an important contribution to our understanding of organisations. In particular, it has denoted a renewed interest in organised action after a long period during which action, activity and work were neglected (Barley & Kunda 2001).

Researchers had in some cases focused their attention on decision systems; information processing; actors’ subjective involvement and motivation; formal and informal rules; market and competition; or technologies. Research in routines also addresses the key role of past experience and organisational history in the development of the present forms of action and competences and

“last but not least it illustrates the complex epistemic nature of action, by showing that acts are not only performed transformations of the world, but also social, historical and cultural meaningful signs, and recognizable segments of complex, recognizable and purposeful social patterns of action.” (Lorino, 2014, p. 1).

Further delving into the area of performative aspects of routines, a new stream of organisational research has emerged in recent years which draws on the notion of mindfulness (Levinthal & Rerup, 2006). At the same time, there is a long-standing body of work that emphasises the role of routine-driven, or less-mindful, behaviour. Levinthal and Rerup (2006) attempt in their research to connect these two seemingly disparate literatures, arguing that at a performative level important elements of less-mindful processes are necessary elements underlying mindfulness. Here they note important elements of mindfulness that underlie less-mindful behaviour, in particular the role of mindfulness in interpreting one’s context so as to identify what constitutes appropriate action in a given circumstance, and in interpreting outcomes that form the basis for processes of reinforcement learning. Essentially, mindfulness is seen as a state of active awareness characterized by the continual creation
and refinement of categories, openness to new information, and a willingness to view contexts from multiple perspectives (Weick, Sutcliffe, & Obstfeld, 1999). The actors consider the context in which they find themselves and ask what behaviours are suited to that context (Pentland & Feldman, 2005) and how they relate to the application of the performance against the routine.

Arguably though, during crisis response the success of the program rests with structure and execution. Here the ostensive routines and supporting artefacts provide the framework and script from which a CMT operates and strives for ‘positive adjustment’. So, while the ostensive routines may, and in fact should, change over time through structured post crisis reviews, it is critical that changes do not occur during the course of managing the response, for the result can be confusion, misdirection and excessive deviation. An actual neglect of processes by the performers can also exacerbate what is initially a routine business incident and turn it into a crisis. This point is reinforced by Fischbacher-Smith (D) and Fischbacher-Smith (M) who highlighted “the central role that management can play in the generation of crisis events. A crisis is not simply about the operational phase or even the processes by which turnaround processes occur but it is a function of the core activities of management.” (Fischbacher-Smith & Fischbacher-Smith, 2016, p. 935)

Debate extends to the role that artefacts play, with one position being that the artefacts such as rules and procedures are sometimes mistaken for the ostensive aspect of the routine. Artefacts such as checklists can provide a convenient trace of the performative, but it is argued that the ostensive and performative aspect of the routines are recursively related; while the artefacts are distinct from the routine and therefore artefact-centred, assumptions about design are not suited to the design of organisational routines (Pentland & Feldman, 2008). A counter-argument brings artefacts to the centre of the routine as they are not passive black boxes; rather they perform a role in directing the actor’s performance. The more successful performative programs manage to utilise an array of materials and tools to create a functional environment, and where the performative elements struggle with competing
agencies, artefacts play a key role (D'Adderio, 2010). This is relevant in the study of ostensive routines during crisis response as artefacts provide the program's direction and guidance for the actors. However, they are often underutilised or not utilised at all, creating script deviation. When evaluating a routine, Gawande (2011, p. 79) notes, we need to acknowledge that a

"routine requires balancing a number of virtues: freedom and discipline, craft and protocol, specialized ability and group collaboration. And for checklists to help achieve the balance, they have to take two almost opposing forms. They supply a set of checks to ensure that the stupid but critical stuff is not overlooked, and they ensure another set of checks to ensure people talk and coordinate and accept responsibility while nonetheless being left the power to manage the nuances and unpredictability."

The importance of checklists as an artefact cannot be understated, since they can “have several objectives, including memory recall, standardization and regulation of processes and methodologies, providing a framework for evaluation or as a diagnostic tool” (Hales & Pronovost, 2006, p. 231). An additional element with the use of a checklists is the “cessation of activity if the steps of the process are not enacted have become cornerstones of the safety movement” (Seifert, 2009, p. 653). Regardless of the context in which the checklist is used, the goal is to control and reduce errors in any industry sector (Degani & Wiener, 1997). This was confirmed in a review of medical studies which found that safety checklists are effective tools for improving patient safety. “Their use has reduced mortality and morbidity. In addition, safety checklists strengthen compliance with guidelines, improve human factors, and reduce the incidence of adverse events” (Thomassen, Storesund, Søfteland, & Brattebø, 2014, p. 15).

In considering the checklist routine in the context of crisis management, it needs to be understood that the checklists will take two forms. They are the ‘DO-CONFIRM’ checklist style and the ‘READ-DO’ style (Gawande, 2011, p. 122).
With the former, the team during their routines perform their job from memory and experience. Then they stop, take a breath, and run the checklist to make sure everything that should be done has been done, and utilise this tool to trigger additional ideas. This is in contrast to the READ-DO checklist, which is akin to following a recipe (Gawande, 2011, p. 123). All steps must be taken in the correct sequence to ensure it is effective (e.g. the ostensive routine applied by a pilot). In the case of a crisis response, the confirmation approach holds specific relevance as it provides that critical stop and check point that enables a validation of the activities that are being performed. Therefore, the integration of a DO-CONFIRM checklist as an artefact in the crisis response program is essential to and supportive of the broader range of artefacts that are applied in a crisis response. Finally, it must be reinforced that, in the context of the routine,

“the checklist is only an aid and if it does not aid, then it is not right. If it is effective as an aid, we must be ready to embrace it while at all times remembering that the checklist must change over time while acknowledging that the checklist does not tell us what to do, rather it helps us to be as smart as possible at each step of the way, ensuring crucial information is on hand when needed” (Gawande, 2011, p. 167).

Ultimately, all these elements need to be factored into the consideration of the deviation from routines during crisis management.

2.4 Enterprise Risk Management

Risk management is a process that assists in the management of uncertainty with the downside elements minimised while the growth elements are maximised. The business operating environment remains complex, volatile and at times ambiguous, with the risks and hazards today being influenced by modernisation and are systemically intensified due to globalisation (Beck, 1992, p. 21). Industry observations have concluded that risk management plays a
pivotal role in resilience and this stems from it residing within a three-dimensional model that encompasses the risk operating environment and processes; governance and accountability structures; and best practice crisis preparedness and response (Gius, Mieszala, Panayiotou, & Poppensieker, 2018).

Enterprise risk management (ERM) is a program that enhances the traditional approaches of risk management and brings the management of risk out of functional silos, thereby enhancing the visibility not only of the risks themselves but also of the controls and management actions applied to manage those risks. It is argued that ERM leads to enhanced business management, organisational effectiveness, improved business performance and increased business value, and assists in the identification of potential crisis scenarios (Gates, Nicolas, & Walker, 2012; Gorzeń-Mitka, 2013). Ultimately, risk is inherent in any given situation and, while risks can be subjective in nature (Das & Teng, 2001), they stem from the business environment which establishes their contextual meaning. Risk is neither static nor objective, but is constantly constructed and negotiated (Gephart, Van Maanen, & Oberlechner, 2009). It is therefore argued that the risk management process assists in ensuring that managers have a system that guides them in the management of uncertainty and “predictable surprises”. It addresses an issue observed by Watkins et al whereby “lapses in recognition occur when leaders remain oblivious to an emerging threat or problem – a lack of attention that can plague even the most skilled executive” (Watkins & Bazerman, 2003, p. 75). Fischbacher-Smith et al (Fischbacher-Smith & Fischbacher-Smith, 2012, p. 56) confirm the importance on understanding the broader dynamics and risks by directing their students “to consider other concepts, such as regulatory gaps that create vulnerabilities to a crisis, the notion that crises incubate over time, and the extent to which organizational cultures may both incubate problems and constrain the capacity to learn from them” which are all sources of risk. Other ‘predictable surprises’ can stem from “bad management, reactive attitudes, not complying with rules, silo thinking and more. Organizations can collectively prepare much better for the unexpected through system-level thinking and activating partnerships with
stakeholders” (Prezelj & Doerfel, 2017, p. 120) with this stakeholder collaboration central to effective risk management.

Therefore, central to the success of an ERM program is ensuring that ostensive routines exist to provide the framework and structure and that the prevailing cultural mindset drives management from considering potential losses to thinking of potential gains, thus requiring a focus away from downside of uncertainty. This requires processes and routines that imbed ERM into plans supporting business growth (Alesi, 2008; Hubert, 2011). This is specifically relevant as risk is often not clearly identifiable and manageable, but emerges and is socially constructed (Renn, Jaeger, Rosa, & Webler, 1992) from “complex and necessarily incomplete processes of organizational attention involving information systems, incentive structures and narratives of explanation which are the source of further uncertainties” (Scheytt, Soin, Sahlin-Andersson, & Power, 2006, p. 1333).

There is however, ongoing debate as to the value of ERM. McShane et al (2011) contend that the abstract nature of ERM creates a perceived difficulty in quantifying value to business objectives. Power (2005) also expressed concern relating to some of the limitations associated with processes around operational (enterprise) risk management particularly the predictive validity of the various calculative practices used and their relevance in complex settings. That said, he contended that a focus on operational risk “invented new visibilities within risk management and new possibilities for intervention and control in the name of risk” (Power, 2005, p. 595). Fong et al (2011) further contended that, as ERM provides a clear linkage between risk and opportunity, it clearly assists in positioning a company to leverage competitive advantage, thus contributing to its resilience and ongoing viability. A flow-on effect is the ability to market the value of a risk and resilience program to underwriters, thereby leveraging significant savings in insurance premiums (Hoyt & Liebenberg, 2011), and thus minimising the cost of insurable risk. Additional benefits rest in the ability of the program to identify potential crisis scenarios, thus ensuring that the correct
ostensive routines and artefacts are implemented to manage the occurrence of the risk.

The ERM routines enable cataloguing of risks and the assessment of the risk parameters. This provides for policy development and formulation of "strategies and tactics for dealing with each potential crisis; and identifying who will be affected by them and devising effective communication channels to those who are affected" (Alas & Gao, 2010, p. 30). As Comer noted, an understanding of the risk management processes and their linkage to crisis response, helps with providing appreciation of "the illusiveness and elusiveness of certainty; to distinguish between what is truly unknowable, what is merely unknown, and what is known but ignored; and to be able to prepare cognitively, emotionally, and practically for and respond wisely, morally, and skillfully to whatever the future may bring" (Comer, 2012, p. 3).

Additionally, the concept of risk identification and the role of early warning are intertwined with crisis management. This is due to the fact that, proactively, businesses should minimise the occurrence of unexpected events which can become a threat to organisational survival if they exceed a certain temporal and spatial scale (Linnenluecke & Griffiths, 2010). “Effective threat recognition is, however, often inhibited by paradigm blindness, where decision makers deny the plausibility of particular threats and fail to develop appropriate mitigation strategies” (Fischbacher-Smith, 2014b, p. 432). ERM enables risk identification and mitigation to occur and can assist in addressing this blindness.

By imbedding ERM into the business resilience framework, businesses are able to find ways to deal with challenging issues not only prior to their occurrence, but once they have occurred in a crisis scenario and before their impacts escalate. Watkins and Bazerman support the argument that there is a critical linkage between risk management and crisis management as we need to be cognizant of the important sequence that involves “recognizing the threat, to making it a priority in the organization, to actually mobilizing the resources required to stop it” (2003, p. 74) and this awareness of potential crisis
situations through enterprise risk management is a critical first step. Processes and routines that support crisis response planning come to the fore at this time because while experience is a component of the mental map of what options the crisis or risk managers have when confronted with seemingly similar events, the ostensive routines are designed to guide them in the response. Furthermore, in these cases, sensemaking becomes a retrospective process in which the risk manager uses their past experiences to judge what makes sense in the future. Judging what constitutes a risk in situations including a crisis is not only the estimated chance of an event, as prescribed by the techno-scientific perspective, or our ability to cognitively identify events as risky, it is also informed by past and present knowledge of similar occurrences (Taarup-Esbensen, 2018, p. 7).

### 2.5 Business Resilience

The definition of terms that are used to share organisational behaviours are an important aspect in framing performance and ambiguity in definitions can impair performance (Fischbacher-Smith, 2017). Resilience is one of the concepts that has been difficult to define and can have a range of different meanings. By way of example, in engineering resilience is often framed in terms of the ability of a system to bounce back, whilst in systems biology resilience is framed in the terms of fitness of organisms and organisations to operate across different environments (Fischbacher-Smith, 2017). Cole (2015) proposed yet another variant to resilience arguing that in the business sense it incorporates strategic and operational elements. Strategically it focusses on diversifying to meet changing situations and incorporates the adjustments to business models and strategies. The operational element relates to an ability to function properly when adverse situations arise. Others, such as Marchese et al (2018) have adopted the definition of the United States National Research Council which defines resilience as “the ability to prepare and plan for, absorb, recover from and more successfully adapt to adverse events".
With this backdrop of complexity, in the business context, it is argued that in recent years the concept of business resilience has undergone a metamorphosis. Conventionally, the concept focused on responding to disruptive events and an organisation’s ability to survive in chaotic and turbulent times (Kantur & Iseri-Say, 2012). In fact, even today some researchers maintain this narrow focus. For example, Teo et al (2017, p. 136) contend that “resilience may be framed as the capacity to bounce back to a state of normality or as an emergent property, when an organization learns to adjust to adversity and, in the process, strengthens its capability to overcome future challenges.” Other research however focuses on a manager’s need to understand the overall structure and conduct of the organisation in order to combine both proactive and reactive business responses with affirmations that the proactive approach improves the ability of an organisation to deal with complexity and risk. (Normandin & Therrien, 2016, p. 108). Proactively, this includes enhancing and culturally embedding routines involving ERM and protective security measures aimed at minimising the likelihood of an adverse occurrence. These proactive measures are then closely aligned to reactive response and recovery strategies such as crisis management and business continuity planning (Burnard & Bhamra, 2011; Fischbacher-Smith & Fischbacher-Smith, 2009). This combination provides flexibility, with the ‘resilient organization’ having flexibility as opposed to rigidity, enabling it to respond more effectively than an organisation that has not embraced this approach (Tillement, 2009). An example of the new paradigm in action as adopted by CCHBC, is depicted in figure 1.

In their article Business Resilience: The best defense is a good offence, IBM (2009) also argue that true business resilience is more than simply having a good response to an adverse event. It starts with having an understanding of exactly what a business requires to survive unexpected events and plan for the future. Central to the reactive elements of business resilience and the continuity of services are several core elements. These include effective event identification which incorporates risk management; mitigation and control planning; business readiness; and the ability to respond effectively and in a timely manner to any
threat or opportunity through strong crisis management and business continuity. This combination of activities ensures that businesses are no longer working defensively; instead they have embraced a combined proactive and reactive business resilience approach. This enables them to leverage growth opportunities and respond to unexpected events promptly, more efficiently and in the most cost-effective manner. Prezelj and Doerfel build on this theme by noting that “resilience involves preparedness measures (planning, risk assessment, training and education), high-reliability organizing (collective capability to manage the unexpected), networking among stakeholders (planning and preparedness) and reactive measures” (Prezelj & Doerfel, 2017, p. 118).

Crisis management resides within the reactive measures category as do elements such as business continuity management and disaster recovery. Supporting the business resilience paradigm shift, Anderson (2014) argues that
businesses currently operate in an environment influenced by volatility, uncertainty, complexity and ambiguity. In response, a resilient business today needs to do several things, and do them well. In essence resilient businesses today need to: understand their risks and opportunities and proactively adapt business strategies to respond to changing circumstances; utilise an exceptional internal and external risk radar that enables them to detect changes in their operational environment; build strong internal and external functional collaborative networks that encourage the sharing of information; work proactively to minimise business exposures and leverage opportunity; and be able to respond rapidly and decisively to a crisis. This aligns with the position of Prezelj and Doerfel (2017) who have presented the proactive and reactive nature of business resilience in their research.

Drawing from the concepts listed, for the purpose of this research business resilience draws together a number of elements and is defined as the ability of a business to manage uncertainty and maintain positive adjustment under challenging conditions while enabling growth. This is achieved through the implementation of preparedness measures (e.g. ERM, security, training) and effective reactive measures (e.g. crisis management, business continuity, disaster recovery) that provide fundamental response mechanisms (Anderson, 2014; Prezelj & Doerfel, 2017; Sutcliffe & Vogus, 2003).

In the context of this research, it is the final component of business resilience relating to crisis management response that plays a pivotal role in protecting brands and reputation. As Caywood and Englewood (2003) argue, effective crisis management is critical as the reality is that bad things can and do happen to good companies.

“Media decry mistakes, missteps and misdeeds. Stakeholders fear the performance of their investments. Customers question loyalty … and in the end the outcomes are determined by how companies behave – by what they do, how they do it and when they do it.” (Caywood & Englehart, 2003, p. 2)
McCann et al (2009, p. 45) further support the alignment between business resilience and crisis management, concluding that “companies exhibiting higher levels of agility and resiliency are more competitive and profitable even with higher levels of turbulence.” Moreover, through critical planning that addresses business plan inaccuracies, an organisation’s risk management program automatically becomes integrated with crisis management and business continuity (Barton, Shenkir, & L. Walker, 2008), thereby strengthening resilience. Building on this theme the importance of assessing resilience before a crisis is identified contributes to effective crisis preparation, while evaluation after a crisis on all aspects of resilience can ensure that recovery measures will not cause an imbalance by placing the correct focus on the required elements and in the correct sequence (Normandin & Therrien, 2016, p. 116).

Finally, Sutcliffe and Vogus (2003) argue that resiliency is not a rare and extraordinary concept, but emerges from an ability to adapt and to maintain positive adjustments under challenging circumstances. Therefore, as businesses adapt to the complexities of a new environment, the resilient organisation is not just able to respond, but rather has the ability to align

“its strategy, operations, management systems, governance structure and decision support capabilities so that it can uncover and adjust to continually changing risks ... and create advantages over less adaptive competitors” (Starr, 2003).

2.6 Theoretical Framework

The theoretical framework and the interaction of the various elements existing within an organisation relevant to this study and the interconnectivity between the ostensive and performative routines together with the business resilience linkages are depicted in figure two. These linkages establish the core themes as discussed in the literature review and establish the question of how the ostensive and performative routines interact in a crisis management situation.
and what factors contribute to deviations from the routines. The framework depicts the time bound nature of organisational events and the influence created by the organisation’s dynamic external and internal environment on resilience, risk and crisis management. The upper section of the process flow illustrates the core preventative elements that support the creation of the state of business resilience. The lower section illustrates the flow as it relates to a crisis response with both process flows resulting in contextual change over time (T=Time).

Figure 2 – Theoretical Framework

The utilisation of time as a research lens enables consideration of both the organisational processes and practices together with temporally-centred phenomena such as timing, pace, change, and flow (Adam, 1995; Bluedorn & Denhardt, 1988). Evaluation of time can be complex with clock time dominating management thinking as it has been standardised in a way that makes it fundamental to industrial production. The difficulty in research is that an individual’s experience of time can be too complex for clock time to capture as an individual comprises a complex mixture of experiences and hence the
complexity of ‘real’ time (Adam, 1995). In the context of this research real time is utilised as a reference point against which activities are mapped.

The timing is influenced by variables along a time continuum with two temporal maps existing, one for the ‘normal’ state of play and the other for the ‘crisis’ situation. Irrespective of the stream, time plays a pivotal role in responding to organisational context changes (internal and external) and creating and modifying ostensive routines.

This discussion of the theoretical framework will delve firstly into the core preventative component within business resilience and that is the area of risk management. Secondly it discusses the dynamics as they relate to crisis management with time dynamics having an influence in both streams.

Commencing with the top stream, risk management is integrated within business resilience and relates to the routines and processes that enable an organisation to effectively manage uncertainty. This involves utilising routines within ERM that minimise the downside of uncertainty while leveraging the upside which embrace identified growth opportunities. As illustrated in the literature review, the risk management process is designed to assist in ensuring that managers have a system that guides them in the management of uncertainty and predictable surprises. In a formalised manner, it addresses an issue observed by Watkins et al whereby “lapses in recognition occur when leaders remain oblivious to an emerging threat or problem – a lack of attention that can plague even the most skilled executive” (Watkins & Bazerman, 2003, p. 75).

As illustrated, the emphasis is placed in this proactive and preventative area on ensuring that the ostensive routines continued to remain relevant to the business by evaluating their suitability against the organisation’s performance over time and this establishes the connectivity to crisis management. Time in this scenario is influenced by both the organisation’s dynamic external and internal contexts and the routines will be modified over time to reflect changes in the operational context. The time variant between t1 and t3 will be driven by multiple factors emanating from external and internal organisational contexts.
which are generally existent over a longer period of time (e.g. 2 – 3 years) and can influence the strategic direction of the organisation.

Within the business resilience paradigm and with strong correlation to risk management, resides the reactive element of crisis management with its ostensive elements guiding the response, with performance, and the linkage to the script, dependent on various artefacts existing and being applied correctly. Crisis management resides in the parallel stream that comes to the fore when there is a requirement to activate the process. Relevant to this research, the crisis management stream and response will be triggered in the event of a crisis event and as outlined earlier, numerous events can trigger a crisis. They can eventuate through the occurrence of an identified risk, from a system or process failure, through poor management (Turner, 1994) or on occasions when stakeholders consider a management response to a minor incident inappropriate, thereby turning what might be a normal business issue into an institutional crisis. Pearson and Sommer (2011, p. 27) observed that “organizational crises can seem to strike and disappear instantaneously, like a bolt of lightning, or they can build momentum and effect slowly, like a glacier.”

This latter point illustrates the core time dynamics associated with a crisis. The time frame that exists between t4 and t5 can indeed be quite limited and the nature of the performative response will influence the time that exists to move from t5 to t6. A deviation from the routines has the potential to extend the time continuum with an increased time in resolving the crisis, having the potential to influence the degree to which organisational performance is adversely impacted over the short and long term. Ultimately the resolution of the crisis and the evaluation of the learnings will drive change in both risk and crisis management. This is important as the evaluation after a crisis on all aspects of resilience can ensure that recovery measures will not cause an imbalance by placing the correct focus on the required corrective elements and in the correct sequence.

Overall, within the framework the routines provide the foundation for preparation and the response. The ostensive routines sit within the overarching
business resilience framework and guide the responses across the various elements. The ostensive routines established in an organisation and integrated in risk management enable it to respond to the dynamics of the external environment and the context that this establishes for the business. Ostensive routines exist to guide the performative elements, so in this case, when a crisis arises, a team has the processes and artefacts which will enable them to navigate the waters around the response. As noted earlier, over time these will need to be modified to ensure that the ostensive routines retain their relevance not only for the internal dynamics of the organisation, but against the external dynamic factors that have the potential to impact the objectives of the organisation over time and from experience. Taken in total, the proactive function of risk management coupled with an organisation’s response to a crisis directly support business resilience and hence viability.

The review of the extant literature across the divergent yet interrelated fields of business resilience, enterprise risk management, ostensive and performative routines, and crisis management, indicated that while extensive work has been undertaken gaps remain. It has been illustrated that while in this specific crisis management space of focus, work exists in the field of crisis team composition, crisis team leadership, and training there is no connectivity to the specific application and interaction of the ostensive routines during a crisis. Returning then to the summation of Bundy et al. (2016) in respect to crisis management research it is reinforced that they concluded that while work on crisis leadership and teams exist, the work is often criticised for a lack of specificity and consideration to the role of resource dependence in crisis situations.

They conclude that research on actions and processes would further inform the research on crisis management (Bundy et al., 2016). This observation confirms the existence of a knowledge gap and therefore the analysis of how ostensive and performative routines interact in a crisis management situation and the factors contributing to process deviation from the routines in a business context would further inform the research in the crisis management field. In addition to informing the subject research the practical application of findings and
recommendations in this field will assist organisations in strengthening their approach to crisis management. Therefore, this gap has created the fundamental research focus to understand how the ostensive and performative routines interact in a crisis management situation and what factors contribute to deviations from the routines.

Lastly it is argued that this is an important gap to address as ultimately, crisis management is effective when operations are resumed, losses minimised, and key learnings occur, with these lessons being transferred to the management of future incidents. This will occur most effectively when the team composition is correct and the existing management routines are executed correctly thereby minimising process deviation.

2.7 Chapter Summary

This chapter evaluated the extant literature and presented the theoretical framework within which this research would be conducted. This literature was subject to ongoing review throughout the research period from January 2014 to December 2018. In respect of the literature, it embraced an evaluation of data across multiple related streams starting with crisis management, then ostensive and performative routines, to risk management and business resilience.

It commenced with a deep dive into the central theme of crisis management. Within this frame of reference there was a specific focus on several core elements. These were: crisis management processes and routines; team composition and dynamics; crisis leadership; and crisis planning and preparation. What is evident is that crisis management research can be fragmented in nature and that the specific research question in this study had not been addressed, creating a knowledge gap. Within the extant literature there are of course beliefs and doubts amongst scholars as to the cause of the phenomenon observed, and the objective of this research is ultimately to remove that doubt. That said, for any researcher both belief and doubt are
necessary for creative action and “the complexity of the world ensures that the interplay between belief and doubt is continuous” (Locke, Golden-Biddle, & Feldman, 2008, p. 909).

From crisis management the focus shifted to the literature relating to ostensive and performative routines which form a basis for the evaluation of process deviations. This included a discussion of the role of artefacts before moving to review of the enterprise risk management and business resilience streams.

Having provided the review of the literature, the chapter moved to address the theoretical framework. Here it was established that the ostensive routines sit within the overarching business resilience framework and guide the responses across the various elements. The ostensive routines are critical, for they provide the foundation that enables an organisation to respond to the dynamics of their external environment. This chapter validated that deviation from process during a crisis response can have an adverse impact on the overall management of the situation. Herein lies the critical focus of this research: minimising performative deviation with the result of strengthening crisis response while mitigating adverse consequences. Ultimately, the literature review has confirmed a gap in the crisis management theory as it relates to the elements of performative deviation from the ostensive crisis management routines.

The debate in this research revolves around business crisis teams, their leadership and the reasons for deviations from routines during a crisis response. While extensive research exists across each of the interrelated streams of crisis management; ostensive and performative routines; enterprise risk management and business resilience, it is obvious that the bulk of the research undertaken to date, while focusing on various elements, is incapable of informing the specifics of this debate. The objective here is to understand the fundamental elements contributing to interaction of the crisis team members with the ostensive routines and to confirm the causes for the process deviation in a business environment. This will be achieved by answering the question of how the ostensive and performative routines interact in a crisis management
situation and what factors contribute to deviations from the routines and suggesting possible relationships which should be further explored.

With the research background established, the next chapter will detail the research methodology adopted.
Chapter 3 – RESEARCH METHODOLOGY

3.1 Introduction

This chapter outlines the methodology that was adopted for this research which sets out to investigate elements of the crisis management paradigm that embrace the routines and performances that contribute to an effective crisis response. The paradigm and its outcome are adversely impacted when, as observed in the business context, deviation from process occurs. As explored in the literature review, crisis management research in the business context has been described as fragmented at times and while research on process deviation and the role of leadership exists, this specific and critical element of deviation in the business application has not been addressed.

This research aims to examine the root causes for this process deviation during a business crisis management response and is qualitative in nature. In summary, it explores the contributing factors relating to two interrelated themes. These are the nature and role played by the routines and artefacts and their application together with an analysis of the composition of the CMT, and the causal effect that can be created by the team composition and its leadership.

The research utilises a case study approach that incorporates interviews with subject matter experts; observations of actual crisis activations and simulations; and the observations of the researcher through his experiences which are documented in the form of vignettes, used commonly in observational research.
(Bennett, 2009). On this last point of vignettes, researcher experience is important as “the qualitative researcher attempts to be fair, balanced, and conscientious in taking account of multiple perspectives, interests, and realities that will exist within any social setting” (Amis & Silk, 2008, p. 464) and this had applicability in this research. The research was also shaped through the researcher’s understanding of the topic at hand through direct interaction, observation and commentary. In doing so it is important to stress that Amis and Silk observed that a researcher's background inevitably shapes the approaches that they take to their “work, philosophically, methodologically, and presentationally” (Amis & Silk, 2008, p. 458). This can result in research bias and a strategy is utilised to manage this risk.

The methodology is broken down into the following subsections:

- Subsection 3.2 discusses the fundamental and philosophical characteristics of logical positivism, relativism, pragmatism and realism and presents the argument for the researcher's critical realism approach;
- Subsection 3.3 provides an overview of the case study research methodology that was utilised. This section includes the for rationale for the case study of TCCS and CCHBC and the reasons why they offered a compelling context within which to investigate the research question;
- Subsection 3.4 discusses the case study approach in detail and outlines the various phases of the data collection. This includes the utilisation of an introductory case study analysis; crisis simulation and response observations (teams in training and in live activation); crisis management subject matter expert (SME) interviews; the role and use of vignettes for illustrating the researcher's observations; and the potential role of personality identification through the use of mechanisms such as Myers Briggs Type Indicator;
- Subsection 3.5 addresses the concept of data reliability and the strategies to manage and mitigate the risk of researcher coding bias. This involved the utilisation of Leximancer, a software program, which enabled an unbiased analysis of the data to occur. This ensured that additional rigour was established;
Subsection 3.6 discusses the process of manual data coding and thematic analysis. This coding was conducted by the researcher, in addition to the automated process with Leximancer, based on critical feedback received on an earlier version of the thesis. The concept and use of research triangulation is also addressed.

3.2 The Case for the Critical Realist Approach

The research philosophy encapsulates the researcher’s belief with respect to the way in which data which is linked to a specific phenomenon should be gathered, analysed and used. At the outset it is important to present the rationale for a case study research model and validate the critical realist approach adopted by the researcher in this study. In order to do this a comparison of the characteristics of Logical Positivism, Relativism, Pragmatism and Realism are presented. They draw on the views of Van den Ven (2007, p. 39) as expressed in Engaged Scholarship: A Guide for Organizational and Social Research. Working through the various characteristics as discussed by Van den Ven this section will outline the definitions, ontology, and epistemology of the various streams. It will establish and validate that realism was the relevant philosophical space for this research due to an underlying linkage to the case study approach.

Logical Positivism is described as a movement emanating from the Vienna Circle and Berlin School and was inspired by empiricism, instrumentalism and positivism. With respect to ontology, it sees reality as the empirical world and epistemologically seeks correspondence between statements and reality through inductive verification or deductive falsification. In this sphere the researcher is independent from the empirical world by being a positive observer with the researcher’s language being value free and providing a means with which to mirror the empirical world.

Relativism is a contemporary intellectual movement that is characterised by scepticism around the foundations of Western philosophy where ontologically the approach is subjective, and reality is socially constructed. Driven by the
incommensurability of discourses there is no privileged epistemology. The language is self-referential in nature with the researcher being in the world and unable to stand outside of their socio-linguistic constructs to view objectively.

With respect to pragmatism it is a philosophical movement that is characterised by the relation of theory and praxis, and specifically with the predetermined outcomes of an inquiry. It is subjective in nature and dependent on practical consequences, with reality placing limitations and constraints on actions. In this realm the researcher has a prior framework that influences their perception of the world with the language used being actionable to meet the researcher’s goals and objectives.

The fourth field is realism, which captures the approach taken in this thesis. It is a movement characterised by the existence of a mind-independent reality and the ability of a concept to capture aspects of reality. Ontologically, reality exists independent of cognition with realism being subjectivist in nature as there is no predefined or predetermined methodology to evaluate the veracity of knowledge. Importantly, the researcher has prior cognitive frameworks that influence perceptions of the world utilising language that is not theory neutral but describes, sometimes partially, the underlying structure and mechanics of the phenomenon. In this study the researcher adopts a critical realist approach specifically, as prior cognitive and practical awareness of crisis management influences the perspective of the world and the phenomenon that is evaluated in order to answer the research question.

Building on this theme and validating the critical realist approach, Van den Ven (2007, p. 70) argues that our individual understanding of the real world is limited and that tangible processes are easier to understand than both reflective and social processes. Therefore, observations and data are theory laden, either implicitly or explicitly and the analysis and evaluation techniques apply theoretical and methodological triangulation and coding (manual and automatic) to create the additional knowledge base. Through the utilisation of the case study approach and researching through a critical realist lens, this research contributes to the existing literature and addresses a specific
knowledge gap through “an evolutionary growth of knowledge” (Van den Ven, 2007, p. 70) as it relates specifically to the field of crisis management response in a business context.

### 3.3 The Argument for a Case Study Approach

The method of building theories from case studies is an acknowledged research strategy that involves using one or more cases or lines of information to create theoretical constructs, propositions and theory from case-based empirical evidence (Eisenhardt & Graebner, 2007). It is considered by Yin (2009, p. 11) to be the preferred inquiry method when examining contemporary events within a real-life context and where the behaviours and issues cannot be manipulated. That is, the observations and raw data occur without interference. The strategy is specifically pertinent in this research, as it seeks to explain ‘how’ and ‘why’ the observed behaviour of process deviation during crisis response occurs. In this respect, the case study approach enables the researcher to deal with a range of evidence incorporating documents, such as the material from specialist interviews, and other artefacts including the tools and checklists, all of which are considered by Yin (Yin, 2009, p. 11) as material that extends beyond what might be available in a conventional historical study.

This case study focuses on the application of crisis response arrangements in the context of the TCCS and the leading role played by a key franchise bottling partner, CCHBC. TCCS specifically created a compelling research context for several reasons. These include the global reach of the company and its bottling partners with operations in over two hundred (200) countries; its high brand profile; an employee base of over seven hundred thousand (700,000); producing twenty (20) brands each worth a billion-dollars; and delivering 1.9 billion servings of their products globally daily (TCCC, 2018). For the system’s consumers, product quality and brand reputation are of critical importance. Intentional product tampering, threats or accidental product quality issues have the potential to erode consumer trust and damage brand equity. As illustrated in the Belgian crisis (table 2), when a crisis is managed poorly it becomes high
profile with social, reputation and financial implications (US$103 million in 1999 terms). The Belgium crisis indeed establishes further contextual importance as it provided for the researcher a unique point in time from which the existing ostensive processes and routines were designed and implemented post crisis. These ostensive processes and routines have become the focus of this research as they are the routines from which deviation has occurred during crisis activation. This is reflective of the theoretical framework and the time-based nature of reviewing ostensive routines or altering processes as a consequence of a crisis.

With respect to CCHBC, as a major franchise bottling partner it has a franchise obligation to align with the crisis program and has been actively engaged in enhancing business resilience capabilities since 2014. The programs that have been implemented, including risk and crisis management elements have received industry recognition in 2016 and 2018 (CCHBC, 2018). These multiple dynamics thus ensure that the case study context as it relates to TCCS and CCHBC is compelling at multiple levels and is highly relevant as a mechanism for investigating the research question. That said, the nature of the research and its findings have applicability across all industry sectors.

Returning to the case study rationale, at the foundation of rigorous or credible empirical research lies a strong grounding in the related literature. This enables the identification of research gaps and, from there, the development of the relevant research questions that address the gaps. The construction of the case study therefore requires the researcher to justify why this specific research area is better addressed by theory building, rather than theory testing, and requires the researcher to frame the research in terms of the importance of the phenomenon and the lack of relevant or plausible existing theory (Golden-Biddle & Locke, 2007). Having identified the gap through the literature review of crisis management material, for this is where the research can be fragmented, the decision was made to adopt a case study approach. While it was deemed the most appropriate approach, the challenge was to identify the number of cases and types of data sources that, when combined and analysed, contribute to
explaining the nature of the phenomenon. This required an expanded program for the collection of the empirical data, for while a single case study can richly describe the existence of a phenomenon (Siggelkow, 2007), a multiple case study strategy enables a ‘deep dive’ to occur, which provides a stronger basis for the theory building (Yin, 2009).

The decision to adopt a multiple case study approach in this instance was based less on the uniqueness of the given theory gap, but rather on the contribution to the theory development that will be extracted from the data through the analysis of multiple cases and approaches and answering the research question. In this instance the multiple case study approach was used to replicate or extend theory and to eliminate alternative explanations (Yin, 2009). Ultimately, the case study presents us with a ‘story’ to tell and the story is not a fictional account since it embraces real life data. At the front of the researcher's mind were multiple questions including: what are the distinctive features of this study, how does the collected data relate to the research questions, have new insights emerged (Yin, 2011, p. 183), and have these new insights marked the entire analytic process?

It was decided that a multi-faceted approach be adopted, as it provided the opportunity to review multiple elements of crisis management response, both within and external to the TCCS, thereby presenting a combination of data sources to evaluate. In this research, with multiple data points, observational techniques were critical with exposure to specific performances and the ability to obtain data through participant observations in the actual operational setting, be that a simulation or real case. There was also the opportunity to step back and look at the world from a critical realist perspective to further build the data repository. The unique ability to interview and question a range of subject matter experts provided the opportunity to deepen the understanding of what was occurring through close interaction with the researcher. The logic for this is that it is difficult to understand what contributes to the phenomenon if a researcher is not engaging with, or observing, the subjects. At the end of the day it is the performer of a routine that ultimately can paint the picture of what is
occurring and why. The following section of the thesis addresses the data collection process.

3.4. Strategies for Data Collection

3.4.1 Field Data Collection

It was determined that the study would collect information from various sources, and these would combine observational and interview techniques. These activities included:

- direct observations of crisis training simulations;
- crisis management responses which formulated vignettes that enabled researcher observations and experience to be captured;
- both formal and unstructured interviews with members of the crisis teams and subject matter experts;
- participant-observations;
- reviews of crisis documentation and physical artefacts.

The researcher was able to observe the operational application of crisis management responses within CCHBC and TCCS and was able to obtain access to subject matter experts for interview both within, and external to, TCCS. The subject matter expert interviews would provide specialist insights into their views and perceptions as experts in the field. As identified by Barley et al this would enable the compilation of “accurate observational records on who interacts with whom and in what ways at what times, as well as data on actors’ interpretations of their behavior” (Barley & Tolbert, 1997, p. 102) together with the actions of others to provide insights into the rationale for crisis teams altering courses of actions and deviation from the routines.

This unique access to SMEs and through the conduct of interviews enabled specific focus on these sources of data which each providing a different lens to view the issue at hand. No single lens offered a ‘complete’ picture, which is known as the observer’s paradox. This combined approach enabled a broad
range of relevant empirical data to be collected for the analysis. The various sources were highly complementary, which is critical in case study research, and hence the focus on these sources.

Observational activities were also central to the data collection methodology. During the period of January 2016 to April 2017, the researcher, a senior manager within CCHBC, had the opportunity to observe several different elements of crisis management dynamics in action. Being embedded in the business enabled the researcher to collect data simultaneously across a diverse range of sources. These included ten crisis management simulations covering a broad spectrum of geographic and cultural territories. Additionally, they included the observations of the activation of the crisis management teams across the business in response to incidents from which vignettes were created.

The multiple data collection modes however also created a risk of researcher bias, due to the researcher’s close proximity to the business and his interpretation of the data through familiar, direct daily interactions. This bias risk was largely addressed through the utilisation of Leximancer software, which enabled concept identification and development outside the influence of the researcher. The necessity to collect as much data as possible is supported by King *et al* (1994, p. 24) who identified it as an important guideline for improving data quality. They further noted that broad data and observations sources enable minimisation in selection bias, a phenomenon that can occur if certain observations are focused on but others are neglected (King *et al.*, 1994, pp. 27-28). The quality of the data for this case study research was supported by the extended sixteen-month observation period, which enabled the researcher to gain significant insight into the topic.

While the research employed several techniques, it relied extensively on direct observational data acquired during the simulation exercises and case response activations. This data evaluated the processes and skills applied in training, together with an evaluation of their real-life application. Data was also collected through a process of structured interviews with the identified subject matter
experts, with this data offering the potential to pose a number of challenges to the researcher. Such challenges included elements such as impression management and retrospective sense making (Eisenhardt & Graebner, 2007, p. 28).

There are several strategies that can assist in mitigating these challenges. In this research, this mitigation involved ensuring that for the observational exercise a diverse range of teams was examined, together with the use of numerous highly knowledgeable and specialised informants who viewed the phenomena from a diversity of perspectives. This use of multiple informants assisted in substantiating the evidence gained from other sources (e.g. documents) thereby assisting in the validation of the data. The breakdown of the data sources is detailed in Table 4, with the specific source details being outlined in the appendices (B) with an example of the SME interview in appendix C. The analysis of the background skills of the subject matter experts, to support their experience, was also contained in the findings.

### 3.4.2 Data Creation

With regard to the data collection in a case study analysis, it is important for the researcher to report on how the data is created and how one came to possess that data (King et al., 1994, p. 51). Regarding the crisis management simulations, data was collected through observing the process without active participation. In each simulation, the core crisis team participants received a verbal briefing on the research and its objectives at the beginning of the simulation day. They were provided with background material to the research, and their signed authorisation to participate was obtained. The hard copies of the authorisations have been filed and scanned for electronic storage. The focus of the observations during the simulation was the adherence of the team and the crisis leader to compliance with the ostensive routines and utilisation of the relevant artefacts.

During the crisis response activations, the data was collected through observational evaluation. In a simulation, the teams were generally requesting
### Table 4 – Research Data Sources

<table>
<thead>
<tr>
<th>Data Source</th>
<th>Period of Collection</th>
<th>Purpose of the Data</th>
<th>Quantity</th>
</tr>
</thead>
<tbody>
<tr>
<td>Crisis Training and Simulation Observations</td>
<td>Observations undertaken between 1 February 2016 and 31 January 2017</td>
<td>Evaluation of the way the CMT and the coordinator responded to the simulation, with a focus on their utilisation of the artefacts, team dynamics, and strategies implemented to resolve the incidents.</td>
<td>Ten (10)</td>
</tr>
<tr>
<td>Crisis Management Subject Matter Expert Interviews</td>
<td>Interviews conducted between 1 February 2016 and 30 June 2017</td>
<td>Specialist insights into the crisis management process with an emphasis on process deviation, strategies to minimise deviation, team dynamics, and strategies to enhance CMT effectiveness. The SMEs were drawn from a variety of business streams. This process also included the creation of a vignette on the researcher’s operational experience. Appendix B: SME data Appendix C: SME Interview</td>
<td>Twenty-two plus one research vignette (23)</td>
</tr>
<tr>
<td>Crisis Response Observations – Vignettes created</td>
<td>Observations of country responses directly supported between 1 January 2016 and 28 February 2017</td>
<td>Evaluation of the ‘real’ life case activation of the teams, and the degree to which artefacts were utilised, which provided a subjective perspective of the value, or otherwise, of the artefacts. In total, there were one hundred and thirty-eight (138) cases during the observation period, of which vignettes were prepared for eleven (11). The selection of the cases was driven by the level of interaction and engagement that the researcher had in the resolution of the matter. Appendix D: Vignette sample</td>
<td>Eleven (11)</td>
</tr>
</tbody>
</table>

crisis management support and therefore there was at times a degree of researcher participation and guidance as part of that intervention. This was in line with the ‘real life guidance’ that would be presented by the researcher. In
respect of observations, the researcher focused on the application of process in the recorded findings with no personal data relating to any individual person being reflected. Rather, only data regarding the nature of the incident and the observations in relation to each element regarding the performative routines was collected. As Marshall & Rossman (2006, p. 98) argue, the observation process entails the systematic noting and recording of events and behaviours in the social setting chosen for the study. Here, this involved evaluating the use of and deviation from the artefacts. In both the simulations and case analysis, the researcher’s field notes, which are detailed non-judgemental descriptions of what was observed, became critical observational data points. The observations from the simulations were captured initially in writing as contemporaneous notes and transcribed generally between one and five days after the event. The observations from the live activations, to which support was provided, were also captured as contemporaneous notes during the course of the collection period, with the vignettes created through data consolidation and review in January 2017. The role and creation of the vignettes is discussed further in section 3.4.4.

### 3.4.3 Subject Matter Experts

The use of subject matter experts (SMEs) to gather requisite data was an important element and differentiator for this research. This was because it provided contributor expertise in that the “expert would be able to use their expertise to contribute to the domain to which their expertise pertains” (Collins, Evans, & Weinel, 2016, p. 105). Collins et al commented that where the target expertise included different domains of contributory expertise then a means of sharing expertise between the different practice languages would be needed and they argue that interactional expertise provided the solution to this problem. This was relevant here in that the expertise of the SMEs would potentially vary across streams and therefore degrees of interactional expertise would need to be identified (Collins & Evans, 2015) and this interaction was provided by the researcher.
Of critical importance was the selection of the SMEs and criterion for selection needed to be established. Firstly, the SMEs were identified by the researcher based on his experience of working with and observations of the SMEs in action across TCCS, consultancies, other businesses, and public-sector organisations. The criteria for selection as a specialist in the field were that the SME had a minimum of five years in crisis response (public or private sector) and had undergone training and simulations in crisis response. A working knowledge of the business application of both crisis management and ERM was also pertinent. Twenty-two SMEs were identified with all agreeing to be interviewed. Each SME was supplied with the background material for the research and all consented to participate, with consent forms being obtained. Before the interviews commenced, the SMEs were provided with a summary of a generic line of questioning to assist in their preparation. The researched as an SME prepared a vignette in respect of his observations for this research (see section 3.4.4).

Statistical material was also collected relating to their background, their experience in crisis management, and their Myers Briggs personality type in order to validate their experience and skills. The purpose here was to validate the level of crisis management knowledge through a comparative analysis of the individuals, their backgrounds and experiences. This was critical to ensure that they would be legitimately considered as specialists in an evaluation of the research. The meetings with the SMEs were electronically recorded and transcribed generally within twenty-four to forty-eight hours after the interview. This process was time consuming, as on average one hour of recording required three or more hours of transcribing. The transcript was then reviewed to identify trends, themes, and any areas that might require further clarification.

Where follow-up questions were identified these were asked via email to ensure that an audit trail of the responses was available. In all instances, the SME interviews were conducted via phone or Skype with the researcher using either an iPhone recorder or the recording mechanism on Skype. It is noted that a
challenge with electronic recording is that while it captures the words and tones it does not capture the non-verbal signs, feelings and emotions. In this research, however, due to the non-emotive nature of the interviews, this element is not considered to impact the validity of the recordings.

In respect of the interviewing of the SMEs, the fact that the researcher also had extensive experience in this field of specialisation focused the dialogue on the crisis management gaps in question. This field experience was an important attribute as it also established a rapport with the SMEs being interviewed and stemmed from the fact that the researcher could show that he ‘has been there’ (Cunliffe & Karunanayake, 2013). Cunliffe et al argue “that ‘being there’ is a hyphen-space in which researcher-researched identities are deeply implicated and mutually influential” (Cunliffe & Karunanayake, 2013, p. 370). This positioning is particularly important for “interpretive, narrative, and discursive forms of research where the nature of conversations and degree of trust are essential to gathering rich data and multiple perspectives” (Cunliffe & Karunanayake, 2013, p. 374). In this research, rapport was established with the SMEs and this created an effective bridge that enhanced the overall dialogue.

### 3.4.4 Researcher Observations – the use of Vignettes

One challenge was how to address and incorporate the observations of the researcher who had observations from nineteen years of experience in crisis management within the private sector to factor into the equation. This was in addition to thirteen years experience from the public sector. It was critical therefore, to provide a suitable mechanism from which to present that voice and observations. Anteby contends that there is a taboo on telling one’s own story and whatever a “researcher’s personal involvement within a given field, the prevailing advice about publishing one’s findings seems to be to convey distance and suggests a fairly blank researcher entering a distant field” (Anteby, 2013, p. 1278). The issue with this approach is that it presumes that personal involvement “inexorably signifies loss of professional distance and that social distance equates with professional distance. This view not only fails to
distinguish distance and involvement, it also fails to recognize the necessity for both distance and involvement. When properly handled, telling one’s own stories can prove quite generative” (Anteby, 2013, p. 1283) and to do this “you need both distance and closeness” (Bazeley, 2007, p. 60) thereby securing a rounded perspective of the data and by default, the findings.

To enable story telling from the perspective of the researcher, this research utilised the creation of vignettes, which enabled the presentation of an insider’s perspective (Cochran-Smith and Lytle 1993). Vignettes are a suitable mechanism as they provide for short impressionistic scenes that focus on one moment, or give an impression about people, an idea or a setting (Bennett, 2009). Miles and Huberman (Miles & Huberman, 1994, p. 81) further noted that “a vignette is a focused description of a series of events taken to be representative, typical, or emblematic.” Therefore, a vignette is not strictly linked with a sequential plot development; rather it establishes meaning through loose symbolic or linguistic connection to other vignettes or scenes, which in this case consisted of the additional data sources. Vignettes are also seen as the literary equivalent of snapshots, often incomplete or fragmented. Characteristically, snapshots are short pieces of writing that capture a moment, scene or incident that tells a compelling part of a bigger story. A key benefit is that vignettes can provide a composite that encapsulates what the researcher finds in the fieldwork through his or her own observations and experiences. In every case, vignettes demand attention and represent a growing sense of understanding about the meaning of the research work. (Ely, Vinz, Downing, & Anzul, 1997, p. 70).

The value of vignettes is that they provide an opportunity for the researcher to present and integrate personal observations into the process. A vignette, by being an obvious literary construct, gives an account of the experience it addresses. The fact that a vignette says, “I am a construction” and “I am written by an author who has interpreted the experience depicted” (Spalding & Phillips, 2007, p. 959) has the ability to make it more trustworthy simply because it
more openly declares its subjectivity. It appears trustworthy because it does not pretend to be anything other than what it is.

In respect of this research the vignettes take two forms. The first vignettes contain a compilation of the knowledge and observations of the researcher over the course of his experience in undertaking and supporting crisis management in the private sector, with these collective thoughts contributing to the framework. Secondly, during the field work the research required the creation of observational notes relating to high risk cases that necessitated specific support by the researcher, or for which the nature of the case and its complexity meant that the researcher closely observed the interactions and the dynamics of the CMT. There were also observations related to the crisis simulations that were conducted during the research period (see appendices E and F). In this regard, it is noted that during the fieldwork period there were one hundred and thirty-eight (138) activations of the CMTs across the Group, of which eleven (11) were subject to detailed observation and analysis, contained in contemporaneous notes and transcribed for analysis and vignette creation. Additionally, ten country crisis simulations were observed and factored into the research. In these instances, the data was documented, and these were subjected to the same data analysis rigour as the other material; that is, via the use of software concept mapping.

3.4.5 Personality Assessment: Subject Matter Experts and Crisis Leaders

One dynamic of the research focused on creating an understanding of the role that the composition of the CMT and the skill sets brought to the crisis management event had in respect to process deviation. It was considered relevant, as part of the evaluation of the skills data of the SMEs, to understand their personality typology, enabling an evaluation of the linkages to leadership and team dynamics. In addition to enhanced understanding of the role that personality plays, this dynamic also potentially provides a foundation for future research into the characteristics that an assigned manager should look for when constructing the team. Several personality assessment tools are available and used across businesses that are designed to measure and describe a person’s
thinking and action preferences. The programs are designed to provide information that can enhance skills application through an understanding of the specific traits. These tools include the Neo Personality Inventory (Neo-PI), Herman Brain Dominance Index (HBDI) and the Myers-Briggs Type Indicator (MBTI).

For this research, MBTI was selected as the tool to gain a snapshot of an individual’s personality, thereby enabling a basic top line position to be established. A key use of the MBTI in management is that it informs individuals regarding “their innate preferences for interaction with each dimension representing both opportunity and liability in a given situation” with the its usefulness being in “helping individuals to understand their innate preferred behavioural styles” (Brown & Reilly, 2009, p. 927). This said, it is acknowledged that controversy surrounds MBTI’s scientific relevance, with critics citing its lack of scientific structure. This is despite MBTI being utilised globally as a preferred personality assessment tool. It is seen by many as an invaluable tool that helps in understanding their own behaviour as well as the behaviour of others. Across the business sector it is commonly applied to the assessment of emerging leaders as an element of leadership development programs. Hence, for the SMEs and others in this study, there was already a level of familiarity with the concept, its question structure and its output.

That said, a brief discussion of the conflicting perceptions is relevant to establish the context and to illustrate the differing trains of thought as to the value of the MBTI. On the one hand, Gardner and Martinko (1996) indicated that MBTI was valid and reliable enough to be used as a tool for examining the relationships between manager personality and attributes. It was also determined to have a role to play in informing individuals on their innate preferences for interaction while acknowledging that those preferences are not irresistible (Brown & Reilly, 2009). Others categorically argued that despite the popularity of the MBTI, which may be driven more by marketing than by scientific relevance, there are problems with its use. Both Burnett (2013) and Pettinger (1993) contend that there is a body of research that suggests that the
claims made about the accuracy of MBTI cannot be supported. In other words, although the MBTI appears to measure something, many psychologists are not convinced that any significant conclusions can be based on the test and that this can become dangerous when it comes to adaptation and utilisation of the results.

There is a case for arguing that other personality testing programs, such as the Neo-PI model, have greater relevance and present a more accurate evaluation. For example, the Neo-PI uses a five-factor model of personality which avoids the risk of boxing an individual into a specific category. It examines the respondent through a hierarchical organisation of personality traits in terms of five basic dimensions: extroversion; agreeableness; conscientiousness; neuroticism; and openness to experiences. It differs from the MBTI in that it does not simply classify an individual into one specific category linked to either extroversion or introversion. Rather, it argues that a situation can dictate the level of extroversion that an individual may exhibit in given situations. The downside of utilising this tool for the purposes of this research was the extent of questioning (two hundred and fifty questions) and the complexity of the further personality evaluation, which is a potential flow on from this research. Ultimately, as Furnham (1996) noted there is sufficient replicated overlap between the MBTI and NEO-PI and whilst “each measure may benefit from examining the extant empirical literature of the other, they would benefit considerably by examining the behavioural and cognitive correlates of the various dimensions of both scales and overlap” (Furnham, 1996, p. 303).

While acknowledging that different personality assessment tools exist, and despite conflicting positions with respect to the value of MBTI, it is important to stress that for the purpose of this research, the objective was not to prove or disprove the benefit of any one particular tool over another. The purpose was simply to build on qualitative observations and assessments in order to gain an initial snapshot of any commonalities existing in those individuals that had been selected to perform the role of crisis leader or subject matter experts. This information would ultimately act as a discussion starter and thought provoker.
regarding the aspect of personality contributions to the crisis team. This mirrors the opinion of Bosanac (2015), who contends that the MBTI test should be used as a conversation starter, rather than a driver of big managerial decisions. He cites the position of CPP Inc., the publisher of the MBTI test, and advises against using it to make decisions about hiring, firing and promoting. This utilisation of the results as a conversation starter fits comfortably into the context of this research.

Figure 3 – Myers-Briggs Personality Types

<table>
<thead>
<tr>
<th>PERSONALITY TYPE KEYS</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>E</strong></td>
</tr>
<tr>
<td><strong>INTROVERTS</strong></td>
</tr>
<tr>
<td>Often like working alone or in small groups, prefer a more deliberate pace, and like to focus on one task at a time.</td>
</tr>
<tr>
<td><strong>T</strong></td>
</tr>
<tr>
<td><strong>THINKERS</strong></td>
</tr>
<tr>
<td>Tend to make decisions using logical analysis objectively weigh pros and cons and value honesty, consistency and fairness.</td>
</tr>
<tr>
<td><strong>F</strong></td>
</tr>
<tr>
<td><strong>FEELERS</strong></td>
</tr>
<tr>
<td>Tend to be sensitive and cooperative and decide based on their own personal values and how others will be affected by their actions.</td>
</tr>
</tbody>
</table>

Source: Tieger, Barron & Tieger (2014)

Figures 3 and 4 illustrate the specifics of the MBTI personality types against the standard keys (see appendix G for additional data). It illustrates that the modelling will label respondents as either an extrovert or an introvert, so establishing the first parameters of an individual’s personality. The MBTI goes on to examine the respondent against the elements of sensor versus intuitive, thinking versus feeling and judging versus perceiving. The combination of the results creates an illustration of the respondent’s personality and the way in which they approach issues. Whilst not a perfect outcome, it does, as previously
pointed out, provide a discussion starter. This is a critical discussion as it generates a dialogue to further understand the role that individuals as leaders, or individuals within a crisis team, play in respect of influencing deviation from the ostensive routines during operational performance.

Figure 4 – Myers-Briggs Personality Categories

![Myers-Briggs Personality Categories](source: MBTI Home Page (2017))
3.4.6 Crisis Leader Personality Evaluations

Having established the skill parameters of the SMEs, it was determined that it was relevant to take the qualitative analysis one step further and this was as it related to the operational crisis leaders. As part of the methodology, the crisis leaders of the nineteen business units covering the twenty-eight countries in CCHBC together with the members of the Group response team, were approached. It was requested that they agree to be evaluated against qualitative and quantitative assessment criteria to assess process deviation and crisis leadership in practice. Additionally, further analysis would indicate if there was benefit in utilising personality assessments in selecting crisis leaders.

Eighteen (18) agreed to participate based on anonymity of the final data, specifically regarding the personality assessment. The evaluation also aimed to validate whether there is a specific need to appoint crisis leaders based on an assessment of a combination of operational experience and personality traits. This would be different from the process of simply selecting an individual based on the function represented, which is the most common practice in many businesses. For example, within TCCS this role is often assigned to the Public Affairs and Communications managers (SME17, 2016) or in some cases Legal (SME8, 2017) managers, irrespective of their actual crisis management experience.

To undertake this evaluation, a panel of four subject matter experts was established, including the researcher. The three other subject matter experts had been interviewed as part of this research and had been in a position, due to their role as trainers and operational support roles, to observe the crisis leaders in action over a period ranging from six months (newest crisis leader appointment) to seven years. The panel’s operational support for the crisis leaders involved observing them in both real-life cases and simulation activations of the crisis team. In total, the panel had over seventy-five years’ operational crisis management experience. They also had a combined exposure to over one thousand crisis team activations spanning private industry and the public sector.
For this process, a structured questionnaire was developed to establish the measurement parameters for the qualitative assessment of the observed behaviours. As the data was going to be tabulated into an Excel spreadsheet the design of the methodology saw the Y-axis measuring leadership skills exhibited during crisis response with a specific focus on the execution of command and control of the team. The X-axis was designed to measure the level of knowledge of the ostensive routines and, during the performative element, the level of consistent application of the artefacts, whether that related to the crisis management plan, the relevant tools, or the checklists. Examples of the key crisis management artefacts are contained in appendix H.

The objective of this exercise was to evaluate whether, when examined in totality, the performative actions were consistent with the provisions of the ostensive routines. Lastly, as visibility was also provided of the country of origin of the crisis leader, a qualitative evaluation was undertaken with respect to the role that culture potentially played as part of the crisis response. The findings of this material were then depicted on a grid, with linkages assigned to the personality type of each individual and analysis conducted during the discussion section of this paper, based on the observed findings.

3.5 Data Reliability, Research Bias and Ethical Issues

3.5.1 Data Reliability

In discussing data reliability, Lincoln & Guba posed the following question:

“How can an inquirer persuade his or her audiences (including self) that the findings of an inquiry are worth paying attention to, worth taking account of?”

(1985, p. 290)

Answering this question lies at the very foundation of the case study approach, with the strategy requiring that each step logically leads to the audience being convinced of the value of the research. To confirm the research value, this
section addresses the approach relating to data reliability and to managing the concept of researcher bias.

To ensure that the data was ultimately deemed reliable, it was subjected to a multi-staged approach. In the first stage the collected data was transcribed and subjected to content analysis, which was used to determine the presence of words or concepts within the collected material. The most common forms of content analysis are conceptual and relational. The conceptual analysis technique involves the detection of explicit and implicit concepts and then breaks down the text into categories against specified rules. This manual technique enables initial thinking to be developed by the researcher. The challenge with this manual process is that coding bias can occur, with this bias emanating from the fact that the researcher, by design, brings to the research their own experience and opinions.

Challenges also arise from the need to manage multiple data sources to make sure that a balance is found, thereby ensuring that information overload is avoided. This means that the researcher needs firstly to find the correct level of data collection and then to confirm the number of records collected and observed, ensuring that the correct balance results (Yin, 2011). The various elements of the data collection have been discussed earlier and from the data collection flowed the data analysis, which is the process of reviewing, cleansing, and modelling the data with the objective of highlighting useful information relevant to the phenomenon under investigation. The ultimate goal of the analysis was to provide the researcher with the knowledge for theory construction and this included ‘playing’ with the data (Miles & Huberman, 1994) and creating a structure that:

- placed the information into arrays and into chronological order;
- created a matrix of categories into which the data can be placed;
- created data displays, flowcharts and graphics for data examination; and
- tabulated the frequency of different events, examining the complexity of those tabulations and their relationships.
Within this context and having conducted an initial evaluation of the data through the content analysis, the focus turned to strategies that would assist in managing the risk of coding bias. It was determined that the most effective way to address coding bias was to utilise a software tool that through its structured methodology and automation mitigates this specific risk. In this regard two systems were considered, the first being NVivo 9, a software tool designed to analyse qualitative research data. This software offers the ability to define a set of codes (concepts) and allocate textual data to the codes. The main drawback, however, is that it cannot prevent analytical bias which, if it occurs, potentially skews the data and adds additional complexities to the research. As an alternative, the Leximancer software was identified and ultimately selected as the appropriate software tool. Leximancer provided the researcher with the additional capability to analyse the collected data in a systematic, comprehensive and unbiased fashion, thereby contributing to the enhancement of the research reliability.

The use of Leximancer addresses the risk of coding bias and its benefits lie in that it is a text analytics tool that analyses the contents of collections of textual documents and then displays the extracted information visually. Its relevance stems from the fact that it allows for a systematic, comprehensive and unbiased analysis of the data. The software is a data repository that enables systematic organisation of qualitative data. The machine code that Leximancer executes enables two types of analysis to be undertaken. One is conceptual analysis, which is the element of concept discovery. The other is relational analysis, which examined how concepts are interrelated. A detailed analysis of the utilisation of the artefacts follows shortly.

Reliability of research data is a contentious topic and the subject of extensive debate in the scholarly community (Thomas & Magilvy, 2011). Hence, it imperative that this risk be addressed. Code reliability, rigour, ability to replicate and level of generalisation, or standardisation, all assist in establishing trust and confidence during the data collection, data analysis and the interpretation phases of the research. Thomas & Magilvy (2011, pp. 152-154)
argue that there are four pillars that are relevant to case study research: truth-value, transferability, dependability, and confirmability. Truth-value occurs where credibility is generated when the study presents an accurate interpretation of experiences. This is accomplished through establishing a common strategy for member checking, or an informant feedback loop, whereby the researcher returns to the source of the data seeking confirmation. This can be challenging if interpretations and themes are not accurately represented. Transferability is the ability to transfer the research findings into other contexts or to other subjects or participants. Dependability ensures that other researchers can follow the decision trail of the researcher in respect of the purpose of the study, the rationale for case selection, and data collection modelling as well as data analysis and interpretation. The last pillar is confirmability, and this can only be validated after the first three components have been established.

It was imperative therefore, that this research catered for the establishment of a structure that addressed the requirements of these four pillars. This was particularly important for dependability, ensuring that strategies were in place to mitigate the researcher coding bias risk. While the selection of Leximancer would aim to do this, prior to the utilisation of the software, as outlined earlier in this section, the researcher undertook initial independent review and analysis of the collected data. This involved coding the data and using informed judgement against the various concepts that were under review. Specifically, there was detailed sentence and paragraph review to identify keywords that described one or more of the concepts. The purpose of this initial coding was for the researcher to establish an initial assessment of the concepts. At all times, it was acknowledged that the process was introducing subjectivity and potential coding errors. This in turn held the potential to generate coding bias emanating from the risk associated with conscious and sub-conscious preconceived conclusions held by the researcher. This is because any researcher runs the risk of seeing things differently from how others may view the data, especially if they come from different disciplines (Richards, 2005, p. 99). This differentiation in perceptions is an issue that is well known among academics.
and referred to as ‘inter-coder reliability’, which is a measure of agreement among multiple coders of how they apply codes to text data.

With respect to strengthening the approach to qualitative analysis, there are several strategies that can be used singularly or in combination to validate the accuracy of the data and the findings. These include using triangulation, member checking, the use of thick descriptions, clarification of researcher bias, the presentation of negative information or discrepancies, prolonging the time of data collection, peer briefings or utilising an external auditor (Creswell, 2003, p. 196). Leveraging this thinking, the current research validated the findings through a combination of these approaches.

Triangulation of the different data sources of information through multiple collection sources, was used to construct coherent themes. The data was also subjected to member checking. This was a concept that was touched on earlier, where the researcher could specifically draw on the collective knowledge of the SMEs to establish the validity of the qualitative findings. This involved discussing the data, interpretations and conclusions with members of the core group of subject matter experts. This enabled the participants to add additional input and insights together with the opportunity to challenge interpretations, providing an additional conduit to the sourced data. The use of vignettes enabled detailed descriptions of researcher observations to be conveyed. This built on the concept of ‘thick description’ as the presentations were in sufficient detail to evaluate the conclusions and the relevance to times, settings and situations, rather than simply being restricted to the fast-moving consumer goods stream. The research activity of spending prolonged time in the field, in this case observations over a sixteen-month period, also enabled a clearer picture to be constructed.

### 3.5.2 Addressing Researcher Bias with Leximancer

Leximancer was selected as the mechanism to automate the analysis with the aim of mitigating researcher bias. It was deemed a suitable mechanism irrespective of commentary that documented limitations of Leximancer. This
was specifically argued for cases where the data could produce false positives as a result of simplifying complex original data through the machine analysis. The counterbalancing argument was Leximancer’s objectivity, face validity and reliability (Dann, 2016) which the researcher determined would outweigh the risk in this exploratory study, with the tolerances being within acceptable boundaries.

The Leximancer program works in four distinct stages: data cleansing and loading; generation of concept seeds; generation of a thesaurus; and the running of the project. In the first step, the data was assembled into the relevant format to provide for effective analysis and uploaded into the program. At the same time, within Leximancer, work was undertaken to install and align the initial thesaurus together with the text processing options. In this case, this included the selection of the relevant dictionary that enables the elimination in the analysis of common words (e.g. ‘a’, ‘the’, ‘and’, etc.). The various process set-up stages are depicted in Figure 5, with Figure 6 illustrating the ability to establish the initial search parameters.

Figure 5 – Leximancer: The process stages

As part of the formatting the work was broken into two streams. The first was the observational data together with the vignettes from the observed simulations and the crisis management cases supported, which in total comprised some forty documents. The second stream incorporated the
transcribed interviews from the subject matter experts. The segmentation was important in this initial stage for the researcher to identify similar concepts and themes, together with specific differences around the identified parameters.

After the initial researcher analysis of these independent streams, the material was consolidated and Leximancer was used to evaluate the completed data streams, thereby providing the additional layer of system output data for review and cross checking of the findings.

As illustrated in Figure 7, the second stage involved the use of Leximancer in *Generating Concept Seeds*. This is where the program automatically identifies the concept seeds, which are the starting point of a concept, by looking for the words that most frequently appear in the text (Amaratunga, Baldry, & Sarshar, 2001, p. 11). As the process progresses, more terms are added to the definition through learning. This research applied variables for the seeding commencing with the default ‘discovery’ mode, whereby the software automatically discovers concepts without any user intervention. This enables the program to be an important means of methodological translation. As an option, which was also utilised, this process could be expanded to incorporate two sub-stages, the use of the *Text Processing Settings* and *Concept Seeds Settings*, which enabled additional data sets to be obtained. In short, irrespective of the option utilised, the processing phase converted the raw documents into the format used for processing.
Figure 7 – Leximancer: Generating Concept Seeds

Figure 8 – Leximancer: Merging of Word Variants

Figure 9 – Leximancer: Example Concept Map Output
For example, the text processing phase (a) splits the information into sentences; the paragraphs and documents phase (b) removes weak semantic information (such as the words ‘and’ and ‘of’), and phase (c) identifies people, places or company names. The Concept Seeds Settings phase depicted in Figure 7 provided the opportunity for the researcher to manually input seed words into the mix to further test the findings. In this case, however, the ability to add manual seed words by the researcher had the potential to input researcher bias
into the equation, so this was avoided by only utilising the automated modelling module.

The third stage is *Generate Thesaurus*. This is the point at which the researcher interacts with the seeds extracted automatically from the previous stage and edits, adds or removes seeds from the list. This was critical to ensure that words that had no relevance to the research and were potentially generic in nature and not contained in the original thesaurus were removed. As Amaratunga et al (2001, p. 79) noted, this editing and merging is important for a number of reasons. One reason is the fact that the automatically generated concepts may contain words that have similar meaning (such as think and thought, or in this research plans, tools, artefacts and checklists), or alternatively other concepts that are not of interest to the user. In the *Concept Editing* stage, the user can merge similar looking concepts into a single concept or delete concepts that the researcher does not wish to explore further (see Figure 8). This also enables word variants to be merged. This is where words with a similar meaning are drawn together (e.g. incident is a word that TCCS uses to describe a crisis event, so it was linked to the word crisis). Additionally, there is a possibility for the researcher to elect and/or create his or her own concepts that they feel are pertinent to the evaluation and the analysis of the data. As mentioned previously, this was not undertaken in this research, due to the risk of generating researcher bias, which was the reason for utilising Leximancer in the first place.

The final stage is *Run Project*, and this is where all Leximancer-generated concepts as well as user-defined concepts are displayed under the “Concept Map” structure. As exhibited in Figure 9, the Concept Map is divided into two distinct sections: a visual display of concepts and their relationships to each other on the left, and report tabs on the right for interacting with the map (Amaratunga et al., 2001, p. 13). Figure 10 presents an example concept map relating to a safety study. The colours illustrate the intensity of the themes and on the right the frequency of the key word hits. As depicted in Figure 10, the tabs can also illustrate the relevance of the concepts.
When the map first opens, only the top 50 per cent of the concepts are visible on the bubble map. These are the concepts that appear most frequently and are the most connected (grey lines on the map) to the other concepts on the map. The user can alter the number of concepts appearing on the map (increase or reduce) by utilising the ‘percentage visible’ concepts slider that is shown at the bottom of the map. The researcher experimented with both increasing and decreasing the number of visible concepts and finally settled on the presentation of the 100% visibility of the concepts. In detailing the methodology surrounding the data depiction it is important to understand that:

- The concepts are clustered into higher level *Themes* which appear as coloured circles on the map. Themes contain concepts that appear together often in the same pieces of text, and therefore tend to settle near one another in the map space. ‘Heat-mapping’ is used to indicate the relative importance of a specific theme, for example, the theme with the most textual hits appears in red, the next hottest in orange, and so on according to the colour wheel. As with the ability to alter concept visibility, the theme visibility can be altered through the *per cent Theme Size* option contained within the map. Moving the slider to the right brought a limitation to the broader themes, which embrace a larger number of concepts. Moving the slider to the left causes the themes to become tighter and linkages to be strengthened.

- Concept frequency is another key component with the concept dots (i.e. the grey dots sitting behind concept names on the map) ranging in colour and in size from *black to light grey*. Referring to Figure 9 and linked to Figure 10, the darker and larger the dot, the greater the number of text references coded at that concept, also referred to as the compound.

- Concept co-occurrence illustrates that the same concept is referenced and coded in more than one concept. In this case, this means that the following words such as ‘process’, ‘processes’ and ‘procedures’ are very close to each other, indicating that the root words that constitute them are often used in a similar context. By drawing the words together via the linkage tool, it is
possible to ensure that the linkages are drawn more closely together and are not duplicated.

Ultimately, the use of Leximancer, within the overall research methodology, aided the presentation of an unbiased analysis of the material collected during the various phases of the research, from which the findings that are discussed in the next chapter were extracted.

### 3.5.3 Addressing Ethical Issues

This research involved elements of human research through the interviewing of identified subject matter experts, together with direct observation of selected crisis teams and their members during simulations. To enable this, approval was sought and obtained from the Human Research Ethics Committee of Western Sydney University (approval reference H11307). The subject matter experts and the simulation participants of the core crisis team were each approached for their consent to participation in the research. At all times, the option to withdraw from the research was available. They were provided the background data for the research project and had the research verbally explained. Research participants completed consent forms, which have been retained by the researcher in accordance with the University Policy.

### 3.6 Thematic Analysis: Supplementary Data Coding

A critical review of an earlier version of this thesis noted that the volume and the type of the data that the researcher was able to collect was one of its real strengths. However, the use of Leximancer was flagged as potentially suppressing the researcher’s interpretation of the data. For example Smith and Humphreys (2006, p. 277), in their testing of functional validity with Leximancer, identified issues with correlative validity that could impact findings. That said, they did conclude that it was apparent that there was an abundance of rich and complex information that can be extracted by utilising a program such as Leximancer. Sotiriadou et al. (Sotiriadou, Brouwers, & Le,
In their review of Leximancer and NVivo found that while a well-designed research study using appropriate qualitative software assists in the analysis of data sets and creates a pathway to increasing the rigour of the research, there is a risk of distancing the researcher from the interpretations of the data. They ultimately proposed that for a researcher to avoid this risk that a combination of automatic and manual text analysis be utilised with this enabling research triangulation to occur.

In this study, it was noted that the adoption of the manual text analysis would enable further validation of the data and therefore the researcher supplemented the automated computer coding with a manual process to further engage in, and confirm, the theoretical interpretations from the data. This process, post-automation, leveraged the reduction of coder bias and introduced source methodological triangulation into the analysis.

Central to the overall approach in the data analysis and the creation of the aggregate dimensions, was the necessity to continually review the source data during collection. This comprised an ongoing review of the interview transcripts and the vignettes, which was an iterative process that was initially undertaken sequentially after each interview was transcribed in order to derive data flows and lines of inquiry for the researcher. This constant comparison and theoretical sampling guided the development of the emergent theory with the overall purpose of validating whether the data supported and continued to support emerging categories (Holton, 2010, p. 268). This ensured that the developing analysis of how the theoretical categories aggregated together with the findings accurately represented the available data (Locke, 2001). This was ongoing and performed prior to the automation in the initial data review.

In respect of the supplementary manual coding process, a challenge with any qualitative research is the way in which the data is manually coded and analysed to ensure that findings are robust and of a suitable quality that supports the findings. Amis and Silk (2008, p. 459) contend that
“quality is judged according to traditional criteria of internal and external validity, reliability, objectivity, and generalizability. Thus, often unwieldy and unstructured data are reduced, systematically elicited, standardized and quantified in relation to predetermined categorizations through a range of techniques, ranging from, but not limited to, keywords in context analysis, componential analysis, taxonomies, word counts, frequencies, cognitive mapping, semantic analyses, and word matrices.”

There are differing views as to the importance of data coding, with scholars such as Jonsen et al (Jonsen, Fendt, & Point, 2017, p. 48) arguing that data coding is not a necessary part of the procedure in exploratory research, as it is the narrative itself that is the sense maker. Despite that contention they go on to note that though coding neither interprets nor builds theory, it remains popular, as researchers appreciate the efficiency of coding when faced with vast amounts of narrative data. The reality is that coding does play a critical role and Miles and Huberman emphasized the importance of coding by stressing that it is not “the words themselves but their meaning that matters”(Miles & Huberman, 1994, p. 56) and that coding assists in formalising and systematising the researcher’s thinking into a coherent set of explanations (Miles & Huberman, 1994, p. 75). Ultimately the researcher “is not coding for conditions or consequences per se, but rather uses the tools to obtain an understanding of the circumstances that surround the event” (Corbin & Strauss, 2008, p. 90).

In approaching the manual coding and data analysis of the multiple information points in this project, the researcher built on the conceptual analysis that was adopted during the data collection process and referred to earlier. During that early stage of the research the interviews were reviewed and analysed post transcription to identify themes and trends. This work created the baseline and was subsequently built on with the researcher adopting broad elements of the analytical coding approach employed by Petriglieri (2015). While that research focused on the damage to the relationship that can occur between organisation and employee, stemming from the way in which BP managed their Deepwater
Horizon crisis, rather than the nature of the crisis response itself, the coding approach was robust and thereby emulated.

In Petriglieri’s approach, consideration was given to the arguments of Walker and Myrick (2006), who evaluated the differing coding approaches of Anselm Strauss and Barney Glaser and stated that “grounded theory is an evolving method premised on the inductive generation of theory derived from data” (Walker & Myrick, 2006, p. 557) and that essentially elements of both approaches could be adopted to formulate a strategy that is most suitable to the researcher. They stressed that central to the “grounded theory data analysis involves the researcher as an actor in the process. They are the people who intervene, manipulate, act on, conceptualize, and use specific techniques to generate or discover the theory. They engage in an intervention process, comprising stages or procedures, to excavate a theory from the raw data” (Walker & Myrick, 2006, p. 550). This philosophy links to the position adopted by the present researcher as a critical realist utilising a case study approach.

Returning to the initial data collection phase, which included taped interviews and transcription of the interviews, the researcher had already examined the data on a regular basis to evaluate the linkage of the commentary to the theoretical framework and research question. This supplementary manual coding phase took this analysis to a deeper level, which saw codes further linked to data. As the coding progressed, patterns of association between the codes became apparent (Bazeley, 2007) and these were then further distilled to identify the core commonalities. The importance here was that “qualitative researchers code in order to get past the data record, to a category, and to work with all the data segments” (Richards, 2005, p. 86) and in the manual coding process utilised, line-by-line analysis was conducted to formally identify common terms, statements and themes, which were grouped into the category of concepts and first-order codes.

This utilised in vivo coding. In vivo, a form of qualitative data analysis that places emphasis on the actual spoken words of the participants and is championed by
many for its usefulness in highlighting the voices of participants and for its reliance on the participants themselves for giving meaning to the data and terms (Manning, 2017). This is particularly pertinent considering the case study approach adopted and the focus on evaluating the views of the subject matter experts, informing the analysis of performative routine and process deviation.

The coding was reviewed and modified as additional data points were identified and analysed. As this manual coding was after the initial collection, this came from a sequential review of the material based on the timing of the undertaking of the interviews, preparation of the observational vignettes and the additional literary insights obtained providing for data and theoretical triangulation. This approach to manual coding focused the review and challenged initial thoughts as new themes were evaluated against their fit to the data obtained from each preceding document. This sequential process of continual review, grouping, regrouping and evaluation led to the creation of the initial concepts. This was important as “the processes of constant comparison and theoretical sampling guide the development of the emergent theory. The purpose of constant comparison is to see if the data support and continue to support emerging categories” (Holton, 2010, p. 268). To be considered an initial concept a theme had to be addressed by a minimum of 75% of the respondents. This cyclical review, where the researcher stepped away and then back to examine the data on the receipt of the additional information (via sequence obtained), also aligned with the concept that “the researchers can theoretically and conceptually think about the data from a distance, while simultaneously maintaining an in-close level of sensitivity and understanding about the process and their involvement in that process” (Walker & Myrick, 2006, p. 551) in order to extract the relevant meaning of the data.

The process then utilised axial coding which is the process of crosscutting or relating concepts to each other (Corbin & Strauss, 2008, p. 195). As noted by Walker et al (Walker & Myrick, 2006, p. 553) in their commentary on Strauss and Corbin (1998), this phase establishes connections through a process that focuses on three aspects of the phenomenon being studied. The first is the
conditions or situations in which the phenomenon occurs; the second relates to the actions or interactions of the people in response to what is happening in the situations; and lastly the consequences or results of the action taken or inaction.

In summary during the axial coding for this research, the researcher worked back through the material to understand categories and their relationship to other categories and subcategories. The purpose was to identify relationships on which the axis of the category is focused and involved consolidation of the initial concepts through selective coding, which distilled the data into categories that became the various overarching themes.

This phase involved documenting the relationships and variations amongst the concept codes. The output from the analysis of the data was then further distilled to present the core elements that the participants determined were influencing ostensive routine utilisation; the process deviation; and impacted effective crisis management and these final categories are the thematic codes. These were consolidated and defined with the final aggregation forming a basis for further review in the discussions on the theme of the process deviation and the way to mitigate this risk.

As this process was post the initial data evaluation and review by Leximancer, it was important to validate the accuracy of the process. To further ensure the reliability of the findings from this manual coding, the research supervisors undertook a limited sampling of the data to validate the approach and output. As would be expected and will be illustrated in the findings, the resulting codes were not an exact match to the researcher’s findings utilising Leximancer, however, there was sufficient commonality in the outputs to suggest that the manual coding process provided a realistic interpretation of the data which further strengthened the findings of the earlier automated and non-biased Leximancer output.

The last element of the exercise involved conducting the triangulation to analyse the findings from Leximancer and the manual coding thematic results. As noted by Carter et al (Carter, Bryant-Lukosius, Dicenso, Blythe, & Neville,
triangulation relates to the utilisation of multiple methods or data sources in qualitative research to develop a comprehensive understanding of phenomena. It is also viewed as a qualitative research strategy to test validity through the convergence of information from different sources. While there are four types of triangulation: method triangulation; investigator triangulation; theory triangulation; and data source triangulation, this research used method, theory and data source triangulation. Method triangulation involved the use of multiple methods of data collection about the same phenomenon and can include interviews, observation, and field notes all which were relevant in this research.

### 3.7 Chapter Summary

This chapter has outlined the research methodology adopted. It commenced with an evaluation of the various philosophical approaches available to the researcher and presented the critical realist approach adopted by the researcher in this study. It then presented the rationale for the utilisation of a case study approach to develop an explanatory theory versus testing a theory. This approach is acknowledged as a preferred inquiry method when examining contemporary events within a real-life context. It is commonly applied in situations where the behaviours and issues cannot be manipulated and where observations and raw data occur without interference. It is specifically pertinent in this research, as it seeks to explain ‘how’ or ‘why’ the observed behaviour of concern, the process deviation during crisis response, potentially occurs.

Within this discussion the arguments for the case study context of evaluating crisis management through a Coca-Cola system lens was presented, thereby providing a compelling context for the examination of the research question. It has also described the strategies that were utilised for the data collection. These included the interviewing of subject matter experts and the observations of crisis management teams during both crisis simulations and ‘real-life’ responses. These observations were captured in vignettes. The vignette, by
being an obvious literary construct, enabled the researcher to present an account of the experience that it addressed. As the research was also examining the composition of crisis teams, their leadership and their contribution to the deviation, the personality types of the participants were evaluated. This evaluation not only examined existing coordinators but also examined the SMEs to look at commonalities. For this purpose, MBTI was adopted and the rationale for selection of this personality assessment tool and a description of the approach was provided.

The chapter then moved to address the topic of data reliability and ethics. In respect of reliability, it outlined the utilisation of the Leximancer software to examine the collected data in a manner that addressed researcher bias. Leximancer was selected as the most appropriate tool as it had the capability to provide reliability and rigour in the evaluation. Additionally, the ability to replicate and standardise the material assisted in establishing trust and confidence during the data collection, data analysis and interpretation phases of the research. In respect of research ethics, the methodology outlined the compliance with the relevant university requirements in this space.

Lastly, the methodology chapter discussed the approach taken to manual coding and thematic analysis. This element was incorporated into the research from feedback that was presented during a critical review of an earlier version of the thesis. This was linked to concerns of relying purely on Leximancer as the coding mechanic. The manual coding process aimed to provide further independent evaluation of the material together with providing additional rigour to the testing and validation of the results as presented by Leximancer. This enabled method triangulation of the data to be undertaken.

With this chapter having outlined the methodology the following chapter, presents the empirical data and the findings of the research. From there, the focus will turn to the detailed discussion of the findings with an evaluation against the extant literature.
Chapter 4 – FINDINGS

4.1 Introduction

This chapter details the findings of the research. As outlined previously, this research set out to understand the root causes of deviations from ostensive routines observed during the actual performance of crisis teams during real life activations. Such deviations have the potential to adversely impact the team’s ability to effectively resolve the issue at hand. Specifically, the objective was to utilise the empirical data to develop a theory that explains this paradox.

The analysis focused initially on two discrete areas. The first discrete area collected data to evaluate whether the deviation occurred as the crisis routines, artefacts and training are either considered inappropriate in their current form or are not modified and enhanced in response to lessons that are learned during a post incident review. The second area of data analysis examined whether the deviation occurs due to an ineffective approach to the structure, leadership and coordination of the CMT; that is, the actors are not cast correctly, so that behaviour and skill sets contribute to the deviation.

The data was collected from a variety of sources, including: documented observations of crisis teams during training and simulation; interviews with subject matter experts; evaluation of crisis leader capabilities; and vignettes of real case responses. This chapter will outline the findings from the research and analysis and commences by presenting the findings as they relate to the qualifications and experience of the subject matter experts, as this is important to confirm their level of experience and competence to comment critically on the topic of crisis management.
The focus then moves to the findings relating to the data itself as extracted from Leximancer and researcher analysis. As documented in the methodology, the data was subjected to initial researcher analysis, which established the starting point for the interpretation of the data. During the second stage the connectivity of themes was evaluated utilising the software, thereby mitigating the risk of researcher bias. This process involved the uploading of the complete data pool into Leximancer where it was subjected to simulation modelling, and this is the focus of the second part of the chapter. Lastly, as was mentioned in the methodology, critical feedback on an earlier version of the paper, recommended the utilisation of manual coding to validate the accuracy of the Leximancer results. The findings from the manual coding and thematic analysis are reported in the third part of the chapter.

In sequence, the first two sections of the chapter will examine the findings as they relate to:

- subject matter experts;
- an overview of the concept findings;
- role of the artefacts;
- observations of process deviation;
- role of the team and the crisis leader;
- role of training and process improvements;
- culture and personality in team dynamics; and
- perceptions of risk management and business resilience.

The chapter will then address the findings from the thematic analysis and supplementary manual coding that will illustrate commonalities between the data sets.

### 4.2 Subject Matter Experts

Prior to discussing the concepts and themes as identified from the data sources, it is important to discuss and validate the background and the experience of the twenty-three subject matter experts who were either interviewed or, in the case of the
researcher, contributed to the creation of the vignettes for the research. While twenty-four were approached, twenty-two participated in the interview process, with operational availability and time zones impacting the participation of two SMEs. The subject matter experts were sourced from the network that the researcher has developed over eighteen years both within and external to TCCS. The researcher’s perspective on what constitutes an SME was established through observations of the performance of SMEs during crisis activations either as core members of teams or as crisis management leaders. The SME pool was considered representative, based on the researcher’s experience of observing over one hundred crisis coordinators during his eighteen-year period as a private sector crisis specialist. The selected number represented approximately 23% of the best-case accessible knowledge pool known to the researcher. The SMEs were selected to ensure that there was representation across geographies and cultures.

As illustrated in Figure 12, the ratio of males to females was weighted towards males, (83%), with 17% female. In Figure 13 it is noted that 74% of the respondents were, at the time of interview, performing the role of crisis coordinator at either a country, business unit or Group level. For this research a business unit within the structure of Coca-Cola HBC, is defined as a group of countries under the assigned leadership of one general manager (e.g. the Baltics Business Unit comprises the countries of Estonia, Latvia and Lithuania). Within TCCC it comprises multiple markets covering an aligned geographic spread.

Figure 14 documents the education level of the SMEs. The majority of the respondents (87%) held postgraduate master’s degrees, and the findings indicate two instances of respondents having multiple master’s degrees. Two of the respondents held a PhD (9%) and there was one respondent who at the time of interviewing held an undergraduate degree (4%). However, this SME was in the process of undertaking his postgraduate degree, which was completed at the end of 2017. This respondent was also the youngest of those surveyed.
Figure 12 – Gender of the SMES

Figure 13 – SMEs as Crisis Coordinators

Figure 14 – SMEs Education Level

Figure 15 – SMEs age range
Figure 16 – SMEs Crisis Management Experience

Figure 17 – Functional Area of SME Expertise

Figure 18 – Operational Location of SME at Interview
Figure 15 indicates that 87% of the respondents were above 40 years of age, with the majority being in the 50–59 age range (52%). This age maturity has a direct correlation to the years of crisis experience, exposure to crisis situations, business experience, and training, which validates the importance of maturity and time in the team in minimising process deviation risk. Additionally, many of the respondents had been exposed to both public and private crisis response and, as depicted in Figure 16, fifteen of the respondents (65%) had worked in the crisis management field for more than 11 years. This linked to the observed correlation between age and experience, which in turn links to functional expertise, that had enabled the skills sets to be developed. For the purposes of this research, most of the respondents came from the security and risk field (52%) followed by the public affairs and communications (PAC) stream of business (30%). From an operational perspective, this can be attributed to the fact that, in many organisations, crisis management is incorrectly seen as correlating with crisis communication. Within TCCC there has been a trend to automatically place PAC as the leader in crisis management response.
Several of the respondents, typically those currently in the security and risk management streams, indicated that they had had previous careers in the military or law enforcement. This exposure to both complex and high-pressure roles indicated that a certain personality type, with exposure to elements such as process compliance and process discipline, tended to be drawn into these types of business roles. What was important to note is that, as mentioned earlier, not all were currently in coordination or leadership roles, as some were strong SMEs in their specific functional area, which did not automatically place them in a crisis leadership position.

The SME sample pool also covered a diverse range of business unit geographical territories as shown in Figure 18, and nationalities as illustrated in Figure 19. The countries with the most respondents, in each instance three, were from Australia, Poland and the United States. This diversity added additional balance to the analysis by avoiding a focus on any one geographic area or specific ethnicity. Despite this diversification strong commonalities in themes and perspectives were observed, thereby validating that the issues with respect to process deviation transcended geographic and social boundaries. For example, all of the SMEs had observed the process deviation issue during the course of their careers.

In summary, while the group was diverse in nature, many commonalities were observed in respect of their experience and the nature of the cases that they had worked on. What was evident was that training, practice, exposure to a variety of cases, and longevity as a member of the crisis team all contributed to the development of the skills sets as displayed by the subject matter experts. Therefore, it will be argued that deviation in the application of the ostensive routines is minimised by experience, which is built up over time, creating a familiarity with the process that is complemented by the team members’ trust in the crisis team’s leadership. The findings in respect of the SMEs, personality types will be discussed in depth later in this chapter.
4.3 Concept Analysis

4.3.1 Concepts Identified by Leximancer

Commencing with the process of the extraction of the findings, it is important to reiterate that Leximancer was utilised to develop an unbiased depiction of the concepts identified from reviews of the simulations, case study vignettes and transcriptions of the interviews with the subject matter experts. This initial section discusses what the concept maps showed and creates the framework for further depiction of the findings. In the first stage of the development of the concept map, a 'low detailed' approach was adopted to capture the core themes, and then a 'high detailed' map was created to highlight in detail the themes captured within each of the clusters. As discussed in the methodology, the colour coding depicts the frequency of the concept, with the red bubble being the ‘hottest’ concept followed by orange, then purple through to the greens. It is from this high detailed chart that the connectivity of the findings to be extracted is obtained.

The concept map provides an illustration of the importance of the team and the crisis leader to the process. This linkage with the utilisation of the tools is also illustrated by the correlation to collection of the information that is required to effectively guide the problem solving. Interestingly, culture is confirmed as an element that was raised on multiple occasions throughout the research, with an emphasis on the impact that culture can have across diverse territories on the dynamics and capabilities of the team. There was a strong interconnectivity between the concepts stemming from the term ‘crisis’, which by default is the central concept.

The common links extended to the importance of the ‘team’ and the ‘people’ and their ability to work together by using the tools or artefacts in managing the response together with a specific linkage of the people to ‘culture’. Within the elements also sat commentary on the role that each of these elements played with respect to deviation. At this point it is important to reinforce that due to the word ‘crisis’ being the central theme and node of this research, with the focus on the process deviation from the ostensive routines, it was omitted as a term from the specific analysis.
Figure 20 – Leximancer: Synopsis of Key Words

Figure 20 depicts the synopsis of the key words and the level of the hits, taking into consideration that in some instances the word stream has been consolidated. For example, the word ‘crisis’ was structured in the system in such a way as to incorporate associated words utilised in TCCS such as ‘incident’, ‘issue’ and ‘event’, which have a common thread as categories in the research focus. These are distinct categories and related to the classification of event types which will lead to the activation of a crisis team within TCCS. The extensive nature of the ‘hits’ for crisis (1,549) stemmed from it being the central theme. As all discussions branched off it, it was important to remove the focus from the word. The visuals and the theme connectivity as depicted in the ‘low detail concept map’ and the more detailed connectivity as shown in the ‘high detail concept map’, both in Figure 21, confirm that the findings should focus on the themes as they relate to: the artefacts (tools and checklists); the team and the elements of experience, structure, personality (people), response and training; the role within the teams of the coordinator; and the impact of culture, be that business or social culture. Intrinsically linked to ‘crisis’ is the concept of risk management. The findings will examine perspectives as to the role that risk management plays in both a reactive and a proactive sense.
Figure 21 – Leximancer: Low Detail and High Detail Outputs
Dealing with these concepts generically first, it is important to examine the findings as they relate to the role of the tools and the utilisation of the key artefacts. In the context of the ostensive routines these are contained within the crisis management plans and they are supported by specific artefacts. These comprise the various tools and checklists. It is evident from the findings that there was both an acceptance of and a heavy weighting placed on the importance of their use in driving the successful resolution of the crisis. In this stream, there was a linkage to ensuring their utilisation in a timely manner, which ensures that the problem is correctly identified and provides for effective root cause analysis. This theme grouping will also examine the commentary as it relates to the observed reasons for the occurrence of process deviation.

The focus of the findings will then shift to address the elements of the team structure and the need for the crisis team to have effective synergies and experience. Within this theme sits the role of the crisis leader, described in the language of TCCS as the IMCR coordinator, and the influence that they have, or should have, in driving utilisation of the artefacts to ensure process deviation minimisation. The findings will also show that a team under effective crisis leadership is central to the undertaking of the performative routines, with training and repetition central to the enhancement of individual and collective skills. When dealing with the individuals, and the team collectively, personality has a critical role to play and this is addressed specifically in the commentary of the subject matter experts. On the periphery of the findings linked to roles sits the concept of culture. This point is illustrated in the blue ‘concept’ bubble with an overlapping to the green ‘role’ bubble that captures the crisis team member’s role and level.

Interestingly, across the SMEs there were differing orders of theme prioritisation. Some SMEs argued that the tools were the first priority in setting the context of the response. Others stipulated the importance of the team and the tools as the core element (SME12, 2017) that provided the framework for the corrective resolution. There was a common focus on crisis leadership and, irrespective of the prioritisation, the findings demonstrate the intrinsic links between: the ostensive routines; the people performing those routines, whether as members of the crisis team or as crisis leaders; the team
dynamics driven by the influence of personality and culture; and, finally, the roles of training and individual experience. With this context now established, the findings will be discussed within the parameters of these overarching streams and their related key linked areas.

4.4 Concept and Data Findings

4.4.1 The role of key artefacts: tools and checklists

The concept of ‘tools’ as shown in Figure 20, rated fifth in the overall analysis of the trends. Therefore, it is relevant to firstly outline the findings for this category as they relate directly to the examination of the first stream in the theory building. This focuses on the value of the routines and the artefacts in supporting the crisis response.

Referring to Figure 21, the high-detailed Leximancer concept map indicates that the tools play a pivotal role in the resolution of the incident and this confirms that the use of artefacts is critical. Depicted in the nodes is the importance of the ostensive processes as a component of a crisis response. This validates the direct correlation to the tools and the effective utilisation during the response. The crisis node has an additional stream that indicates time factors driving problem solving and fact finding, with information collection a component within the tools bubble. With these concepts in mind, this section focuses on these elements and the relevant themes.

A deep dive into the responses finds several common themes as presented by the subject matter experts. Firstly, it was noted that the crisis management tools were in fact introduced because what had been commonly observed was a very inconsistent approach to crisis response. Consistency is critical and comes about through standardisation, not only of approach, but of the tools that are used by the teams during the crisis response (SME1, 2017, p. 2). The logic behind process standardisation is that once a manager is trained, in theory, that individual could move to any other part of
TCCS and participate in the crisis team, as the artefacts and the ostensive routines are the same. This program originated with TCCS, for most part, because of the ineffective response to the Belgium crisis, as discussed earlier in this thesis and outlined in more detail in appendix C. As SME9 (2016, p. 2), who was involved in the Belgium case, stated in respect of that crisis response, “at the end of the day Coke comprehensively resolved the wrong problem.” This was in part driven by the fact that no structured and consistent ostensive routines existed that provided for a standardised approach to be executed, thereby impacting the capabilities and response of the team.

As for the tools themselves, SME22 (2016, p. 2) confirmed that the “tools are absolutely essential because they provide cues to consider things that people would not necessarily do. It is a way for people to consider their approach to a problem and an incident in a holistic way.” SME8 (2017, p. 2) further argued that

“the tools are fundamental and vital...and it is very important that you follow the process and that you don't get deviated and that you don't start panicking. Deviation occurs when the coordinator does not follow the process... and when people start to panic, or senior people exert a presence that results in process deviation. The tools provide the structure.”

The value of the artefacts is demonstrated “in the heat of battle, when a lot of things are going on, it makes sure that you answer all the fundamental questions that need to be answered, which you might forget about if it is a very big incident and there is a lot of pressure. It makes sure that you don’t miss anything” (SME21, 2016, p. 2). In essence, the tools were consistently acknowledged by the SMEs as providing the framework for the establishment of the crisis management response (SME16, 2017), with all of the artefacts linked to the core ostensive routines as documented in the crisis management plan.

The concept map indicates that the tools drive information collection and that the crisis dictates the methodology and approach. As SME10 (2016, p. 4), a retired Chief Superintendent of Scotland Yard’s Counter Terrorism team, noted,
“the tools are extremely helpful because they give someone a visual guide and a visual clarity as to what it is they should be looking for. I think that in the middle of the process that there are times that I have observed, and I am sure you have as well, where you lose sight of the wood from the trees. Where you think you are going with this ends up not being on the destination plan anywhere at all and the roadmap suddenly gets very, very confused. So, I think having the tools is very, very good and I think they are exceptional in finding out what the problem is. They are a Sherlock Holmes idiots guide to doing an investigation to find out the basic facts”

SME18 (2016, p. 2) also validated the importance of the tools when she noted that “the tools are very valuable and very useful, especially for the leader as this is something that in general allows people to think before they jump into the action and the conclusion.” With this objective in mind SME17 (2016, p. 2) further argued that in fact the tools mitigate the risk of the process derailing and deviation. She stated that

“I think that one of the biggest risks, in an IMCR process, is that people get caught up on a particular track, train of thought, component of an issue and they lose the bigger picture. So, one of the advantages of tools is that it makes sure that you are stopping, checking, and considering all the components.”

The data also validated that the tools were not only determined to be extremely beneficial but were described as providing the backbone and the structure that is critical in reacting and analysing the crisis in order to achieve the correct outcome. They are fundamental to the success of the crisis team (SME7, 2017; SME17, 2016; SME21, 2016). Their value is exhibited particularly in the high pressure stages, for crises are not static, but dynamic events, which ebb and flow, and through correct utilisation the tools ensure that nothing is missed by the team (SME8, 2017, p. 3). The role of the tools is directly linked to collection of the relevant information that is pertinent to the situation, enabling the team to deep dive into the operational linkages and trends that are occurring. This is core to effective crisis investigation and provides the structure that is required to assist in the identification of the root cause. Furthermore, SME21 (2016, p. 2) noted that the tools provide a framework that ensures “that we do not miss any of the basics when we are gathering information on the incident and when dealing with the incident.”
Others argued that, irrespective of the level of experience possessed by a team, all teams can benefit from actually working their way through the tools with the known information. By leveraging the tools and the checklists they challenge their thinking and are guided towards the data gaps (SME7, 2017, p. 2). It was also evident that the common theme was that the teams that performed effectively in crisis situations clearly understood the role of the ostensive routines and utilised the tools, ensuring that process deviation was kept to a minimum. As SME2 (2016, p. 2) observed, in situations where crises have not been managed well it is because weaker teams either do not understand the tools, and therefore do not apply them correctly, or in worst case situations simply pay ‘lip service’ to them. This validates the importance of leveraging the tools on a continuous basis and always within the time constraints presented by the case at hand. The importance of regular training and simulation exercises was highlighted in driving compliance with use. This is because this not only educates, but tests the capabilities of, the crisis team members.

Interestingly, the relationship of the tools to the teams was identified as a critical influencing factor in the minds of some of the respondents. This was because the critical element that influenced the importance of the tools was very much linked to the teams themselves. One observer noted that, dependent on the teams, the effectiveness of the tools may actually vary from medium to significant value (SME20, 2016). Others argued that, while the tools are very valuable, their continued use over the years by an experienced crisis leader may create a situation in which their utilisation becomes intuitive in nature (SME21, 2016; SME23, 2016). SME6, for example, argued specifically in favour of the relevance of intuition. Here the most important aspect was to have an understanding of the tools and their utilisation, “making sure that when they run IMCR sessions that they follow, you know, the steps, the principles of the tools, but not necessarily having a print out in front of them” (SME6, 2016, p. 3). SME17 took the view that, while the tools were central to successful resolution, “you can’t just manage the crisis by the process, there is a whole, not to sound fluffy, creative, artistic, intuitive component that has to blend in with all of this” (SME17, 2016, p. 7). The acknowledged risk here is that even with intuition something can be missed and therefore there is a need to revisit the documents to validate thinking. These views tended to contradict the majority of the other arguments, that there was value in always having the tools present.
The findings also confirmed the role that experience and longevity of the team members and crisis leader play in influencing utilisation of the artefacts. The role of the crisis leader was seen as essential to driving utilisation of the tools and this is where “good leadership, effective leadership” plays its part, for where things have gone wrong “sometimes it is the process leader not following the process” or allowing “too much discussion” (SME21, 2016, p. 7) to occur. This theme will be outlined and built on in more detail in discussing the role of the team and the crisis leader. Having presented the importance that the SMEs placed on the tools, a deeper evaluation of the tool bubble indicates a variety of critical commentary in relation to the types of tools that are used. SME23 (2016) argued that of the crisis tools available the problem analysis tool (see Figure 27, appendix H for detailed descriptions) was critically important. This was because it provided the initial response context by enabling the team to understand the problem presented, thereby ensuring that the team were working on the correct ‘problem’. This was not the case, for example, during the Belgium crisis. Understanding the problem and the dynamics provided information that would feed into the commonly referred to 10Q document (see Figure 28, Appendix H). This is because, as SME23 (2016, p. 5) noted, if you were able to answer those ten questions it illustrated that the team had an effective understanding not only of the problem but of the strategies implemented, or required to be implemented, to manage the crisis response.

While the findings indicated that the current tools utilised by the teams were effective, some observers felt that there was a need for additional artefacts to be designed. For example, SME19 (2016) noted that while he liked the current suite of tools he saw the need for additional material to be available. This was particularly related to ensuring that there was more structure for the meetings. Without this guidance and support for the crisis leader a team continually ran the risk of allowing the meeting to flow out of control, with instances noted where the crisis management calls and the in-person meetings turning into chaos. From an artefact creation perspective, this illustrated the importance of a model agenda to support the crisis leader in creating structure. Overall, though, many of the suggestions related more to the importance of checklists, and their value to the coordinator in particular, than to the development of additional tools (SME11, 2016; SME19, 2016; SME21, 2016; SME22, 2016).
An argument was presented that the tools, and in particular the checklists, needed to be tailored to ensure that they cater for the relevant scenario. This confirmed the importance of avoiding generic checklists and developing checklists that support responses to specific themes such as product quality. This aligned with one respondent’s position that the more effective crisis leaders utilised checklists that were "tailored to the nature of the specific crisis that they may face" (SME14, 2016, p. 6). The importance of the checklist and the role that it plays in supporting the direction of the team was highlighted by SME2, who stated:

"The word checklist, I think has a difficult connotation in people’s minds, they think it’s the case of you just have to go, just go over it. The checklist is, have we actually satisfactorily answered this question, do we have this? So, the checklist approach can have a very beneficial thing, particularly going back and making sure. Because like a murder, in these incidents we have limited information at the start and we have to make some assumptions. Then we start building our actions through those assumptions and we gather more information." (SME2, 2016, p. 11)

Checklists, combined with the plans and the tools, were seen as providing the definitive and ultimate guide to a coordinated response, with SME1 arguing that “checklists are vital in that they establish the playbook. The crisis leader needs to drive the process, follow the playbook” (SME1, 2017). SME17 went on to validate this position by noting that what is needed is “some really good, just single page like checklist stuff that you could quickly run your eye down and say, ‘Oh, we haven’t done that, let’s make sure that we are comfortable and that we have not glossed over this’ for example” (SME17, 2016, p. 8). This would therefore ensure that all elements are addressed. SME9 went further, observing that crises are not linear events and that it is critical that the stakeholders are identified and managed; to this end “checklists make sure that you know that you have to communicate with all these people…and you know that you need certain information’ in order to do this effectively” (SME9, 2016, p. 4). Building on this theme, SME3 (2016, p. 10) stated that

"the ISO process is typically about checklists. But at the end if you are ISO certified it doesn’t mean your plane will not crash, it means you followed the structured
process to build your plane, but the checklist will not tell you whether your plane is able to fly. So, all the time you have to look at the two sides of the coin. Yes, there is a checklist of process management and then also the real management.”

It was noted that reviewing and potentially redesigning the checklists would be a valuable exercise, as would be the specialised training of the crisis leader in the correct utilisation of the complete collection of artefacts. In addition to enhancement of the checklists, there was certainly a perspective shown that there was now the opportunity for TCCS to become more modern with the creation not only of digital tools (SME6, 2016; SME15, 2016; SME21, 2016) but also of tools that would assist a team in addressing the changing social media landscape (SME21, 2016, p. 3). This could include the design and roll out of an ‘app’ to support the response and automate the existing routines. Ultimately, the findings in respect of the tools validate that they, irrespective of whether they are plans, checklists or analysis tools, are vital as they provide the structure for the response. Further, they assist in establishing the correct path and in creating calmness, while enabling the ostensive process to be effectively performed through ensuring that the teams are thinking the ‘right way’ in terms of the crisis management response (SME4, 2016; SME8, 2017).

4.4.2 Observations on Process Deviation

Having established the importance of the artefacts in guiding the crisis response, the data analysis now turns to examining and addressing the central theme of why the performative deviation from the ostensive routines occurs in the first place. As an important initial observation, it is noted that all the subject matter experts had observed the occurrence of process deviation at some point during their careers, irrespective of industry sector, or public or private service. It was further acknowledged that this behaviour had inevitably contributed to adverse outcomes, often creating new risks or exacerbating the crisis.

SME14 summed up the situation by stating that the problem stemmed from “the people that manage the tools...always its people, it is never the fault of the tool” (SME14, 2016, p. 3). This position argues against building a theory that argues that it is the design of the tools that impacts their level of use or is the reason for the process deviation to
occur. He went on to observe that while the tools are available “when the IMCR is opening, looking for the solution is in some way the priority, more than following the process” (SME14, 2016, p. 3). Building on this was the view that the process deviation has two causes. Firstly, ignorance of the existence of the tools. Secondly, an individual’s or team’s arrogance in thinking that the tools are not needed as they believe that they know how to solve the problem (SME1, 2017). SME10 observed that the tools sit in the background and it is known that they are there. However, the practical reality is that when the crisis commences the team becomes focused on ‘looking for the solution’ which in some way becomes the priority, rather ‘than the following the procedure’ (SME10, 2016, p. 3). An incorrect team structure, with members thinking that they know the solution before addressing the issues by leveraging the tools, leads to deviation (SME7, 2017), and it was argued that teams with strong leadership, where the coordinator ensures that the tools are utilised, perform the most effectively. SME15 (2016, p. 2) noted that in the CCEP teams of which he is a member, and from his experience, there is no sign of deviation “as the tool is on the table” and since the tools are seen as essential, they act as a compass in guiding the team on its journey to successfully resolve the event. This is attributed to the training of the individuals, the selection of the crisis leader, and the cultures that influence the behaviour (SME8, 2017; SME15, 2016).

Process deviation can result in investigations that have limited structure and, in some instances, lack logical direction in their fact-finding endeavours. One perspective following along this line was that team members rely on their own experience rather than leveraging the tools within the existing crisis management framework. This is compounded by the fact that “some of them may just not be familiar with the tools” (SME23, 2016, p. 3), which raises concerns with reference to the level of training afforded to the individual team members. Training can be enhanced through a formalised review process, thereby turning tacit knowledge into explicit knowledge supporting the utilisation of the artefacts. This will be addressed further in the discussions in Chapter 5.

SME20 (2016, p. 3) argued that “when people are under pressure, then they do not use the tools, they embark directly into managing the situation as it emerges.” This can be
linked to culture, which can impact process discipline and result in people running off and doing their own thing. Linked to this is the inexperience of the leader and the team members, where “people don’t actually know what they are doing” coupled with a “lack of role clarity and people not respecting other people in the room, and I think if I am really honest, where I tend to see it go horrible wrong, is where there is not enough constructive discussion and debate and review of options at each stage” (SME17, 2016, p. 2). These are elements and activities that can be minimised through the correct and timely application of the ostensive routines.

SME19 (2016, p. 3) contended that there is also a human nature element that requires the culture of the business to accept that when there is an incident

“reporting that incident and managing that incident in the proper way shouldn’t be viewed as a failure but rather as a success. A success because the processes and procedures are working...and recognising the severity of the issue, or recognising that the tools, in and of themselves, and the processes provide a framework whereby the situation should be properly resolved, if the tools are followed.”

This requires a positive business culture that accepts that bad things can happen, but that it is the way in which the business response is managed that will define the business in the eyes of its stakeholders. So, this means a business must be supportive in the receipt of ‘bad’ news and also have confidence in the capabilities of their crisis team to successfully resolve the issue.

SME19 went on to argue that there was a second element at play in influencing deviation and this related to team dynamics. Specifically, “within many team dynamics, you tend to get an element of ’I know better’ ” (2016, p. 5). That is where the team members believe that, as they have handled these types of situations many times before, the processes and routines are irrelevant. In these cases they perceive that they can simply jump to the solution without understanding what the issue really is (SME19, 2016, p. 4). Building on this SME10 (2016, p. 11), also argued along these lines and noted that where the team is of the view that they have experienced this type of case before they can fail to examine it through a fresh lens and this results in assumptions being made and the risk incorrectly addressed. In respect of this theme, SME9 believed that
“the natural action once you get into the crisis room is to do what you are comfortable with, what you understand, what you know. Now that’s a problem in a crisis, because very few people have extensive experience in it, so what tends to happen is, they don’t have time to read the plan, or don’t understand what is in that plan.” (SME9, 2016, p. 3)

Experience, or lack of experience, was also deemed to be an influencing factor as an inexperienced team often lacks process knowledge and the team members do not actually know what they are doing. Conversely, the experienced team has the awareness to understand that the tools act as a guide and therefore leverage them to drive their thinking and response. An aspect that can contribute to the deviation is a “lack of role clarity and people not respecting other people in the room, and I think if I am really honest, where I tend to see it go horribly wrong is where there is not enough constructive discussion and debate and review of options at each stage” (SME17, 2016, p. 2). This lack of constructive dialogue can have a variety of causes. SME16 (2017, p. 3) noted that “deviation can be caused by the desire to have a speedy resolution and the formulation of assumptions that we believe we already know the problem and we assume something, we don’t want to waste time on this (the process) and that is the beginning of the failure.”

SME21 also reflected that there is a moral and ethical dilemma that sometimes influences the utilisation of the process. He observed that “when things get bad it’s because people try and cover up something that went wrong in the beginning, it is more of a potential moral or ethical issue than did they use the tools correctly” (SME21, 2016, p. 9). Ultimately, while numerous rationales for the deviation existed the main theme related to the crisis leadership and the nature of the team itself. SME22 (2016, p. 3) identified a combination of leadership and culture in stating that:

“I think it is leadership, pure and simple, the person leading the meeting will either use the tool or they won’t, or they are not a strong person and they are afraid of being booed out of the meeting for wanting to instil discipline.”

The skills and attributes of the crisis leader and their team are critical particularly as that knowledge relates to: the broader business objectives; crisis and operational
experience; managing internal politics (an area that is often underestimated, according to SME3); and culture. Add to this mix team members and a crisis leader who are process adverse, and a formula for process deviation from the ostensive routines is established. It is then imperative that, through training and practice, the process framework is embedded, with a focus on highlighting the role that the artefacts play in minimising process deviation (SME3, 2016; SME4, 2016; SME8, 2017; SME9, 2016; SME10, 2016). This is a core element of the training regime which must be implemented. That is, there is a need to build the leader, build the team, and reinforce the ostensive routines and the utilisation of the artefacts (SME10, 2016; SME11, 2017).

In summary, several critical challenges were observed in relation to process deviation minimisation. SME14 acknowledged that the ongoing human interaction was a factor and that while the ostensive routines minimise deviation “having the right people in place is the most critical challenge” (SME14, 2016, p. 9). SME 4 (2016) conversely argued that the issue was created by the fact that the role of the coordinator is assigned by the virtue of their seniority and the nature of their ‘day job’ rather than their experience of crisis management. The risk here – and perhaps this can be described as an unintended consequence – is that they lapse back into their ‘normal’ role rather than focusing on the duties of the coordinator, and this creates a formula for process deviation. Lastly, SME 01 (2017, p. 12) stated that process deviation minimisation is all about getting the group dynamics right. This can be achieved through having a mature and professional coordinator, an individual that can interpret the team dynamics, and navigate the chatter, the psychology and the personalities, thereby drawing the best from the team. This thinking presents a lead in to the next sub section that addresses the role of the team and the crisis leader.

4.4.3 The role of the team and the crisis leader

The previous sub-section presented the findings of the value and role that the artefacts play as the core pillars, or elements, of the ostensive routines. This section examines the findings as they relate to the team’s involvement in process deviations. The discussion on the team incorporates the role of the crisis leader in the application of the ostensive routines and the utilisation of the artefacts that support the response. Referencing the
cluster map in Figure 21, the interconnectivity of the concept nodes illustrates that there are various related themes with respect to the team, with this element having the second highest number of referencing results. The team’s importance to crisis resolution is exhibited via the direct linkage to the core concept of the crisis, with related connections extending to: the experience of the team; the structure of the team; and the ability to enhance the team through training and simulations. The coordinator, or crisis leader, is central to this concept, with an intrinsic link to the personality type of the person selected to perform this role. An outlier in this space, but of no less importance, is the role that different cultures play and, interestingly, this links to both the leader and the process application.

From the outset, the observations reinforce the importance of the team for, irrespective of the tools that exist, it is their application by the team that will critically impact the performance. As SME7 (2017, p. 2) noted, the team is “fundamental to the success of the response” with the key being to have the correct team leader to ensure that the processes are adhered to. While the tools may need a little refining, the process failure comes from human deviation. So, it can be argued that with

“weaker teams, sometimes it is the makeup, there is no clear strong leadership, sometimes there is over bearing leadership and other people can’t actually get their ideas onto the table, which are necessary. Then sometimes it is a general lack of structure, and again I think that underpins why the tools are very useful to help guide us through in various stages.” (SME2, 2016, p. 5)

To begin with, the discussion will focus on the team leader, or, in the language of TCCS, the crisis coordinator, and the role that leadership plays in this regard. This is because the team works best when there is a “good coordinator” with management consequently “trusting the team” (SME14, 2016) and their recommended courses of action. It is the strength of that leadership that ensures performative process deviation minimisation.

In this regard, it is acknowledged that one of the greatest challenges faced by the members of the crisis team is that this is very rarely, if ever, their ‘day job’. The members will come from a variety of business disciplines and, while each has experienced different types of stress and pressures, crises are unique in their
complexity, and the high stakes of the situation can influence behaviour. SME10 (2016, p. 2) described the situation of a team coming together when it is still underprepared. Imagine: “the tiger bursts into the room and starts mauling everybody. And that’s where I think they lose it. They are somewhat out of their depth, as it is not what they do as a full-time role.”

That said, it was also argued by SME9 (2016, p. 6) that this does not “mean that a team that just comes together for one purpose cannot effectively look at the problem, and I think that is where the tools come in, they enable you to sort of step back and have a broader look at the problem. It doesn’t then matter if you have been together for ten minutes or ten years.” Issues with experience can also come from the fact that the careers and personal backgrounds of the team members will influence their behaviour in a crisis, as very often members of the team are selected due to the position that they hold rather than the result of an assessment of their relevant capabilities. Compounding this is a business perception that an individual is unlucky to be chosen for the crisis team rather than there being an acknowledgement as to the importance of the role. This needs behavioural change and to “remedy that it would have to come down from the top letting people know that IMCR (crisis management) is a KPI for everyone and that everyone in the company will rotate through” the crisis team (SME21, 2016, p. 8). This would acknowledge the contribution to crisis response by all relevant managers.

Within the team dynamics artefacts play a pivotal role in being able to support an otherwise novice team in overcoming the complexities of the crisis response. This is linked to the structure of the team and ensuring that the right people representing the right areas are present. This ensures that the correct resources are applied to the problem at hand. SME7 observed that it is important not only to have the right functions but the right calibre of people in place, and this is part of the process governance during the first phase of a crisis. She argued that this is the role of the crisis leader, making sure “that there is a clear owner, that everybody knows their roles” (SME7, 2017, p. 6). SME14 (2016, p. 5), when commenting on the team, reinforced the importance of keeping the team small as “too many actors can add confusion” for he had observed on a number of occasions that too many “people inside a meeting, especially a crisis meeting, can only add chaos.” This leads to issues with the quality and timeliness of the decision
making. This was noted by SME11 (2017) in his observations on the cases cited in the vignettes for 2016. In his market, a lack of leadership direction created an environment in which chaos became the norm. In addition, trust within the team is critical and here SME20 argued that there is a necessity for the actors to come together to rehearse when there is no crisis, for

“If you don’t work on the good days, you cannot work well on the bad days, so that is, if I were to recommend something is to do some kind of team building or those people who are working on the crisis teams to somehow connect them when things are good, make them opportunities, not only put them under pressure” (2016, p. 5).

Consequently, the composition of the team was a common theme. Selecting the right type of people ensures that not only can a team approach the problem in a more effective way, but an understanding of the individuals and their personalities creates an environment in which the coordinator can drive effective process compliance. This would then lead to a more effective process response. In totality, the SMEs saw similar traits as being critical in this regard. SME21 stated that it was important to have

“people who are responsible and accountable, people who are proactive, don’t wait for a problem. So, proactively they would have the inclination to deal with something early on rather than wait until it festers. I would want people who have good analytical ability and who can write, who can do scenario planning, and people who are good analysts, and proactive, and also good communicators” (SME21, 2016, p. 10).

SME3 commented that in his experience a team is effective and really works well together when a strong team spirit exists. This is created through longevity of the team and its members, and he built on this theme by observing that the “longer the team is operating the more better [sic] it is going. That is clear” (SME3, 2016, p. 6). Longevity through keeping team membership consistent is crucial to success as it builds capability through experience.

A risk, however, existed with respect to the selection of the crisis leader in that while the coordination element is critical “one of the undermining factors that happens is that
someone looks at a coordinator in a crisis situation as not an equal team member at the table, but almost like a note taker or someone who is not critical to the discussion” (SME17, 2016, p. 8). The title utilised creates a perception that they are not an equal contributor to the process, versus the use of the title of crisis leader. Additionally, SME21 (2016, p. 6) went on to argue that there is another misconception, which is that this role is only important during the response to the crisis. The reality is that the role serves a broader purpose from both a pre-crisis and a post crisis perspective. SME7 agreed with this concept and stated “that there are three things that make the role of the coordinator really important. One is before the crisis, always make sure that the materials are up to date, that the team knows what to do, that you practice once in a while without an audit.” (SME7, 2017, p. 5) There is also the importance of the post incident review and debrief that strengthens capability through critical self-assessment of the team’s performance.

Therefore, the importance of the crisis leader’s role was reinforced. Respondents acknowledged that it is vital that the right person is in place and that due to the criticality of the role it is essential to ensure that businesses should think twice about whom this position should be assigned to (SME3, 2016, p. 3). This requires the business to actively move away from criteria that see selection linked to a specific function such as public affairs and communications (PAC). SME17 (2016, p. 4) supported this position by arguing that “I think you are looking for a personality style versus functional knowledge” yet with strong acknowledgement of the importance of functional expertise. In identifying the correct person for the role, SME18 (2016, p. 5) commented that she would seek an individual that is “open and willing to cooperate...open minded looking very broadly at the issues...with an ability to listen.” The listening element is crucial as it engenders respect and trust which are the foundations on which the crisis leader creates trust within the team. Without trust amongst the team members the response can become dysfunctional and this can create occasions where individuals will ultimately “want to verify every single sentence” and piece of information coming from members of the team (SME14, 2016, p. 4).

The importance of the crisis leader was also illustrated via the use of various metaphors by the SMEs. This is because the leader is in fact critical in navigating the team through
the complexity of the situation, the associated administration and the complexity of the correct application of the processes, routines and utilisation of the artefacts (SME18, 2016, p. 3). SME19 (2016, p. 6) commented that “they are the team captain and it doesn’t mean they are the best player, and in fact they need to recognise when they are not the best player” to leverage the team to focus on the problem at hand. Building on the acting metaphor that sets the theme of the paper, SME20 (2016, p. 6) saw the crisis leader as the conductor of the orchestra. However, with that said, the conductor is only as good as the orchestra that they are conducting and their skills and ability to work as a team, which can be argued as linking back to the importance of experience within the crisis team. SME2 (2016, p. 9) used a slightly different metaphor, seeing the crisis leader as:

“a ringmaster, who brings the people in, subject matter experts, he frames the discussion, tell us what we know now, what’s happened here, what don’t we know, how can we find out, who’s going to take that work forward. Ultimately, when they are performing well they also have the ability to ensure that the team remains calm and focused.”

The role has a process orientation, in that the crisis leader must ensure that the artefacts are being used, yet it is also critical to “have the right people at the right time, work as a team, following the process no matter what the issue is” (SME23, 2016, p. 4). SME23 also asserted that he saw the crisis leader as also needing to have some core attributes, specifically the ability to be “transparent, responsible, disciplined, experienced, skilful, team work, cooperative and have the capability to orchestrate constructive debate. They must be independent, being able to raise questions, challenge the boss, and also the company” (SME23, 2016, p. 4). SME2 (2016, p. 3) reinforced the importance of a coordinator who has the ability to “step in and kind of help guide the process”, particularly in those cases where she observed that “people’s personalities started to take hold and it seemed that whoever spoke the loudest in the room got most of the attention.” Additionally, SME1 made the observation that

“if someone isn’t necessarily shepherding that process with a strong sense of confidence, open mindedness and willingness to kind of understand what the
accomplishments need to be in terms of the process then it doesn't work well. That to me is the corner stone right there. A strong capable coordinator with the right leadership backing, I think the process works really well” (SME1, 2017, p. 3).

While having the right people with the correct skill sets around the table is important, it is the capability of the crisis leader to leverage those skills to the best possible outcome that is critical.

Within the concept bubble containing the coordinator (crisis leader), which emphasises the importance that needs to be placed on the coordination, a further deep dive of the findings noted the importance of the leader as being the critical element in ensuring that the team works effectively. In this respect SME4 outlined his view of the importance of this theme by stating that

“in my opinion, I think that teams perform well when there is a clear guidance or leadership. In our case this is the IMCR coordinator, or crisis manager, who is more process orientated making sure that everything is being done according to the processes, procedures and rules rather than just jumping into conclusions and trying to resolve the incident” (SME4, 2016, p. 3).

Thereby, as the role of the coordinator in TCCS is viewed as that of a leader, the focus moves to understanding, in the opinions of the subject matter experts, what are the attributes of an effective crisis leader. SME9 noted that he saw two key elements at play, for “what you really need is someone who has the personal and professional skills to lead a process as opposed to performing some functional role within it” and “someone with a skill set that can facilitate a meeting” (SME9, 2016, p. 5). SME23 (2016, p. 5) argued further that “the coordinator's main responsibility is making sure the IMCR process works well and get everyone on board, timely, and the right people on the team and also this coordinator is responsible to connect sufficient information, conduct analysis of the problem, timely escalate to senior management for their decision making.” Leadership, and not that conferred by seniority, was critical. As described by SME22 (2016, p. 5)
“if you had poor leadership, if you had a poor leader, it could exaggerate that aspect where people defer to the senior most person who does not uncover, raise concerns, questions, doubts, to strengthen the discussion, to strengthen what is known about the understanding of the case and how we are going to deal with it.”

This acknowledged the importance of leadership skills as a trait that needed to be present in an effective crisis leader. SME10 (2016, p. 3) presented the opinion that the coordinator needed the following attributes:

“Definitely self-confidence but not to the point of arrogance. An ability to make quick decisions, an ability to assess the evidence that has been put in front of them. An ability to give directions for a more thorough investigation to take place to verify the evidence, and a very clear ability, having used the process which we currently have, and gone through the tools that we currently use, to be able to use that information, impose one upon the other to come up with options available and then be able to reach that consensus with others.”

Others (SME8, 2017; SME11, 2016; SME16, 2017) observed that possessing business experience and business insights were critical attributes for the crisis leader as they assisted in gaining the respect of the team members. With this respect flowed team engagement and cooperation. This led to SME17 (2016, p. 7) observing that there is a need to speak in “terms of someone who is heavily process orientated and someone who has got that intuition, experience, ability to kind of keep moving it along” and that additionally there was the importance of having experience in “coordinating things, not necessarily crisis management. But someone that works with diverse teams and manages the best of people” (SME20, 2016). The individual needs to be detail orientated as a priority, with a level head and professional maturity, and to be calm, cool and collected. These attributes of demeanour are seen as contributing considerably to the effectiveness of the role through creating the mechanisms for structure and discipline (SME1, 2017; SME10, 2016).

In respect of this element, the crisis leader, in addition to being process driven, with a cool head and the ability to lead a team of multi-disciplined members, needs to be a strong communicator, ensuring that team members understand the role sort and task
allocation. This is because when things really go wrong, in addition to allowing process deviation to occur, which can be linked to poor discipline, there is a direct correlation to poor and ineffective communication amongst the team members. This is often allowed to occur due to a lack of leadership and team coordination (SME6, 2016, pp. 7,8). Therefore, effective coordination is essential.

To close this topic, it is fitting to cite the views of SME13, who encapsulates some of these core themes, in particular the element of team trust which allows the team to avoid such issues as panic. SME13 (2016, p. 5), in discussing the operational dynamics relating to a crisis response spanning over a year, stated that

“at all times, we did not panic. We did not blink I would say, we understood that at one point this crisis would have a finish. So, we try to look to see what are the, how do you say, what are the boundaries of what can happen. What is the worst-case scenario and what is the very optimistic scenario pretty much trying to act within these boundaries? Because the crisis was not just the risk about losing assets for example, or just about the people, but it was also about business continuity.”

When a team understands all the core elements and the linkage back to other core aspects such as risks and worst-case scenarios that are brought into vision by utilisation of the tools, the crisis can be effectively managed. An interesting footnote to the topic of teams and crisis leadership is: where ultimately should the focus of the development reside – with the crisis leader or with the crisis team, or should there be a balanced focus on both? This guides the presentation of the data findings into the area of people development.

4.4.4 The role of training and suggested process improvements

Referring again to the concept bubbles in Figure 21, the next of the interrelated themes to be examined in more detail relates to the role that training plays. The importance of training was evident both through the observations during the simulation exercises and from feedback; it was also a common thread within the SME observations. Training is critical as it enables a team to build on the existing specialised capabilities both of the team members and of the team leaders. So, while it is critical to select the right people
for the team, people with the correct capabilities, authority, respect and experience, it is even more crucial to implement a training program that contributes to the ongoing capability development, and at a frequency that ensures that those crisis teams that do not experience a live activation on a regular basis remain ‘battle ready’.

Training therefore is critical to ensuring the overall effectiveness of the crisis response. SME18 (2016, p. 3) in her observations said that if we want to enhance capabilities and response then “training is the key”, with some observers noting that it was second in importance only to ensuring that the correct people were placed onto the team with the training enhancing interoperability and connectivity (SME2, 2016; SME10, 2016). In fact, one of the reasons why the deviation occurs was linked by the SMEs to a lack of training due to the environment that crisis team members experience when they are thrust into the complexity of an unfamiliar situation. This can drive individuals to reverting to thinking that the issue is out of control. SME10 (2016, p. 5) argued that this was in his opinion one of the major contributors to process deviation for it is a business failure not to exercise and train teams with a high level of frequency. A lack of frequency means that the teams miss out on gaining vital pre-crisis experience in the use of the artefacts. These are skills and understanding that can be forgotten, unless tested in real life between the training sessions. While simulations may not fully test the team, they are central to developing a baseline understanding of the processes and routines together while enabling the team members to become comfortable with one another.

Where, though, should the focus of the training be positioned? One view, as presented by SME 10 (2016, p. 11), was that there should be an equal weighting placed towards both the crisis leader and the team. Here there is a fine balance to be attained and conversely it was argued that an emphasis should be placed on the coordinator. Here SME4 (2016, p. 8) noted “that an 80/20 approach in favour of coordinators” would provide the most value-add. This would require the training to provide a focus on leadership, decision making and the core element of process management. This was aligned with SME1 (2017, p. 11), who presented a position that the focus must be on the coordinator, particularly as they have the potential to maintain stability while other members of the team may come and go. SME21 (2016, p. 12) built on this by arguing that it is vital “to have a dedicated coordinator who acts as the nexus for coordination” and from there it
becomes that individual’s responsibility to train and educate the team members. However, the additional counter argument was presented by SME 23 (2016, p. 8) with support from SME14 (2016, p. 9), who argued that the priority should be “focused on how the team members act effectively as a strong team rather than as any one individual.”

Ultimately, though, there was a solid argument for ensuring a focus on the crisis leader. The reality is that no matter how good the team is, it is the crisis leader who will be responsible for providing the fabric of the structure, for ensuring routines are followed and for keeping the team on track. This requires those responsible for the development of the training modules to create a stream that builds on the team approach yet enables specific time to be allocated for the crisis leader’s development. Here, the focus would be on the critical actions that need to be applied to minimise process deviation and the mechanisms that can be applied to control a team that attempts to take short cuts. This training then needs to be held at a frequency that enables it to become second nature and automatic for all participants. By becoming second nature, the training creates confidence in how the crisis team should perform in a real life situation (SME3, 2016; SME11, 2017; SME15, 2016).

Central to the training theme was the importance of the training being strongly aligned to real life experiences. This alignment is generated through effectively capturing the lessons learnt from active cases, dissecting them and creating the training scenarios from that data. This requires the creation of models that bring together organisational learning and involves structuring the approach to case reviews and their analysis, and to dissecting lessons learned. By ensuring a lesson learned and review program is integrated into the ostensive routines an organisation is able to ensure that effective organisational learning is implemented. It is from this process that a business can identify best practices, particularly as they relate to process deviation minimisation. This knowledge is then shared and its integration into the training ensures that the team avoids similar situations occurring in the preventative stage, and, in the event that a situation eventuates, it ensures that the correct protocols are in place to respond to the crisis (SME2, 2016; SME17, 2016).
One of the challenges faced in gathering this important data is the attitude of the team and an inability of the individuals to see past their own real-life experiences and recognise different types of crisis warning signals. A position where individuals are not willing to look more broadly and acknowledge that a change in direction may be required can contribute to making the learning process in both the pre-crisis and post crisis stages of the crisis management cycle quite challenging (SME3, 2016). This is another dynamic for the crisis leader to consider. The pre-event planning and how a team can develop further from the learnings of others. Post crisis, the lessons learned sessions are only accomplished by finding the time to draw the team together after the crisis is over. It has been observed that there is often no real desire to do this as the crisis team members are simply keen to return to their day jobs. “Everyone is so busy in the business that once something is resolved, there is no real opportunity or really an appetite to get together and do that” (SME1, 2017, p. 3). This attitude must be overcome to ensure that data sources exist to enhance the training program and participant experiences. There are numerous ways to do this. The most effective is for a business to formalise it as a governance requirement, thus it becomes mandatory to conduct a process review prior to the case closure. To obtain this executive endorsement is critical as it will drive the organisational compliance.

Linked closely to the discussions and views on training were mechanisms to enhance the overall training and actual response capabilities. A core theme that emerged was the importance that technology can play as a response enabler. Some of the subject matter experts wondered if, with all the advances in technology since the tools were designed in 2001, there was a way in which the tools could in fact be automated (SME22, 2016, p. 8). SME6 argued that there is an immense opportunity to leverage software and develop by way of example an “app to guide the conversation and if you have not yet fulfilled the actions that are needed in the process step you are not allowed to the second or third or fourth” (SME6, 2016, p. 4) steps. However, if the checklist is too rigid it would have the potential of becoming a ‘READ-DO’ checklist, controlling the thinking and removing innovation which ensure that the resolution is carried out in a timely manner. Checklists do have a role to play. However, this is arguably more with respect to the confirmation checklist modelling style. Therefore this would require any application to provide flexibility for the team to move efficiently through the processes, while
minimising the risk of process deviation (SME11, 2017). It would be critical here to ensure that the automated tools are embraced. Simply creating a new automated artefact does not necessarily translate to utilisation and the risk of process deviation would not be mitigated if the medium was simply changed.

4.4.5 The role that culture plays

Culture, whether organisational or national was a theme that was linked to various concept elements. Referring to Figure 21, culture as a theme was linked to the people concept. This dealt with the nature of the people on the team, and the concept that addressed the processes themselves in operation and extended to the crisis team dynamics and to the crisis leader themselves. During the simulation observations, the role that culture played was particularly evident. SME8, who has oversight of the crisis management response across the CCEP markets (e.g. France, Spain, Germany and the ‘Nordics’ operations), noted that that culture is a central risk. Culture has resulted in teams going off on tangents and deviating from the process as they think that they know best. This had been observed particularly in the Nordics, where culture had etched responses into the team approach, resulting in the routines not being utilised due to the fact that the team held the view that they knew what a response should be, simply by the scenario presented. The result was that on several occasions this deviation had seen the incorrect problem being managed. Building on culture from an organisational perspective, SME3 (2016, p. 7) commented that

“culture plays a significant role from step one. From problem identification... a lot of times people feel that, they will not report IMCRs as they think it will reflect badly on themselves, that they made mistake or are not doing their job right, and the culture of reporting mistakes, or the fear of you know of punishment or retribution is very pronounced. Whereby if you can build a different kind of culture that promotes transparency and encourages people to act on issues, to proper communications early, sooner rather than later, that is the kind of cultural that we would like to have but we don't necessarily have all the time.”
Hence, the business culture had the ability to influence the response and this was often exacerbated by the dynamics of the national culture. SME14 (2016, p. 7) continued in this vein and argued that

“culture is fundamental because culture has a direct relation with people which are at the centre of the management of the crisis. Crisis management is not the tool, is not the procedure, it is not the policy, it is the person, so culture has a huge impact. The important thing is that there is not a right or wrong culture, the important point is to know that culture works in that way.”

Ultimately culture was observed to influence a number of elements. These ranged from influencing the manner and extent of process deviation, which will differ across markets (SME8, 2017, p. 3), to the nature of leadership that exists and its application in the operational response stemming from cultural interpretations (SME10, 2016, p. 5). Culture plays a role as “there are disciplined people and not disciplined people. So the more you come to the south the more undisciplined they are, the more you go to the centre of Europe, the more disciplined” (SME20, 2016, p. 4). This was in reference to European cultural dynamics and an observed behavioural shift across geographic regions. This insight links to an example that was noted during the simulation observations in a market in southern Europe. As the simulation progressed, the team in question became very noisy, disjointed and appeared unstructured in their response. The situation at times became extremely chaotic and at one point the General Manager, who was sitting with the researcher observing the response, made the comment that “we are quite loud and appear somewhat disorganised. You know though that we [nationality removed] will get there in the end” (SME11, 2017). Post this simulation the researcher trialled a specific training program for the crisis leader. The focus was on process adherence, creating structure, and guidance on managing individuals on the team. Through one on one engagement over several months this crisis leader developed significantly, to the point where she became one of the strongest observed. This validated the value of one on one crisis leadership education.

Returning to the specific simulations and the observations, these were considered from the comments of SME11 that related to the performance contrast between southern and
northern European cultures. This was a theme which resonated with many of the SMEs. This contrast was observed in both the simulation and real case responses in the Balkan region and southern Europe, including Italy and Greece. Here a higher level of disorganisation was observed (SME11, 2016), including a lack of adherence to process and structure. This was in sharp contrast to the approaches observed in Poland and Switzerland, for example, where adoption of structure and the routines appeared second nature. In respect of the team dynamics and interaction, the cultural element also plays a significant role in whether or not members of a team voice their opinions. This is particularly evident in Asian markets, such as Japan and South Korea. Here it has been observed that managers will defer to, and not challenge, those that are considered ‘older’ and ‘wiser’. This can impact decision making, since having an opinion and voicing it while on the crisis team is crucial to ensure that processes are followed, and innovation and opportunity are leveraged. The examples of cultural dynamics illustrate the importance of understanding cultural nuances and adapting the operational response guidance and field training to take these into account.

However, culture also plays a slightly different and perhaps somewhat more critical role outside the dynamics of the core response and the linkage to process deviation. This role relates to the area of ethics, trust and transparency. SME19 (2016, p. 8) noted that “culture plays a big role in people speaking out and of course during crisis management you hope for clarity and transparency, you need that to be able to make the right decisions.” This drew the inference that there can be a cultural tendency not only to hide the emergence of the crisis itself, but, in the response, to play a specific role in impacting the information being provided to the members of the crisis team. SME17 (2016, p. 6) built on this theme by observing that as

“westerners we have a very, fairly clear line in the sand around truth and non-truth but for a lot of cultures that line is very grey. It is self-preservation from history, and that also makes crisis management very difficult, because people feel if they describe what has gone on, that someone will be held to account or blame and culturally that just doesn’t work”.
This creates concerns in respect of the outcomes that may arise and can result in a tendency to cover up some aspects while also downplaying events so that they are not considered a crisis or an incident (SME23, 2016, p. 4), thereby reducing senior management visibility. The response therefore presents a clear linkage both to culture, with a strong link to the experience of the people on the team, and the personality types of the individuals (SME21, 2016).

While culture played a role, a critical takeaway was that there was a necessity to focus on strengthening the leadership capabilities of the crisis team leader. This included educating the leader regarding mechanisms to help in maintaining control, which was as easy as a new process involving a clear meeting agenda. These observations on culture and personality create the foundation for the next section of the findings which relate to personality styles and the role that personality plays with the crisis team members, the crisis leader, and the linkage of behaviour to process deviation.

### 4.4.6 The role of personality types in crisis team dynamics

Building on the earlier findings, it was noted that for a team to be effective it was crucial that it “first and foremost experiences working together as a team” (SME2, 2016, p. 4). Teams must also have the ability to understand the bigger picture with a composition of “people who are calm under pressure, people who work well together and have a proven track record of working well, people who know what their limitations are and when they need to call in subject matter experts” (SME19, 2016, p. 7). In the discussions with the SMEs their views consistently support the importance that understanding personality can play in the teams’ response. This supported the direction taken in this research to undertake a preliminary analysis of the role that personality plays. As noted previously, the abilities and skills of the crisis team members and the crisis leader are fundamental to the response, and these abilities directly contribute to minimising process deviation.

In examining the current approach to creating the structure of the crisis team, it is observed that this is often achieved through the placement of functional senior managers onto the team. The logic here is that these managers bring with them specialised skills, and that due to their position in the organisation and their work experience they will operate effectively in a crisis situation. This has been observed on
multiple occasions as not necessarily being the case. Therefore, it is argued that there should be a shift to create teams based on skills and attributes versus seniority or role sort. This modelling drove the question: what impact does an understanding of the personality types, of both the crisis team leader and the crisis team members themselves, have on the effectiveness of the team? This included discussions that centred around which function should take the lead in the crisis response.

In discussing this with the SMEs and with the crisis team participants during the post simulation debriefs, it was evident that there was a strong view that a level of understanding in respect of personalities would contribute to the overall effectiveness of the crisis team. SME20 (SME20, p. 3) noted that “we should be looking for a personality style versus functional knowledge”, which is diametrically opposed to the common model for selecting crisis team members. Building on the finding that effectiveness comes from the experience of working as a team, which is linked to the level of team work and collaboration (SME2, 2016, pp. 4,6), it was noted that it was important to respect each other’s abilities. It is “not just about getting these things ticked off, its let’s think this through, let’s work at this to get different perspectives and how do we come up with the best strategy to leave us in the best possible position” (SME9, 2016, p. 6). Acknowledging the importance of having the right team members, the subject matter experts saw the benefit of deep diving into the personalities of the team members assigned to the team. In this regard, SME7 noted that it would be an excellent idea, as that process would provide “us the most appropriate insight.” Additionally, she went on to provide her unprompted view, based on MBTI, of the personality type that in her view would make the best leader. She stated, “I think if there is a type, and if you asked me, give me a type, I would argue that ESTJ would be the best coordinator” (SME7, 2017). SME19 also acknowledged the role that personality assessments could play. When presented with the concept he stated that, “any type of psychological profile in terms of how people work and then assembling a team that complements each other, from a skills and weaknesses, strengths perspective would be useful” (SME19, 2016, p. 8).

SME8 (2017, p. 7), while acknowledging the important contribution this could make, did extend a caveat in that, while determining the personality type has a role to play, care
must be taken to not use that as the mechanism to automatically discount a person. Rather, for the crisis team the purpose should be to leverage this understanding and utilise that knowledge to implement strategies to enhance the team's capabilities. This would enable additional discipline to be instilled, ensuring that teams are not composed of exactly the same type of qualified people. This would also ensure that the team has the correct balance and competence to address the issue at hand and effectively answer all the questions that are posed by the processes and the tools (SME21, 2016, pp. 3,5).

In this regard, as outlined in the methodology, the research conducted a preliminary evaluation of the role of personality by focusing on the application of MBTI against both the subject matter experts and the crisis leaders observed in Coca-Cola HBC during simulations and ‘real life’ case responses. Addressing the subject matter experts first, as detailed earlier the participants were all experienced crisis management leaders who the researcher had had direct experience observing their performance in this field. As part of the interview process each of them agreed to undertake a Myers Briggs evaluation with the objective of presenting a top line initial evaluation for comparative purposes. Figure 22 illustrates the breakdown of the personality types within the subject matter expert sample pool.

Of the SME’s eighteen responded to the survey with the prevailing classification being ESTJ (39%) and overall extroversion was the primary factor in the categorisation (67%). In discussions with the SMEs about this finding it was noted that while the level of extroversion varied in the respondents, extroversion as a trait may enable a crisis leader to exert more influence on the dynamics of the team. This, coupled with the sensing dynamic or the intuitive dynamic, had the potential to influence thinking and problem solving with both potentially influencing the individual’s ability to minimise process deviation.

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3 Myers Briggs Type Indicator methodology and the classification model are addressed in detail in Appendix I.
The second evaluation focused on an assessment of operational crisis leaders that were in position in the field during the period January to March 2017. As detailed in the methodology, there were two elements to this evaluation. The first was a qualitative assessment of the individuals based on the observations of a panel of four SMEs that included the researcher. Each of the observers had the opportunity to evaluate the individuals in operation for a period of between six and thirty-six months. The first stage was an evaluation of their capabilities in crisis leadership (Y axis), the second being in the field of application of processes and routines (X axis) with a focus on their ability to minimise process deviation. Of the total group of twenty-four (24) SMEs and field participants approached to participate in the personality type evaluation, seventeen (17) agreed to undertake the Myers Briggs evaluation. These were depicted in the coordinator evaluation chart which is shown in Figure 23.

Having concluded that evaluation, the Myers Briggs data of the respondents was assessed. This was then modelled against the capability matrix to identify if there was a specific Myers Briggs personality type linked to the high performing individuals on either the leadership or process application axis. For the purpose of classification, the highest performing leaders were deemed as rating at eight and above for both leadership and process adherence. Six respondents were identified in this quadrant. Two additional elements were recorded, these being the nationality of the leader and the function that they represented on the crisis team. These were logged to enable an evaluation of the inter-relationship of culture (derived from nationality), function and
personality type. The evaluation depicted in figure 24 illustrates that in total 44% of the coordinators were ENTJ, which may be linked to their actual business role sort. In this instance, the majority (8) of the ENTJ respondents had a role in the area of Public Affairs and Communications. Of the six rated as the highest performers, three were ESTJ, one was ENTJ, one was ENFP and one was ENFJ. Of the ESTJs, there was no stand-out function, with the roles covering risk, security and sustainability. With respect to the respondents from the risk and security field this may be linked to the nature of the roles that they had undertaken during their pre-business careers with a strong link to disciplined roles in law enforcement and the military.

In respect of country of nationality of the six identified high performers, the countries represented indicated Australia, Bulgaria, Ireland, Switzerland, Ukraine and the United Kingdom. This did partially support an inference that a northern European background may positively impact the ability and skill set of the crisis leader. It was interesting to note that the Bulgarian respondent had a strong business and educational background stemming from operating in a northern European environment. It is concluded that there is certainly an opportunity for further research into both the personality type that best fits with a crisis leader, together with the role that culture plays in process deviation.

Figure 23 – Crisis Leader Skill Evaluation
Table 5 – Crisis Leader Personality Data

<table>
<thead>
<tr>
<th>Nationality</th>
<th>Leader</th>
<th>Function</th>
<th>MBTI</th>
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<tbody>
<tr>
<td>Croatian</td>
<td>1</td>
<td>PAC</td>
<td>ENTJ</td>
</tr>
<tr>
<td>Dutch</td>
<td>2</td>
<td>Sustainability</td>
<td>ENTJ</td>
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<tr>
<td>Estonian</td>
<td>3</td>
<td>PAC</td>
<td>ENTJ</td>
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<td>Belarusian</td>
<td>4</td>
<td>PAC</td>
<td>ENFP</td>
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<td>Bulgarian</td>
<td>5</td>
<td>PAC</td>
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<tr>
<td>Russian</td>
<td>11</td>
<td>PAC</td>
<td>ENTJ</td>
</tr>
<tr>
<td>Swiss</td>
<td>12</td>
<td>Sustainability</td>
<td>ESTJ</td>
</tr>
<tr>
<td>Ukrainian</td>
<td>13</td>
<td>PAC</td>
<td>ENTJ</td>
</tr>
<tr>
<td>Australian</td>
<td>14</td>
<td>Risk</td>
<td>ESTJ</td>
</tr>
<tr>
<td>Serbian</td>
<td>15</td>
<td>Security</td>
<td>INTJ</td>
</tr>
<tr>
<td>Dutch</td>
<td>16</td>
<td>PAC</td>
<td>ENTJ</td>
</tr>
<tr>
<td>United Kingdom</td>
<td>17</td>
<td>Security</td>
<td>ESTJ</td>
</tr>
</tbody>
</table>

Figure 24 – Myers Briggs Personality Chart - Crisis Coordinators

In respect of the personality assessment itself, the findings validated that there was a variance in the views as to which personality assessment provided the most effective evaluation of individuals. As outlined in the methodology, there is specific debate questioning the validity of Myers Briggs due to it compartmentalising individuals into
specific boxes. The potential weakness of Myers Briggs was identified by SME17 (2016, p. 4), who noted that the Hogan’s Assessment or Hermann Brain Dominance Index (HBDI) may be more effective tools as they do not compartmentalise individuals. Additionally, other tools such as NEO Personality Index (NEO PI) exist and have been utilised by the researcher as part of his business career. In this respect the researcher has a preference for NEO PI, as it categorises extrovert and introvert traits against situations, rather than boxing an individual generically into one of those two spaces. That is, the nature of the situation that an individual finds themselves in actually determines whether they will exhibit introversion or extroversion tendencies. The difficulty with NEO PI is its complexity and length, which for this research meant it was not suitable. However, for future research into the specific crisis management personality types of crisis team members, it would be argued that this potentially is a more appropriate tool. The findings also identify that future research into cultural dynamics and how they can be managed to gain the best out of the crisis team would be valuable.

Ultimately though, irrespective of the tool utilised, the benefit of applying a personality assessment was generally observed as an effective next step in the evolution of the design and modelling of the crisis team and its leader. The relevance of the findings will be evaluated in further detail in the discussion chapter.

4.4.7 **Perceptions of the role of risk management and business resilience**

The focus now moves to the discussion in respect of how the empirical data addresses the overarching theme of risk management and business resilience. This theme is evaluated as not only is it a common cluster, but it featured as a common background theme within the literature review. This was commonly observed as a critical pre-crisis routine (SME2, 2016; SME10, 2016; SME14, 2016; SME21, 2016) and was observed as having a role that “is lessened if it is restricted to the management of an ongoing incident and does not feature in pre-mitigation planning” (SME2, 2016, p. 17).

In the view of SME21, this pre-alignment is linked to a “direct correlation between the top risks identified and the actual incidents” (SME21, 2016, p. 12) that were experienced. The importance is related not only to the development of the preventative
planning but also to the creation of a positive management mindset that creates a
difference during the period of a crisis (SME2, 2016, p. 18). SME23 noted that from a
process perspective risk management must be more than an incident management tool.
“It covers the timely detection of the red flags” and due to the pre-work stage prepares
the crisis team for a “quick response and responsible root cause analysis.” The ultimate
benefit is that this process enables managers “to take intelligent risk that supports
healthy business growth” (SME23, 2016, p. 8) while enabling the preparation for risks
that generate crisis scenarios.

So, risk management was acknowledged as a critical proactive ostensive routine that is a
core component of the new business resilience paradigm. Additionally, there was strong
support for a business resilience design that incorporated proactive risk management
elements and was supported by effective response routines. As SME10 stated,

“preparation for and response to incidents can only work well if it forms part of the
same structure or function. If one department is charged with proactive work and
then fails, in the sense that a risk has become critical and become an incident, then
inevitably the parachuting in of a response function to ‘pick up the pieces and
repair the damage’ works against the concept of team work” (SME10, 2016, p. 10).

SME21 supported this thinking by stating that

“the risks identified through the risk management process are the most likely sorts
of risks that may turn into a crisis and thus identifying them upfront and making
mitigation plans should ameliorate any consequences if the identified risks turn into
a crisis” (SME21, 2016, p. 12).

Lastly, SME14 argued that

“having developed proactive and reactive tools gives the possibility to all the
management to work on the same page, taking responsibility for choices, that is
what to do with this risk, and then speak the same language during the
crisis”(SME14, 2016, p. 9).
Therefore, there is a need to ensure that the management of deviation is a focus not only during the crisis response stage but also for the aligned proactive activities. The pre-event stage is a critical time and the crisis leader must participate actively in the risk assessment and evaluation process. In this activity, process deviation minimisation also needs to be a focus and requires leadership to ensure that crisis management, and by default risk management, “is a core competency for all function heads and that they will be held accountable” (SME21, 2016).

4.5 Supplementary Thematic Analysis

4.5.1 Overview

This section outlines the findings of the thematic analysis from the manual data coding process. This activity was undertaken post the initial data evaluation by Leximancer, as a strategy that was recommended to validate the accuracy of those findings. The manual coding results are summarised in figure 25 with this depicting the findings in terms of 1st order codes, 2nd order themes and the thematic aggregation of the data. This section further dives into the findings by illustrating the construction of the 1st order codes by outlining in table form (tables 6-8) the supporting data and includes providing definitions for the 2nd order themes and contextualising the aggregated data. While it is evident that the resulting codes were not an exact match to the findings from Leximancer, as noted in the triangulation section, there was sufficient commonality in the outputs to validate that this coding process provided a realistic supportive interpretation of the initial data that further strengthened the initial findings.

As depicted in figure 25, the manual coding process resulted in the creation of ten “1st order codes” with these feeding into the six “2nd order themes” and subsequently into the three aggregated themes. In order to be rated as a 1st order code, 80% of respondents had to have referenced the concept of the code. The findings have been consolidated into three separate tables each capturing one aggregated theme. These tables define the theme, and SME quotes provided to illustrate the context. The tables
also note the percentage of the SMEs aligning with the concepts as linked to the identified themes.

The three thematic aggregations related broadly to the areas of crisis leadership; CMT composition; and a validation of the ostensive routines, artefacts and enhancing the performative element. The following sub-sections describe the findings further.

4.5.2 *Aggregated Theme: Context of crisis leadership*

This theme addressed the importance of the selection, experience and training of the crisis leader (referred to as the coordinator in this research), since they are the lynch pin between the ostensive routine and its performance. It is noted that linked strongly to leadership was the second theme relating to the construct of the team. Three first order codes fed into this theme. The first related to the effective selection of the leader and avoiding *ad hoc* approaches based on seniority and role or position with 96% of respondents aligned with this conceptual theme. This was because the team works best when there is a “good coordinator” with management consequently “trusting the team” (SME14, 2016) and their recommended courses of action. It is the strength of the crisis team’s leadership that ensures performative process deviation from the ostensive routines is minimised.

The second code related to the importance of ensuring that the individual had the correct skill sets, while the third element addressed the role that personality assessments could play not only in respect of the leader but of the broader team. This is crucial as a key contributor to the deviation from the ostensive routines during their performance in a crisis was linked to inexperienced leadership and having “a very inexperienced team on the whole. A lack of process, like people don’t actually know what they are doing” (SME17, 2016, p. 2). This second concept was endorsed by all respondents.
Figure 25 – Manual Coding Output
The context of crisis leadership focuses on the importance of the selection, experience, and training of the crisis leader which drives adherence to the ostensive routines by a leader's ability to leverage the capabilities of the team.

## Ostensive routine for crisis leader selection

<table>
<thead>
<tr>
<th>1st Order Code</th>
<th>Statements</th>
</tr>
</thead>
</table>
| Leadership selection is critical – avoid selection based on business seniority/role alone | "it depends on who is leading the team so it is clear that the coordinator role is critical" (SME3, 2016, p. 3)  
"do we have the right people at the table and have we made the right decision on who is going to lead this crisis" (SME7, 2017, p. 2)  
"subject matter experts, people that don’t panic, and people that are strong enough professionally" (SME8, 2017, p. 3)  
"I am not a big fan of role based. Actually, I think with team dynamics you need someone with a skill set that can facilitate a meeting." (SME9, 2016, p. 5) |
| Crisis leaders: unique skill sets, and experience enhances understanding of the ostensive routines and aligns the performance | "you do need people who are good at dealing with crisis and...there are people with certain natural abilities that lend themselves to being good crisis management managers" (SME2, 2016, p. 8)  
crisis manager should be "process orientated making sure that everything is being done according to the processes, procedures and rules rather than just jumping to conclusions" (SME4, 2016, p. 2)  
"best in class leader ... that is the key issue...a person who is really devoted, committed and understands the thing and manages to organise the work in a proper way and to use resources from different people different functions" (SME12, 2017, p. 3)  
"the right capability and the experience gives the good result. I think one without the other will not deliver" (SME16, 2017, p. 2) |
| Personality testing for leaders (and teams) strengthens the capability to adhere to the ostensive routines | "a way of making sure that team are collaborating and peoples experiences leveraged" (SME2, 2016, p. 10)  
"we should work closer with HR to spot the people having the right, having the potential to play, and manage” crisis situations (SME3, 2016, p. 9)  
"it is good to know each other's strengths and weaknesses as it will also improve the team dynamics when it is necessary" (SME7, 2017, p. 7)  
assessments would "encourage candour, to encourage the type of trust that is necessary in a team" (SME22, 2016, p. 7) |
### Context of crisis team composition

This theme integrates the importance of team dynamics, their experience, selection and an understanding of skill capabilities to minimise deviation from the ostensive routine.

<table>
<thead>
<tr>
<th>Team dynamics influencing performati ve routine</th>
<th>Experience, skills, knowledge minimises ostensive routine deviation</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>1st Order Code</strong></td>
<td><strong>Statements</strong></td>
</tr>
<tr>
<td>Culture: Understanding the role of culture (business/geographic) in performance of the ostensive routines</td>
<td>&quot;culture is always playing a role&quot; (SME3, 2016, p. 5)</td>
</tr>
<tr>
<td>86%</td>
<td>&quot;culture can influence leadership style and behaviours relating to adhering to process&quot; (SME11, 2017, p. 18)</td>
</tr>
<tr>
<td></td>
<td>&quot;if you have got a culture, that is based on hierarchy, it can have a huge impact&quot; (SME17, 2016, p. 6)</td>
</tr>
<tr>
<td>CMT members selection imp acts performance of the ostensive routines – skills v seniority</td>
<td>&quot;concept of we should select people that have, the natural traits to be good crisis managers&quot; and be part of the team (SME2, 2016, p. 12)</td>
</tr>
<tr>
<td>96%</td>
<td>&quot;we can be railroaded into selecting people because of their role, as opposed to their ability or capability itself&quot; (SME10, 2016, p. 7)</td>
</tr>
<tr>
<td>Crisis team member skills contribute to deviation from the ostensive routines</td>
<td>Lack of experience through &quot;having to come up with next steps as quickly as possible because this is crisis...we cannot waste no time&quot; (SME6, 2016, p. 3)</td>
</tr>
<tr>
<td>100%</td>
<td>&quot;the natural action once you get into the crisis room is to do what you are comfortable with, what you understand, what you know. Now that’s a problem in a crisis, because very few people have extensive experience in it&quot; (SME9, 2016, p. 3)</td>
</tr>
<tr>
<td></td>
<td>&quot;its people, it is never the fault of the tool&quot; (SME14, 2016, p. 3)</td>
</tr>
<tr>
<td>Crisis team members lack of experience, a belief of knowing best, contributes to deviation from the ostensive routine</td>
<td>&quot;quite frankly a little bit of arrogance on people's part. They felt that the situation didn't warrant using the tools or even reporting the incidents&quot; (SME1, 2017, p. 2)</td>
</tr>
<tr>
<td>91%</td>
<td>&quot;we sometimes jump to the solution...we know what to do, let's just do that and get on and back to normal business&quot; (SME2, 2016, p. 5)</td>
</tr>
<tr>
<td></td>
<td>&quot;without actually taking into consideration all the other things that may have impact on the incident itself&quot; (SME4, 2016, p. 3)</td>
</tr>
<tr>
<td></td>
<td>&quot;when an IMCR is opening, the look for the solution is some way the priority, more than the following the procedure&quot; (SME14, 2016, p. 2)</td>
</tr>
</tbody>
</table>

Table 7 – Theme in Manual Coding: Context of crisis team composition
Validation of ostensive routines and enhancing performance

This relates to the perception by the respondents as to the operational value of the routines and artefacts in supporting the crisis response and the criticality of learning and training in strengthening capabilities.

<table>
<thead>
<tr>
<th>Creating performative behaviours by leveraging routines</th>
<th>Training and perceptions drives utilisation of the ostensive routines</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>1st Order Code</strong></td>
<td><strong>Statements</strong></td>
</tr>
<tr>
<td>Ostensive routines and artefacts are robust and value adding with positive perceptions minimising deviation</td>
<td>&quot;even the most experienced teams benefit from actually going through the tools&quot; (SME3, 2016, p. 2)</td>
</tr>
<tr>
<td></td>
<td>&quot;usually in a crisis situation there is a lot of stress and they help you not to overlook certain things&quot; (SME8, 2017, p. 3)</td>
</tr>
<tr>
<td></td>
<td>&quot;these tools put the whole concept and work that we have to do in crisis situations in proper order&quot; (SME12, 2017, p. 4)</td>
</tr>
<tr>
<td></td>
<td>&quot;tools are essential and provide in fact the backbone to react and to analyse the crisis&quot; (SME15, 2016, p. 2)</td>
</tr>
<tr>
<td></td>
<td>&quot;one of the advantages of tools is that it makes sure that you are stopping, checking, and considering all the components&quot; (SME17, 2016, p. 2)</td>
</tr>
<tr>
<td></td>
<td>&quot;the crisis response process in place, was a key contributor to the fact that we managed to go out of this situation with the business growing&quot; (SME5, 2016, p. 4)</td>
</tr>
<tr>
<td></td>
<td>&quot;the right process, the right tools, and the concentration on this path that is given through this framework&quot; (SME16, 2017, p. 2)</td>
</tr>
<tr>
<td>Artefact utilisation guides the performative routine while enabling performance flexibility</td>
<td>&quot;For me they are very valuable, they are the bread and butter&quot; providing the framework and guiding the response. (SME7, 2017, p. 2)</td>
</tr>
<tr>
<td></td>
<td>&quot;extremely useful thing that has to be followed, because if you don't follow it, nine out of ten you are set up for more trouble&quot; (SME8, 2017, p. 2)</td>
</tr>
<tr>
<td></td>
<td>&quot;Checklists I think are really important... they sort of work hand in hand with the tools&quot;(SME9, 2016, p. 4).</td>
</tr>
<tr>
<td></td>
<td>&quot;So the tool is essential, the tool is a kind of as I said a compass&quot; (SME15, 2016, p. 2)</td>
</tr>
<tr>
<td></td>
<td>&quot;way for people to kind of consider a way to approach a problem and an incident in an holistic way&quot;(SME22, 2016, p. 2)</td>
</tr>
<tr>
<td>Review of the ostensive routines and performance post incident and integrate lessons into training</td>
<td>&quot;how did we manage the IMCR process? How do we think we did, let's give each other a grade, what do you think you would have done differently?&quot; (SME1, 2017, p. 10)</td>
</tr>
<tr>
<td></td>
<td>&quot;with the proper framework, proper people, proper experience, proper training should be as effective&quot; (SME16, 2017, p. 7)</td>
</tr>
</tbody>
</table>

Table 8 – Theme in Manual Coding: Validation of routines and artefacts
As SME 2 commented, deviation from the ostensive routines can come about through overbearing leadership where team members are not presented the opportunity to table their ideas. This general lack of structure underpins the importance of following the ostensive routines and utilising the artefacts that can guide the team through the various stages of the crisis response (SME2, 2016, p. 5). Therefore, in a business context, leadership selection should be formalised and structured with a resulting ostensive routine (2nd order code) driving the selection process. Importantly, in a business environment leadership should not be conferred by seniority or role/title, rather through an evaluation of the overall capabilities of an individual. This is important for as described earlier by SME22 (2016, p. 5)

“if you had poor leadership, if you had a poor leader, it could exaggerate that aspect where people defer to the senior most person who does not uncover, raise concerns, questions, doubts, to strengthen the discussion, to strengthen what is known about the understanding of the case and how we are going to deal with it.”

Additionally, “there are people with certain natural abilities that lend themselves to being good crisis management managers” (SME2, 2016, p. 8) with these crisis leaders possessing a combination of unique skills. These include strong process orientation coupled with an ability to remain calm, disciplined, be a good listener and decisive as and when required. This combination of skills and attributes contributes to process deviation minimisation.

The final 1st order code in this theme related to an understanding of personality types as they related to the leader and to the team, with 83% of respondents aligned with the concept. There was a prevailing view that this understanding would contribute to the overall effectiveness of the crisis team with SME20 (SME20, p. 3) stating that “we should be looking for a personality style versus functional knowledge”, which is diametrically opposed to the common model for selecting crisis team members. In this respect, SME7 noted that not only would this give leadership the most appropriate insight but that it could be used to confirm the personality type contributing the most to the process, which in the context of MBTI she cited as ESTJ (SME7, 2017, p. 7). Reinforcing the Leximancer observations it was also noted by SME19 that, “any type of psychological
profile in terms of how people work and then assembling a team that complements each other, from a skills and weaknesses, strengths perspective would be useful” (SME19, 2016, p. 8).

A caveat on the use of personality testing was positioned by SME8 (2017, p. 7) in that, while determining the personality type has a role to play, care must be taken to not use this as the mechanism to automatically discount a person. Rather, there is an opportunity for the crisis leader to leverage their understanding of the team dynamics and to thereby implement strategies to enhance the team’s capabilities. This would enable additional discipline to be instilled ensuring linkage between the ostensive routines and their performance.

As SME20 (SME20, 2016, p. 4) asserted, the crisis leader is ultimately the conductor of the orchestra and an experienced and skilled conductor needs to be supported by very experienced orchestra members who know what they need to do and how to do it. This illustrates the interconnectivity to the 2\textsuperscript{nd} theme relating to composition of the team.

### 4.5.3 Aggregated Theme: Context of crisis team composition

The second theme deals with the context of crisis team composition and integrates the importance of team dynamics, their experience; and understanding their skills and capabilities which when leveraged correctly minimises process deviation. There was a strong correlation to effective leadership for while the leader should drive performance, a role must be played by the team members to course correct back to the ostensive routine if a deviation occurs. This is reliant on several factors and the 1\textsuperscript{st} order codes against this theme related to the role that culture plays; the selection of the members; the skills that they bring to the table; and their level of experience with training presenting as a strong correlation between the first order codes.

Addressing culture SME21 (SME21, 2016, p. 7) saw a correlation in the composition of the crisis team as they noted that culture can play a role in members of the team speaking out, articulating the issues, and where this does not occur this can lead to a lack of clarity and transparency, both of which are critical behaviours during the management of a crisis. SME3 (2016, p. 5) also had the view that in respect of team
performance and adherence to the ostensive routines “culture is always playing a role” which was supported by SME11 who argued that “culture can influence leadership style and behaviours relating to adhering to process” (SME11, 2017, p. 18).

The concept of culture was seen as influencing a number of additional elements including the manner in which it could affect deviation from ostensive routines both positively and negatively across different markets (SME8, 2017, p. 3); its influence on leadership; together with its application in the operational response stemming from cultural interpretations (SME10, 2016, p. 5). The concept was described as playing a pivotal role as “there are disciplined people and not disciplined people. So the more you come to the south the more undisciplined they are, the more you go to the centre of Europe, the more disciplined” (SME20, 2016, p. 4). This posed the question of whether a cultural approach can be modified through specialised training and, as outlined in subsection 4.4.5, this was tested through one on one engagement with a crisis leader over several months during the course of this research. This structured training delivered strong talent development and illustrated that the role that culture plays from all facets must be understood as from this understanding remedial strategies can be introduced. As noted previously in this paper, this validated the importance of one on one crisis leadership education as an addition to the existing structured team training and testing.

The next code related to the areas of selection and skills that are again intrinsically linked. This is driven by the fact that one of the greatest challenges faced by managers placed onto a crisis team is that this is very rarely, if ever, their ‘day job’. CMT members by default come from a variety of business disciplines and, while each has experienced different types of stress and pressures, crises are unique in their complexity, and the high stakes of the situation can influence behaviour. As illustrated in the Leximancer section and with the same relevance in the manual coding, SME10 (2016, p. 2) described the situation of a team coming together when it is still underprepared. He described this as “the tiger bursts into the room and starts mauling everybody. And that’s where I think they lose it. They are somewhat out of their depth, as it is not what they do as a full-time role.” This point aside, as presented by SME9 (2016, p. 6) this does not “mean that a team that just comes together for one purpose cannot effectively look at the problem, and I think that is where the tools come in, they enable you to sort of step back and have
a broader look at the problem. It doesn’t then matter if you have been together for ten minutes or ten years.”

Ostensive routine deviation minimisation was viewed by the respondents as being directly linked to the experience of the leader and the team members, with all respondents aligned with the importance of CMT members possessing the requisite skills and experience levels. Where these elements existed, process deviation was minimised. It must be noted that the business reality is that the careers and personal backgrounds of the team members will influence their behaviour in a crisis, as very often members of the team are selected due to the position that they hold rather than through any formal assessment of their relevant capabilities. This links back to the first aggregated theme whereby appointment to a crisis team based on position or seniority needs to be avoided. The problem however, is exacerbated by the fact that there is often in business a prevailing perception that an individual is unlucky to be chosen for the crisis team rather than there being an acknowledgement by the executive that this is in fact a critical and important role. This requires behavioural change and to “remedy that it would have to come down from the top letting people know that IMCR (crisis management) is a KPI for everyone and that everyone in the company will rotate through” the crisis team (SME21, 2016, p. 8). This would acknowledge the contribution to crisis response by all relevant managers.

Selecting the correct members thus ensures that a team does not only approach the problem in a more effective way, but an understanding of the individuals and their personalities creates an environment in which the leader can drive effective compliance with the ostensive routines. By having the correct team composition, a more effective overall crisis response is achieved. The SMEs agreed that similar traits were critical in this space with SME21 (SME21, 2016, p. 10) noting that it was critical to have team members that were responsible and accountable, proactive, analytical, planning and strong communicators. Building on this, SME3 commented that in his experience a team is effective and works effectively together when a strong team spirit exists. This is created through longevity of the team and its members, and he built on this theme by observing that the “longer the team is operating the more better [sic] it is going. That is
clear” (SME3, 2016, p. 6). Longevity is achieved by keeping team membership consistent and it builds capability through experience.

The final code in this theme with 91% alignment was the concept of team member experience as it related to process compliance and a belief by the individuals on the team, supported by poor leadership, that they know best. This lack of constructive dialogue can have a variety of causes. SME16 (2017, p. 3) noted that “deviation can be caused by the desire to have a speedy resolution and the formulation of assumptions that we believe we already know the problem and we assume something, we don’t want to waste time on this (the process) and that is the beginning of the failure.” This clearly links back to the fact that this is not an individual’s day job and they often automatically revert back to what they are comfortable with.

This belief that “I know best” is a common fault, and as SME 1 (2017, p. 2) describes the CMT members lack of experience lulls them into a false sense of security and potentially arrogance creating a belief that following routines will not add any value and therefore why follow the ostensive routines. This is because “we sometimes jump to the solution...we know what to do, let's just do that and get on and back to normal business” (SME2, 2016, p. 5) without understanding the complexity of the issue that they are facing. This links to the fact that when a crisis is commencing finding “the solution is some way the priority, more than the following the procedure” (SME14, 2016, p. 2) and this is undertaken “without actually taking into consideration all the other things that may have impact on the incident itself” (SME4, 2016, p. 3)

The following captures the essence of this first order code for as SME 18 noted experience is critical and this embraces “experience in working together, at ease with the majority of the team members on real IMCR cases, so we know how to work together, what to expect from each other and what role everybody has in the team” (SME18, 2016, p. 2), for this in turn relates to the position of SME20 whereby she argued that there is a necessity to build trust and for the actors to come together to rehearse when there is no crisis, for “if you don’t work on the good days, you cannot work well on the bad days, so that is, if I were to recommend something is to do some kind of team building or those people who are working on the crisis teams to somehow connect them
when things are good, make them opportunities, not only put them under pressure” (2016, p. 5). This experience lends itself to the utilisation of the ostensive routines and strategies to enhance performance which are discussed in the following sub-section.

4.5.4 *Aggregated Theme: Validation of ostensive routines and enhancing performance*

The third aggregated theme related to the SMEs confirming the value of the ostensive routines and associated artefacts, together with the importance of training to enhance operational performance and preparedness. This was an important consideration in answering the research question as one of the potential reasons for deviation from the ostensive routine could have resided with the routines themselves. In this theme, three 1st order codes consolidated the various elements of the commentary. They related firstly to the perception of robustness of the ostensive routines and artefacts, including the overall perceived value add and observations that experience with their utilisation leads to a positive perception as to their value. The second code confirmed that the use of the artefacts effectively guides the response while still allowing innovation and flexibility in the crisis response. The third 1st order code consolidated the views relating to conducting post incident assessments of the ostensive routines and performance and the integration of associated learning into training.

Examining the value of the ostensive routines and artefacts, all the respondents were aligned with their value in ensuring that crisis situations were effectively managed and in respect of the specific utilisation of the artefacts a clear majority (91%) of the respondents aligned with this code. As SME3 commented “even the most experienced teams benefit from actually going through the tools” (SME3, 2016, p. 2) for in a “crisis situation there is a lot of stress and they help you not to overlook certain things” (SME8, 2017, p. 3) by providing the guiding framework within the ostensive routines that ensures critical elements are not missed. This is because “the right process, the right tools” are integrated into the ostensive routines that create the path for the crisis leader and the team to follow (SME16, 2017, p. 2), with a respondent noting that it was the existence of the processes and routines and the ability of the team to follow them in a real situation that enabled the business to manage the crisis while at the same time growing the business (SME5, 2016, p. 4).
Building on the value of the ostensive routines and the artefacts, SME21 stated that in respect of the artefacts that the “tools provide a good framework to ensure that we do not miss any of the basics when we are gathering information on the incident and when dealing with the incident” (SME21, 2016, p. 2). The routines and artefacts enable the CMT to consolidate the data and workflows from the crisis situation into a proper order (SME12, 2017; SME15, 2016), with one of the main advantages being that the process and tools make “sure that you are stopping, checking, and considering all the components” (SME17, 2016, p. 2). An experienced CMT and leader have the awareness to understand that the ostensive routines and the artefacts act as a guide while allowing for flexibility in the response. They thereby leverage them to drive their thinking and response.

Taking this theme further, SME22 (2016, p. 2) confirmed that the “tools are absolutely essential because they provide cues to consider things that people would not necessarily do. It is a way for people to consider their approach to a problem and an incident in a holistic way.” SME8 (2017, p. 2) further argued that

> the tools are fundamental and vital...and it is very important that you follow the process and that you don’t get deviated and that you don’t start panicking.
> Deviation occurs when the coordinator does not follow the process... and when people start to panic, or senior people exert a presence that results in process deviation. The tools provide the structure."

In essence, the tools, as part of the ostensive routine, were consistently acknowledged by the SMEs as providing the framework for the establishment of the most effective crisis management response (SME16, 2017), with all of the artefacts linked to the core ostensive routines as documented in the relevant crisis management plan.

As an additional observation, while the value of the ostensive routines was clear, two elements were contributing to the performative deviation and link to the interrelated aggregated themes of the crisis leader and the team composition. One of the elements was the lack of role clarity in the team, the lack of experience and familiarity with the routines, and where due to the processes not being followed constructive debate and discussion does not occur (SME17, 2016, p. 2). This can be linked to a cultural mindset
that there is no need to follow the process and checklist correctly (SME10, 2016, p. 7). This was of course coupled with a perception that individual experience outweighed the necessity to follow a routine or utilise the relevant artefacts (SME23, 2016, p. 3). Ultimately, while numerous rationales for the deviation existed, the main theme related to the crisis leadership and the nature of the team itself. SME22 (2016, p. 3) identified a combination of leadership, experience and culture in this respect, and noted that a strong leader will be prepared to instil discipline around the ostensive routines and use of the tools.

The final 1st order code for this aggregated theme, with 91% of the respondents strongly aligned, related to post incident evaluation of the ostensive routines, the artefacts and the performance of the CMT and linking the observed behaviours from a live response into the training programs. However, this was consistently observed as an area of challenge. This is due to the fact that post the crisis, evaluations and lessons learned sessions are only accomplished by finding the time to draw the team together which is complicated by the fact that the CMT members are keen to return to their day jobs and this can lead to a lack of motivation. As SME1 (2017, p. 3) commented “everyone is so busy in the business that once something is resolved, there is no real opportunity or really an appetite to get together and do that”.

Central to this theme was the importance of the training being strongly aligned to real life experiences. This alignment is generated through effectively capturing the lessons learnt from active cases, dissecting them and creating the training scenarios from that data. This requires the creation of models that bring together organisational learning and involves structuring the approach to case reviews and their analysis, and to dissecting lessons learned. By ensuring a formal debrief and review program is integrated into the ostensive routines an organisation can ensure that effective organisational learning is implemented. It is from this process that a business can identify best practices, particularly as they relate to process deviation minimisation. This knowledge is then shared and its integration into the training ensures that the team avoids similar situations occurring in the preventative stage, and, in the event that a situation eventuates, it ensures that the correct protocols are in place to respond to the crisis (SME2, 2016; SME17, 2016).
The crisis leader plays a pivotal role in ensuring that this attitude is overcome as the evaluation ensures that a critical analysis of the ostensive routines versus performance is undertaken. The findings are then inculcated into the training program to ensure that capabilities are enhanced. A strategy here is to ensure that the post incident analysis exists as an ostensive routine.

Learning from experience and training were perceived as critical in the business environment and could be obtained by leveraging strategies as adopted by law enforcement and the military where training is imbedded. As SME18 (2016, p. 3) noted, if a business is serious and wants to enhance capabilities and response then regular and focused training is the key. As illustrated also in the Leximancer analysis the SME respondents perceived that understanding the ostensive routines and practicing them we second only to composition of the team and its leaders drawing the additionally linkages between the three aggregate themes (SME2, 2016; SME10, 2016; SME18, 2016; SME21, 2016).

As noted previously, a lack of training can contribute to deviation from the ostensive routines which can lead to CMT members reverting to thinking that the issue is out of control. SME10 (2016, p. 5) argued that this was in his opinion one of the major contributors to process deviation, for it is a business failure not to exercise and train teams with a high level of frequency. A lack of frequency means that the teams miss out on drawing from previous reviews and gaining vital pre-crisis experience in the use of the artefacts. Training and simulations supported by leadership commitment to the process are central to developing a baseline understanding of the ostensive routines and the artefacts, together with building trust within the CMT. The respondents also presented the perspective that the training needed to focus, both on the CMT and the crisis leader. While team interaction has in the past been the focus, building the specialised crisis leader for a business was critical with SME4 (2016, p. 8) commenting “that an 80/20 approach in favour of coordinators” would provide the most value-add. This would require the training to provide a focus on leadership, decision making and the core element of process management. SME1 (2017, p. 11) supported this by arguing that the focus must be on the leader as they have the potential to maintain stability while other members of the team may come and go. While conceptually supporting this,
SME14 (2016, p. 9) argued that a priority should be “on how the team members act effectively as a strong team rather than as any one individual.”

4.6 Method Triangulation

While commonalities in the data analysis were flagged in the previous sub-section, this section undertakes the formal method triangulation to analyse the findings from the Leximancer output and the manual coding thematic results. Triangulation is the process for utilising more than one approach to researching a question, with the objective to increase confidence in the findings by using two or more independent measures. This combination of the findings from two or more rigorous approaches, in this case automated results from Leximancer and the manual coding that produced the thematic analysis, aims to provide a more comprehensive picture of the results than either approach could do alone. The triangulation compares, and contrasts observed similarities and differences between the two analysis techniques.

Table 9 details a consolidation of the key themes from Leximancer, the central themes as identified in the thematic analysis and the observations in respect of the commonalities and differences between the two analysis streams. For this triangulation exercise the core automated (A) findings were labelled A1 – A4 and the manual (M) were labelled M1 – M3 respectively.

A comparison of the findings, as outlined in sections 4.4 (Leximancer) and 4.5 (Manual coding) and summarised in table 9, confirmed that strong linkages existed between the two data sets. It is noted that while the three aggregated themes and their 1st order codes were not an exact match with the data extracted from the automated Leximancer output sufficient commonality in the thematic outputs existed to validate that the manual coding process provided a realistic supportive interpretation of the data extracted in the first analysis stream from Leximancer, thereby further strengthening the research findings.
Table 9 – Method triangulation of Leximancer and Thematic analysis data

<table>
<thead>
<tr>
<th>Leximancer: Automated (A)</th>
<th>Thematic Analysis: Manual (M)</th>
<th>Observations</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>A1</strong> Role of the key artefacts – tools and checklists: this theme focussed on the value of the ostensive routines and the importance of utilisation of the artefacts in guiding the response.</td>
<td><strong>M1</strong> Context of crisis leadership: this theme focused on the importance of the selection, experience and training of the crisis leader. This drives adherence to the ostensive routines by a leader’s ability to leverage the capabilities of the team. Personality evaluation state within this theme.</td>
<td>1. A1 and M3 are linked, with the theme relating to the operational value of the ostensive routines and the supporting artefacts as seen by the SMEs.</td>
</tr>
<tr>
<td><strong>A2</strong> Role of the team and crisis leader: this theme focussed on elements including the selection and composition of the crisis team and the crisis leader. It also focussed on team and leader dynamics in respect of deviation from the ostensive routines.</td>
<td><strong>M2</strong> Context of crisis team composition: this theme integrates the importance of team dynamics, their experience, selection and an understanding of skill capabilities to minimise deviation from the ostensive routine. Culture was also linked to this theme.</td>
<td>2. A2 aligned with M1 and M2. These themes related to the composition of the teams, the importance of skills and selection of members and the CMT leader.</td>
</tr>
<tr>
<td><strong>A3</strong> Role of training and process improvements: this theme centred on the importance of training in ensuring that process deviations were minimised. It linked to learning from cases and the development of improvements to the ostensive routines based on learning.</td>
<td><strong>M3</strong> Validation of ostensive routines and enhancing performance: this relates to the perception by the respondents as to the operational value of the routines and artefacts in supporting the crisis response and the criticality of learning and training in strengthening capabilities.</td>
<td>3. A3 and M3 are linked through the relationship to learning and training. In both instances, the data to varying degrees supported post incident review of the performative aspect and modification to ostensive routines as required.</td>
</tr>
<tr>
<td><strong>A4</strong> Culture and personality types in team dynamics: these themes centred on the role that culture, both business and national, played in influencing the crisis response and deviation from the routines. It also discussed the role of personality in crisis team dynamics and crisis leadership.</td>
<td></td>
<td>4. A4 is linked to M1 and M2 in respect of the role that personality and culture respectively play in deviation from routines.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>5. While the strength of the relationships between A and M categories was not evaluated, there is still sufficient commonality in the data streams to support a finding that the ostensive crisis management routines are robust and that it is the human element, driven by a multitude of factors that drives the deviation.</td>
</tr>
</tbody>
</table>
4.7 Chapter Summary

This chapter presented the findings of the research. The data was collected from a variety of sources including: documented observations of crisis teams during training and simulation; interviews with subject matter experts; evaluations of crisis leader capabilities; and vignettes of real case responses. It commenced with a summary of the SMEs’ backgrounds to position their level of experience and competence in crisis management.

Having established the benchmark for the SMEs, the focus moved on to the findings relating to the data itself, as extracted from Leximancer. As noted in the methodology, the data was subjected to initial researcher analysis, which provided the first interpretation of the data. During the next stage the connectivity of themes was evaluated utilising the software, thereby mitigating researcher bias risk. The software analysis process involved the uploading of data pool into Leximancer for the simulation modelling. This then compartmentalised the findings from Leximancer into the categories of:

- Concept findings overview;
- Role of the artefacts;
- Observations on process deviation;
- Role of the team and the crisis leader;
- Role of training and process improvements;
- Culture and personality in team dynamics; and
- Perceptions of risk management and business resilience.

Lastly, the chapter examined the findings obtained from the manual coding and the thematic analysis results. This manual coding data was added due to a recommendation arising from an earlier iteration of this paper, as a strategy to validate the accuracy of the Leximancer outputs. The findings from both Leximancer and the thematic analysis were then subjected to triangulation to compare and contrast observed similarities and differences. As shown, while the resulting manual coding and the thematic analysis results were not an exact match to the automated findings from Leximancer, there was
sufficient commonality in the thematic outputs to validate that the manual coding process provided a realistic supportive interpretation of the data as presented by Leximancer, thereby further strengthening the initial findings.

The empirical data findings addressed the question of how the ostensive and performative routines interact in a crisis management situation and what factors contribute to deviations from those routines. From the material obtained, a theory was developed to explain the deviation with this theory being that while the ostensive crisis routines and the related artefacts are robust the process deviation during a crisis response occurs due to the human dynamics. This incorporate the behaviours of the members of the crisis team and the crisis leader. The core causes of deviation are ineffective crisis leadership and weaknesses in the crisis team structure.

With this chapter having detailed the findings in respect of the research, the next chapter will discuss the findings through an evaluation of their meanings as contrasted with the extant literature that was evaluated as part of this research.
Chapter 5 – DISCUSSION

5.1 Introduction

The objective of this research was to identify the reasons for process deviation during the performance of ostensive routines within crisis management. Specifically, the objective was to examine empirical data to understand how ostensive and performative routines interact in a crisis management situation in a business context and to understand what factors contribute to deviations from the routines. By answering this question, it aimed to develop a theory to establish the reasons for the occurrence of this phenomenon. In doing so the research focused on the analysis of two data streams. The first stream challenged whether the deviation occurred due to the fact that the crisis routines supporting the artefacts are either considered inappropriate in their current form or are not modified and strengthened in response to lessons that are learned during a post incident review. This discussion would establish if the processes were the underlying cause.

The second stream examined whether the deviation occurred due to an ineffective approach to the composition, leadership and coordination of the CMT: that is, the actors who are the team members and include the leader, are not cast correctly, so that their behaviour and skill sets contribute to the deviation. This would establish a theory that was focused on the human dynamics. To evaluate the data in these two streams the discussion brings together the field work as presented in Chapter 4 with the bodies of literature that were evaluated in Chapter 2. This combination enables ‘data and theory
coupling’ (Golden-Biddle & Locke, 2007, p. 52) to occur and provides for an examination of the field work data concepts against existing theory.

This process can be described as creating a bridge between the academic world and findings from professional practice as identified through the conduct of this research. As noted by Golden-Biddle and Locke (2007, p. 53), the process aims to theorise fragments of life as identified in the study. In this research, the bridge is created through an analysis of the data excerpts that are related to the core concepts, as extracted through the Leximancer analysis and illustrated in figure 21 in chapter 4. As noted previously, feedback from an earlier version of this thesis recommended that manual coding also be conducted to develop a thematic analysis that would validate the accuracy of the Leximancer output. The output from that process was captured in figure 25 and the commonalities described in the method triangulation.

For each of the core concepts, a cross analysis was made against the literature review. This was done in order to provide theoretical support to the field findings of this research and to confirm gaps in the literature. In support of this, further literature reviews were undertaken against the field data and analysis, creating a double testing of the validity of the findings as they related to the theoretical framework. Through this evaluation and discussion, the theory in respect of how the process deviation occurs was constructed.

Analysis of the combined data sources confirms that the routines and artefacts are not the cause of the deviation. Rather, the findings confirm that the deviation derives from the structure and leadership of the crisis management team. Therefore, by identifying the answer to the research question, the following theory has been developed to explain the process deviation within a business context:

“Ostensive crisis routines and their related artefacts are robust. The process deviation from the ostensive routines during a crisis response occurs due to human dynamics which incorporate the behaviours of the members of the crisis team and the crisis leader. The core causes of deviation are ineffective crisis leadership and weaknesses in the crisis team structure.”
The data supporting this theory is captured in this chapter. The discussion will address: the streams in business resilience and risk management; processes and routines; and ultimately the core element of crisis management. While addressing the various dynamics of crisis management this last part of the discussion will have a focus on the composition of the crisis team and elements impacting the capabilities of the CMT and the crisis leader.

5.2 Business Resilience and Risk Management

It has been argued that the business resilience paradigm has undergone significant transformation over the past decade. The complexities of the definition of resilience has been illustrated (Cole, 2015; Marchese et al., 2018) and for the purposes of this research business resilience was defined as the ability of a business to manage uncertainty and maintain positive adjustment under challenging conditions while enabling growth. This is achieved through the implementation of preparedness measures (e.g. ERM, security, training) and effective reactive measures (e.g. crisis management, business continuity, disaster recovery) that provide fundamental response mechanisms (Anderson, 2014; Prezelj & Doerfel, 2017; Sutcliffe & Vogus, 2003). This definition derives from the fact that the literature generally supports the position that resilience has transformed from the traditional conceptual model of being purely reactive to one that embraces strong proactive and preventative elements (Cole, 2015; Marchese et al., 2018).

The construct of the definition utilised differs from the recent work of Toe et al (2017) and an earlier study by Kantor et al (2012), in which the concept is still framed as the capacity of an organisation purely to bounce back from an adverse position, rather than integrating the components that create both a preventative and a reactive capability. The main weakness of that argument is that it is rigid in its focus on recovery. In contrast, Filament (2009) argue the importance within resilience of having organisational flexibility as opposed to rigidity. This position is supported by Sutcliffe and Vogus (2003), who contend that resiliency emerges from an ability to adapt and maintain positive adjustments under challenging circumstances. Flexibility aligns to the
concept of examining business resilience within the proactive and reactive compartments and that the combination of elements including crisis management enhance an organisation’s overall capabilities (Prezelj & Doerfel, 2017). In fact, it could be argued that a model of constant positive adjustment is the new norm, driven by a global business environment that creates new business challenges daily.

This position is in line with the findings of this research and the observations provided by the SMEs both through the Leximancer automated analysis (figure 21), and as observed while conducting the thematic analysis through the manual coding (figures 25). The consensus is that capabilities are lessened if business resilience is restricted to recovery and, in the context of this work, the management of an ongoing crisis, as this can impact the threat identification process resulting in ineffective resource allocation (Taarup-Esbensen, 2018; Watkins & Bazerman, 2003). Uniformly, the SMEs argued the importance and value of preventative planning through thorough enterprise risk management (SME2, 2016; SME10, 2016; SME21, 2016). As seen in the concept map (figure 21), risk management is intertwined with crisis management, highlighting the interconnectivity of the concept themes. In this respect, ERM is considered a process enabler within the overarching business resilience umbrella that enables and guides the management of uncertainty, which includes those risks that could generated a crisis, while at the same time supporting business growth through the identification of opportunities for business growth (SME10, 2016; SME21, 2016). Through applying the ERM processes and addressing the mitigation of the identified risks, the process establishes a positive mindset that establishes an operational difference during crisis response. Here again, the SMEs were aligned on the importance of identifying, interpreting and preparing the crisis teams for the correct response.

The upfront identification of risks is therefore confirmed as being a critical activity, as it guides an organisation’s response to uncertainty (Watkins & Bazerman, 2003) by engaging with stakeholders through system level collaboration (Prezelj & Doerfel, 2017, p. 120). Not only does it support the creation of mitigation plans for the uncertain events, it allows for the testing of the crisis routines against identified scenarios (Comer, 2012). Risk management culture needs to drive the integration of the program and requires “rich and varied risk management ecology which is not biased to a logic of audit
and its demands for evidence” (Senior, 1997, p. 852). Through preparation, a business can limit impact, and this confirms the view that companies can contribute to their own crisis situations through their actions and poor and ‘sloppy’ management behaviours in the lead up to the incident (Pearson & Mitroff, 1993; Turner, 1994) and then exacerbate this element during the management of the crisis response leading to even greater issues. Fischbacher-Smith (Fischbacher-Smith, 2014b, 2016a; Fischbacher-Smith, 2016b) reinforced this view by arguing that management can play a role in the generation of crisis events and that through actions and inactions of management a crisis can incubate. As he noted, this is because crisis response is not "simply about the operational phase or even the processes by which turnaround processes occur but it is a function of the core activities of management” (2016, p. 935). Fischbacher-Smith and Fischbacher-Smith (2012) also commented that it is critical for management to utilise mechanisms that enable the consideration of the broader aspects that can create vulnerabilities and this can require an organisation to “ensure that they have frameworks and capabilities to cope with high levels of uncertainty” (Smith, 1990, p. 268). In the management of uncertainty it is also suggested that the role of ERM has shifted to embrace risk sensemaking whereby management engages with their social and physical environments, both internal and external to the organisation (as depicted in figure two), to gather data that can indicate how future events may unfold (Taarup-Esbensen, 2018). Therefore, by using ERM as a formalised process to understand the business uncertainty, appropriate management strategies can be developed, and potential crises prevented.

Within this proactive stream the importance of ensuring the existence of sound ostensive routines and the minimisation of process deviation was also highlighted. SME10 (2016, p. 9) contended that, in the preparation for incidents, ERM plays a critical role. However, the process only works if it forms part of the business structure and is embedded in a function. The SMEs were aligned with this thinking that ostensive routines relating to ERM are a component of the wider business resilience response. Therefore, there is a need to ensure that deviation is managed within all streams.

This requires the presence of routines that drive a cultural mindset change in management thinking from focusing on potential losses to focusing on potential gains. It
was evident that it needs to be a focus of the management across the business to ensure that enterprise risk management, and by default the intrinsically linked element of crisis management, “is a core competency of all function heads and that they be held accountable” (SME21, 2016). This requires ostensive routines that are embedded and accepted as a strategy that enables business growth (Alesi, 2008; Hubert, 2011). Within this space sits the concept of turning a crisis into an opportunity. Effective leadership during the management of a crisis event provides more latitude to explore opportunities and innovate (Langan-Reikhof, Avanni, & Janetti, 2017).

In summary, there is a strong argument for the existence of processes and routines that enable a structured approach to the identification and management of risks that could evolve into crises. The main identified inconsistency resides within the interpretation and definition of business resilience. Putting this difference relating to the proactive versus reactive nature of business resilience to one side, it is evident that crisis management remains a core response component with preparedness and the ability to respond to a crisis contributing to business resilience (Staupe-Delgado & Kruke, 2017, p. 215). It is also evident that effective execution of the crisis response is critical in order to ensure a speedy and successful resolution to a crisis situation. This in turn depends on robust processes and routines and a reliance on their effective execution.

### 5.3 Processes and Routines

Having established the interconnectivity of risk management and crisis response, the discussion now shifts to the concepts of processes and routines. As illustrated in figure 21 the Leximancer output indicated that the element of process resides within the concept bubble that captures the crisis tools that are linked to routines. The intensity of the connectivity was depicted in the third largest heat bubble in size and colour after the concept of the team and, by default, the crisis coordinator. For ease of reference in this thesis the ‘coordinator’ is interchangeable with the term ‘crisis leader’. The importance of the ostensive routines and the related artefacts were also identified as key elements within the supplementary manual coding outputs.
In regard to the processes and routines for crisis management, it is argued that Mitroff et al (2003) established the initial groundwork in respect of crisis response theory. They present the argument that the risk of a crisis prepares companies not only to develop plans, but to have plans and routines to cater for a wide array of emergencies. It is these routines and the interrelated actions companies take that make major crises less likely to occur. To be successful, crisis teams require executive engagement, understanding and support. So, as confirmed in this research, while serious incidents can and will occur, it is management action that will determine the severity and potential extent of the crisis (Mitroff & Pauchant, 1990).

5.3.1 Artefacts – Plans, tools and checklists

This section discusses the findings as they relate to the various identified components of the ostensive routines and their performance. It focuses on the role of the artefacts within the routines together with the observed reasons for the process deviation.

It is clear from both the Leximancer output and supplementary thematic analysis that the ostensive routines and the associated artefacts support the effective execution of a crisis response. While the focus of this research was on the processes designed for and applied within TCCS, the presence of routines and tools to guide a crisis response is common across business sectors. As documented in the Belgium case study, the ostensive routines and artefacts (including the tools and checklists) that are currently used within TCCS were designed and implemented post the crisis in order to bridge an identified gap.

When examining this crisis management program, it is evident that the behaviours as presented by Feldman and Pentland are present in the adapted model. As noted previously, “the ostensive aspect of the routine is the idea; the performative aspect, the enactments. Both aspects are necessary to constitute what we understand to be the routine” (Feldman & Pentland, 2003, p. 102). From an ostensive perspective, the routines that support crisis management incorporate artefacts, including tools and checklists. It is evident that the presence of the ostensive routines, which find their roots in the crisis plan, and which incorporate the core artefacts, provide a crisis team, irrespective of experience and location, with a framework that can guide uniform
responses. The SMEs unanimously endorsed the importance of the artefacts for a number of reasons.

The artefacts not only act as a guide by providing cues, but they also construct the framework from which the response can be driven. By using this structure, a team is provided with the framework that establishes set parameters for the response. The artefacts have been described as providing a visual guide and process clarity, which can support less experienced teams. This is important, as teams can drift away on a tangent from their destination plan (SME10, 2016). While acknowledging the importance of the tools, there was conflicting opinion as to the level of utilisation that is required. Some argued (SME7, 2017; SME18, 2016) that the tools should be leveraged at all times. D’Adderio (2010) supports this position and argues that the artefacts perform a critical role in directing the performance of the actor. The more successful performative programs manage to utilise an array of materials and tools to create the most effective response environment. Applying this metaphor to crisis management, the script embraces the plans, tools and checklists, which in combination provide the backbone of the ostensive routines. These scripts are the recurrent activities and observable patterns of interaction (Barley & Tolbert, 1997) during the crisis response. Other researchers in the extant literature, together with the participants in this research, contended that while the framework should be there, it should not be utilised to the extent that innovation is stifled (SME3, 2016; SME10, 2016). This aligned with the position of Iannacci and Hatzaras (2012) in respect of routines not being accepted as a single level of reality being flat and horizontal which diminished the existence of emergent properties.

While acknowledging the value of the routines and artefacts, there was also a consensus that process deviation did not occur simply due to a negative perception of the value of the tools. Feldman (2000) noted that deviations could occur for a number of reasons. These included a perception by the user that the routines were not achieving their intended outcome or because other opportunities were revealed. This position was not reflected in this current research in which the evidence indicated that the routines and the associated artefacts were universally perceived as value adding. Rather it was argued that a lack of direction and structure within the crisis team and the crisis team’s
leadership, were the core contributors to the process deviation. This supports previous findings that the use of the artefacts must in fact become ingrained into team member behaviour and where this occurred, positive perceptions resulted. The most effective way of achieving this is through continuous rehearsals by the actors. In this way the routines can become second nature and automatic, at least to the extent of reaching for, and utilising, the supporting artefacts.

It was observed that teams tended to utilise a combination of what could be described as tools and checklists. The tools, such as the problem-solving tool served as a thought prompt and guide that established for the crisis team lines of investigation and specialised thinking. The checklist provided a different approach from that of a guiding tool having several objectives including memory recall, standardisation and providing a framework (Hales & Pronovost, 2006) and ultimately minimising human error (Degani & Wiener, 1997; Gawande, 2011; Hales & Pronovost, 2006; Seifert, 2009; Thomassen et al., 2014). In the context of crisis management, a checklist is a mechanism that allows the crisis leader or a crisis team member to ensure that specific steps of the process have been adhered to. SME17 emphasised the importance of the confirmation checklist, as it provided a tool for members of the team to run their eyes across during any stage of the response. SME9 built on this, by arguing that since crises are not linear events the checklists ensure sure core requirements are revisited, particularly as it refers to communication to stakeholders. Building on this Gawande (2011, p. 79) argued that routines need to balance a number of virtues, in particular freedom and discipline, craft and protocol, and specialised ability, while most importantly fostering collaboration within the group. Ultimately the routines “supply a set of checks to ensure that the stupid but critical stuff is not overlooked, and they ensure another set of checks to ensure people talk and coordinate and accept responsibility while nonetheless being left the power to manage the nuances and unpredictability” (Gawande, 2011, p. 79) that will be experienced in a crisis response. Mistake minimisation is an overarching objective from the use of the checklist (Degani & Wiener, 1997; Thomassen et al., 2014). That said, one factor to bear in mind is that there is a risk that “checklist users may also become dependent on these tools in practice, which can interfere both with their professional judgement and the objectivity of their decision-making processes” (Hales & Pronovost, 2006, p. 234) and the leader needs to be cognisant of this risk.
The perspective of the importance of checklists was supported in the findings by confirmation from the SMEs, supported by the observations of the researcher, that the artefacts utilised by the crisis teams were extremely effective due to their ability to easily guide thought processes. This is linked to the ability of the checklist to provide operational structure and reduce errors (Degani & Wiener, 1997; Gawande, 2011; Thomassen et al., 2014). While the artefacts in their current form were confirmed as solid, there was discussion about potentially automating the process. This discussion related to leveraging technology to transform the artefacts into tools that would further enhance the capability of the crisis leader, and thereby enable them to provide more effective leadership. The considerations here mainly focused on consolidation of the existing artefacts into applications that could be utilised with smart technology.

Having validated the value of the ostensive routines and the artefacts, the question moves to the reasons for process deviations during crisis activation.

### 5.3.2 Reasons for process deviation

The central objective of this research was to understand the reason for the deviation by a business crisis management team from the ostensive routines during the performative stage of the crisis response. From this the presented theory was developed. The research has confirmed the importance of routines and artefacts, which is supportive of the extant literature. Previous research, however, has not examined this aspect of process deviation from a crisis management perspective, hence the existence of a gap in the extant literature.

The extant literature does confirm a general issue in respect to process deviation. It is worth reiterating that Feldman (2000) concluded that deviations occurred where there was a perception that the routine was not achieving an intended outcome, or because the outcomes identified new possibilities. In these instances, the subjects strove to adjust the tools through trial and error and learning adjustment. Others argued that process deviation may not in itself be negative, as long as positive benefits eventuate from the improvement (Parmigiani & Howard-Grenville, 2011). In this regard, the findings of this research present a different perspective on the issue.
Firstly, without exception each of the SMEs had observed the occurrence of process deviation by crisis teams. This had been observed by the individuals both in real cases and during crisis simulations. This was irrespective of the industry in which they had worked, or whether it was in the public or private sector. That said, the SMEs consistently reported that the routines and the tools themselves were not the issue, pointing rather to human dynamics which included perceptions as to the value of both the ostensive routines and the artefacts. In addition to this, rather than contributing to a positive adjustment, the deviations inevitably resulted in adverse outcomes and, through the creation of new risks, exacerbated the crisis.

Unanimously, the SMEs formed the opinion that the ostensive routine and the artefacts, be they tools, checklists or plans, were not the cause of the process deviation. That is, the deviation did not occur because of a perception among the users that the tools were in some way inadequate or ineffective. This is of course contrary to the general position as outlined by Feldman and others. While various arguments have been presented to explain process deviation, the central theme in this research was linked by the respondents to either the role the crisis team, or the leadership provided by the crisis leader. This observation may stem from the fact that human nature dictates that teams often want to jump to the conclusion, solve the problem, and return to normal at speed, rather than leverage the tools to take them in the appropriate direction. This role of the actor, in this case the CMT member, was noted by Barley and Tolbert (Barley & Tolbert, 1997, p. 98) for they observed that while the “scripts are observable, recurrent activities and patterns of interaction characteristic of a particular setting” the institution is reliant on the actors interpretation. Barley et al (1997, p. 102) in their findings determined that actions created deviation and “in many cases, however, enactment does not involve awareness or intentionality: actors simply behave according to their perception of the way things are.” Of course the challenge here is that improvised behaviour can have a negative consequence and the appropriateness of the behaviour can only be evaluated in the aftermath (Martínez - Córcoles, 2018, p. 241).

It was also noted that the pressure of the crisis situation can contribute to the deviation. “When people are under pressure, then they do not use the tools, and they embark directly into managing the situation as it emerges” (SME20, 2016) and this can be
contributed to the fact that the CMT is working in a dynamic environment under suboptimal conditions (Lapierre et al., 2015). Others argued that the deviation stemmed from a lack of experience. Teams with longevity accepted the artefacts as they had used them previously to achieve a successful resolution. On other occasions, the crisis team made assumptions, often incorrectly, based on prior experience. They assumed that as they had managed cases of a similar nature in the past that they could go with intuition rather than following processes and leveraging the tools. This was presented by some SMEs as illustrating a level of arrogance in the crisis team. Additionally, the SMEs noted that there needs to be an understanding that the tools are a guide and they are not designed to stifle creativity in the response, for creativity per se is not deviation (Sonenshein, 2016), rather it can be described as a process in itself of thinking ‘outside the box’ to resolve the issue at hand (SME6, 2016).

In respect of crisis management in general, it is critical to note that no two crisis situations are the same. They are unique in many ways, and while bringing experience to the table is a positive attribute it cannot come with the loss of structure. Therefore, the construction of the team is critical, as is the selection and development of the crisis team leader. What needs to be stressed at this point is that the crisis team leader is not necessarily the company leader. Both roles are important, however, they have distinctly different parts to play. This will be addressed in more detail shortly.

Time and again the experience of the crisis leader and their control of the crisis team were also raised as contributing to the deviation. The lack of experience of the crisis team and a potential lack of awareness of the performative routines were evaluated as having a direct correlation to the level of training, practice in simulations, and real case activities undertaken by the crisis team and their leader. The crisis leader may lack experience and practice, with the situation being compounded by an inability to manage the dynamics of the team and the establishment of core procedures. The crisis leader needs to be proficient in decision making under pressure and complexity, established by experience in crisis response (Dionne et al., 2018, pp. 97, 104) and they need to ensure that they leverage the capabilities of the team and also to ensure that they control any perception among the team members that individually they may know best and that routines can be ignored. As SME9 (2016) noted, the
This concept of managers reverting to what they are comfortable with is supported by scholars (Fischbacher-Smith & Fischbacher-Smith, 2012), who note that managers under pressure behave differently to their normal management approach. This links not only to experience but is where command and control by the crisis leader must come to the fore. Therefore, it is concluded that tools are not the reason for the process deviation. The deviation occurs due to an ineffective approach to the structure, leadership and coordination of the CMT; that is, actors are not cast correctly, so that their behaviour and skill sets contribute to the deviation. This became the central concept of the developed theory.

As this is the basis for the theory development, various elements require reviewing and further discussion. There is the requirement to further discuss the construction of the team and this incorporates the elements of selection, personality and culture. The second component relates to the selection of the crisis leader and the performance of their role. This again necessitates an evaluation of personality. Intrinsically linked to both the casting of the actors and the selection of the director is the way in which capabilities are developed. This links into the role that rehearsals, together with real life experience, play. This extends to the importance of capturing ‘real case’ learnings as these are critical in both individual and team development. The discussion will now examine the specifics of these elements.

5.4 Crisis Management: Teams, Leaders and Rehearsal

The discussion now turns to the actions of the crisis team, its leadership and the role that training and simulations play in minimising the process deviation. Referring again to figure 21 the concept of team was the second largest identified. Within this concept
bubble also resided the role of the coordinator who in this research is the crisis team leader. The role of the leader, crisis team composition, culture, personality and training were identified as intertwined themes during the supplementary manual coding process and was seen as pivotal to the deviation from ostensive routines during performance. It is noted that in respect to the extant literature on crisis management that it has at times been described as fragmented (Bundy et al., 2016) and that while elements of the literature that deal with crisis management examined aspects relating to the construction of the team and its leadership the role that the multiple facets play in respect of process deviation in a business context has not subject to previous research.

This section of the chapter will focus on: team composition; the crisis leader; culture and personality; and, lastly, preparation and training. As part of the discussion, the definition of 'leadership' needs to be addressed. In the sphere of crisis management, it can be concluded that this is specifically at odds with the business leader who plays a different yet very specific role as the figurehead, and potentially the spokesperson, of the business.

5.4.1 Team Composition

At its basic level a crisis team comprises “individuals who share interactions and experience in decision making” (Sommer & Pearson, 2007, p. 1243), and who, while following processes, can arrive at conclusions that are novel and contribute to effective resolution of the situation. This requires experience in both business management and crisis response. King (2002) observed that a CMT is a cross functional group of people brought in to handle a crisis with Robert and Lathe (2002, p. 187) describing a crisis team as a chemically unstable mixture of people that has its own personality, history and emotional dynamics. As identified in this research, the reality is that members of a crisis team are generally not selected due to their experience in, or exposure to, crisis management. By default, and due to resourcing, it is extremely rare for this to be classified as any manager’s ‘day job’. The reality is that it is generally the business role that the individual holds, together with their seniority, that dictates their participation in the team, rather than their possession of crisis experience or skill sets. Often lacking ‘crisis response’ skills, managers are thrust into situations where they do not know what
they are doing, with limitations of the clarity of their role and objectives (SME20 p3) and this can adversely impact the process of decision making under conditions of pressure when managing a threat (Smith, 2000). Taking all this into consideration and reflective of the Leximancer and supplementary manual coding results, the research concluded that the selection and combination of the crisis team members is critical as this has a direct correlation to the team’s adherence to process and utilisation of the artefacts. Smith and Fischbacher (2009, p. 72) support this by noting that “the selection of the CMT members should reflect the individual’s ability to fulfil key roles and tasks within the context of a functional specialism or positional affiliation.” Effective selection requires the implementation of a more formalised strategy, one that focuses on skills, expertise and personality.

Acknowledging the importance of the correct team construction, it is important to ask: what are the elements that should be considered? Rerup (2006) contended that a crisis team needed the ability to focus on many issues at the same time, as well as the ability to analyse and interpret the complex and often contradictory information that arises. This was supported by the SMEs who argued that central to the success was having the right people, from the right areas of the business, thereby ensuring correct knowledge is brought to bear. This extends, however, from the simple ability to interpret elements of one’s day job and to apply those skill sets under the pressure of a crisis response. Smits and Ezzat (2003) noted that the desirable core attributes of the CMT’s members are that they must be dependable, calm, self-confident and assertive. These attributes were also described by the SMEs, with SME21 noting that an additional attribute was the ability to be proactive.

Within the discussion of a the team’s composition Rerup and Feldman (2011) also argued the importance of longevity. In their research into routines and their impact on organisational change they recognised the complexity of the relationship between routines and the trial and error learning process. They deduced that trial and error during crisis management built capability and that longevity of the team is therefore critical. This was because routines to be applied both during and after the performance can improve over time. Pentland et al (2010) noted that, with each performance or iteration of a pattern of action, actions can be evaluated against the prior actions, and
thereby linked to the performance of the routine. This enables revisions and improvements to occur over time.

Longevity was also perceived by the SMEs as being a vital element in minimising process deviation and this was also reflected in the data relating to the SMEs. SME3 specifically noted that teams with a strong team spirit were the most effective, and that the building of the team spirit was linked to the longevity of the team. What was illustrated by the experience of the SMEs was that longevity in the specialist field played a significant role in capability, and it can be argued that maintaining a solid crisis structure built on longevity strengthens the overall response.

The additional benefit stemming from team longevity is the creation of trust. Early research (Roberts & O'Reilly (3rd), 1974) theorised that a lack of trust was one of the elements, together with influence and mobility, that contributed to communication failure in business. In the context of this research, communication would translate to both within, and external to, the crisis management team. Trust was also raised by King (2002) as a critical element of a cohesive team, and that team trust can be influenced by factors of time, information resources, procedural conflict, poor leadership and prior interactions. Again, contrasting this to the current research, in the context of trust, time can be linked to longevity, procedural conflict can be linked to understanding and application of the routines, and poor leadership can be linked to the capabilities of the crisis leader.

5.4.2 The importance of the crisis leader

There has been an enduring interest shown in the role of leadership within a crisis management team (Fischbacher-Smith, 2016a; Pearson et al., 1997). In fact, it was concluded that leadership within the context of a crisis team’s operations was a critical area of further study. The context specifically related to whether the leadership skills, attributes and approaches required in a crisis mirrored normal operations. It is contended that the answer lies at the heart of the examination of minimising process deviation.
This research clearly supports King's (2002) position that a cohesive team is critical to success. Cohesion, though, does not come automatically. Here the role of the crisis leader becomes crucial, for a team can have the right people in place, with the right personalities yet may still be dysfunctional and the transformational leader's role is to leverage capabilities to meet expectations (LePine et al., 2011), rather than let a team become dysfunctional. With dysfunction and lack of cohesion comes process deviation. Perhaps, therefore, the most important element to address is the selection of the crisis management team leader and as Dionne et al (2018, p. 117) concluded, the best person to lead the team many not be a formal leader holding the highest position of authority.

As noted earlier, it is important firstly to validate who is being referred to during discussions in respect of the crisis leader. With regard to the role of the crisis leader, there can be confusion between the role of the business leader versus the crisis leader. This can be confusing for, as King (2002) argued, crisis leaders must display confidence while at the same time expressing empathy. In this perspective, it is argued by this researcher that King is referring to the senior spokesperson, who by default should generally be the CEO of the organisation. By the very nature of their role the CEO must have the ability to appear empathetic in order to ensure that they establish and maintain the trust of both their internal and external stakeholders. This is important as there have been many crises where this has not occurred. For example, during BP's Deepwater Horizon crisis, CEO Tony Hayward is remembered for his quote that lacked empathy: “I'm sorry. We're sorry for the massive disruption it's caused their lives. There's no one who wants this over more than I do. I'd like my life back” (Lubin, 2010). This was observed as not being empathetic due to the extreme loss of life experienced in the event. It also links back and is an illustration of the Hubris Syndrome as described by Owen which permeated the BP culture and potentially contributed to that catastrophe (Owen, 2008, 2011). This was in stark contrast to the approach of Richard Branson in respect of the Cumbrian rail crash involving Virgin Rail in February 2007. In that case, which involved a fatality and multiple injuries, Branson clearly was not the leader of the crisis team, but the spokesperson of the business, and he followed the communication CAP technique of Concern, Action and Perspective. This illustrates the separate yet critical role of the business leader.
The role of the business leader is to provide the external face, and there must be a clear delineation between the role of the senior spokesperson and that of the crisis team leader. It is argued that empathy in leading the CMT’s response is not necessarily a critical trait, whereas calmness is vitally important. It is stressed that, while there is a difference in the interpretation of the role of the leader, one of the functions of the crisis team is to ensure that the correct spokesperson is identified and that they have undergone relevant media training. The crisis team must take responsibility for ensuring that the correct messaging is provided to the spokesperson, and this should be established in the routines.

There are a variety of attributes that should be considered when moving to a discussion of the relevant skills of the team and its leader. Smits and Ezzat (2003) contended that crisis team members needed to be dependable, calm and self-confident, with personalities that can influence perception and decision making. Barley and Tolbert (Barley & Tolbert, 1997) noted that possession of a stock of practical knowledge relating to behaviours was beneficial, and this was supported by the SMEs who contended that this was a way to positively influence team dynamics. Certainly, it will be argued that these traits are even more critical for the crisis leader.

In his research Weick discussed the role of the bricoleur and routines in high pressure situations. He argued that “recovery lies not in thinking then doing, but in thinking while doing and in thinking by doing” (Weick, 2002). A bricoleur by design applies a high level of innovation in a crisis response and by default is creative while under pressure, having the ability to routinely act in chaotic conditions and to achieve order during chaos. This position was supported by Mallak (1998) in his study of adaptive behaviour. He argued that having individuals who could respond quickly to change confirmed the relevance of the bricoleur, because for them a crisis is the normal operating environment. However, this poses the question: where should the bricoleur reside? Should they be an innovative member of the crisis team or the leader of the crisis team? Innovation is certainly a characteristic that needs to be present. Yet it raises a question as to whether innovation is potentially counter intuitive to enabling a focus on process minimisation. Or, perhaps, do the two elements potentially complement each other? From the observations and the SME feedback it was confirmed that innovation is a
complementary skill and comfortably sits alongside process discipline. Therefore, innovative thinking is a trait that should be present in an effective crisis leader, or if not within the leader definitely within members of the team.

In this research, the SMEs categorically agreed that the crisis leader is the linchpin. This person held the team together by ensuring that processes and routines are followed. Various metaphors were used by the SMEs to describe the role of the crisis leader. These included being the 'team captain', the 'conductor of the orchestra', or the 'ringmaster'. This aligns with the metaphor of this research: that the crisis leader is the director and the role is to align the actors to the script. These metaphors relating to leadership have a commonality in that they create the framework for a uniform and consistent response while always embracing innovative adjustments, however with discussion and alignment.

In aspect of the selection of the crisis leader, a common risk was identified. This risk emanates from the fact that many organisations have traditionally assigned this role to a ‘function’ rather than identifying an individual with the attributes of an effective crisis leader. For example, in many instances within TCCS the Public Affairs and Communications (PA&C) Director has been selected. While there is no clear rationale for this, there is a possibility that traditionally this was related to an incorrect perception that crisis management equalled crisis communication. Hence the crisis leadership role defaulted to the PA&C director, which created the risk of drawing a key resource away from their area of specialisation. The risk here is that the specialisation of focus is lost, or that the individual focuses on their specialisation rather than the leadership and the processes. To counteract this role allocation by function, there is a need to have a process in place that formalises the identification of the crisis leader to ensure that they have at least a majority of the core attributes. Specifically, SME18 (2016, p. 5) stated that she would seek an individual who is open and willing to cooperate, open minded, with the ability to look broadly and analytically at issues, and most importantly, had the ability to listen. The coordinator also needs to be process orientated. In this way, they can minimise process deviation by ensuring that routines are followed and that they have the right people in place, at the right time, working as a team and adhering to the processes.
SME23 (2016, p. 4) saw the core attributes of the crisis leader as being transparency, responsibility, discipline, and cooperativeness, as well as the ability to encourage constructive debate. The crisis leader also needs the ability to manage personalities within the team, to identify and understand an individual’s strengths and weaknesses and leverage their capabilities (SME2, 2016, p. 3). This aligns to the views of Martinez-Corcoles (2018) that a leader’s openness to differing perceptions and allowing team members to voice opinions can stem from their knowledge of the team dynamics. SME 10 (2016, p. 5) described the coordinator (leader) as needing to have: self-confidence, but not to the point of arrogance; an ability to make quick decisions; and an analytical mind. These need to be coupled with a strong business knowledge – that is, the ability to take the available material and utilise it within the context of the overarching business strategy and environment.

In summary, the identified attributes of the crisis leader as described in the extant literature mirrored the findings of this research. A comparative table is contained in Table 10. It is argued that these attributes should be formally categorised and considered in the selection of the individuals to perform this crucial role. It is concluded that the model of selecting a crisis leader based on the functional role that they perform is outdated in concept and approach, because it does not necessarily provide the team

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<td>Creative</td>
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with the correct calibre of leader with the right skill sets or personality. There is an opportunity moving forward to confirm the criteria to drive the selection of the crisis team members and thereby shift from appointments based on role and seniority. As will be touched on in the section on training (5.4.4), there is also the interlinked question of whether these attributes can be taught to a crisis leader, and what elements the training should focus on.

5.4.3 Personality Types and Culture

Acknowledging that there are commonalities in the attributes of an effective crisis leader, the research posed an additional question: is there a personality type that incorporates attributes that enhance sense making, thereby creating an effective crisis leader? The importance of understanding personality is due to the fact that skill set and dynamics directly influence the approach adopted by the crisis leader and the team. Within the literature, Weick and Sutcliffe (2006, p. 516) examined personalities and argued that when individuals are paying attention to failure, simplification and resilience then mindfulness can result. This mindfulness can broaden environmental scanning, generate interpretations that are more context relevant, and produce behaviours that are described as more discriminating. These elements can become critical in the evaluation of information. Yin and Jing (2014, p. 30) built on this and found that the broader the nature of the crisis the more complex and dynamic the environmental pressure becomes. This can impact the team by adversely affecting critical thinking, communication and judgement. These are all elements that can be linked to the personality traits of the team members. The importance of critical thinking drove the focus on personality types and the potential link to process minimisation.

In discussing this aspect with the SMEs, there was a strong consensus that there would be a benefit in gaining a greater understanding of the personality types within a crisis team and how this influenced behaviour. This was seen not so much in respect of selecting the members of the team, but rather to enable the crisis leader to understand the team dynamics in order to leverage their capabilities in the most effective way. There was however a view that this should be specifically relevant to the selection of the crisis leader. In order to evaluate this concept, the research utilised MBTI as the personality assessment tool. MBTI was selected as in management analysis it informs
individuals regarding “their innate preferences for interaction with each dimension representing both opportunity and liability in a given situation” with the its usefulness being in “helping individuals to understand their innate preferred behavioural styles” (Brown & Reilly, 2009, p. 927). While there is debate as to the benefits and value of using MBTI, it was leveraged primarily since it was readily accessible to the participants. Most importantly, from the discussions with respondents it was clear that it was well known and accepted amongst them principally because they had utilised the process previously during their business careers. Additionally, as Furnham found (1996) there is sufficient replicated overlap between the MBTI and other formats to validate the suitability of its utilisation.

The findings in this study identified that the majority of the recipients of the test were extrovert in nature, with differences primarily in the area of sensing versus intuitiveness. Interestingly, there was a difference observed in the findings between the classifications as they related to SMEs and the independently evaluated crisis leaders. While a high level of extroversion was identified across the board, within the SMEs the classification of ESTJ dominated. In the evaluation of the operational crisis leaders the focus was on those located in the top quadrant in the field of process management (sector 8+) and crisis leadership (8+). Here the contrast was highest, with those who were members of the PA&C community being ENTJ and those who were within the risk management or quality management fields being ESTJ. So, extroversion was confirmed as a common characteristic, the variance being in the aspect of whether the subject was more sensing (S) versus intuitive (N). This therefore indicated that crisis leaders, who were deemed as strong, had a process orientation toward extroversion, with the level of extroversion varying. It is argued that this extroversion potentially leads to the ability of the crisis leader to exert control, and in this way mitigate the process deviation. While the basic nature of this initial evaluation means that no definitive conclusions can be drawn from this snapshot into personalities, the path is now open for a more detailed examination of this element as part of future research.

It was also found that there was a variance in perceptions regarding which personality assessment methodology provided the most effective evaluation of the individuals. In respect of the MBTI methodology, there is ongoing debate as to its validity (Brown &
Reilly, 2009; Furnham, 1996) due to the compartmentalising of individuals into specific categories. The potential weakness of MBTI was flagged by SME17 (2016, p. 4), who noted that potentially the Hogan’s Assessment or Hermann Brain Dominance Index (HBDI) may be more effective tools as they do not compartmentalise the subjects. Additionally, other tools such as NEO PI exist and have been utilised by the researcher. While the NEO PI contains over 200 questions, there is a preference on the part of this researcher for its utilisation in future research. This is because the tool categorises extrovert and introvert traits in different situations, rather than boxing an individual generically into one category regardless of the external environment. Ultimately, irrespective of the tool utilised, for as observed there is sufficient replicated overlap between systems (Furnham, 1996), the use of a personality assessment was generally thought to be an effective next step in the evolution of the design and modelling of the crisis team and the selection of the crisis leader and confirm literature findings which support “the notion that team personality composition can act as a relevant social cue that influences individual personality-behaviour relationship” (LePine et al., 2011, p. 321). It is recommended that future research be undertaken to focus on this specific aspect. This would be undertaken by firstly identifying and agreeing on the most appropriate type of personality tool and then utilising this in a study of crisis management team behaviours.

The research also confirmed the role that culture plays in team effectiveness and, by default, adherence to processes and deviation minimisation. In Figure 25, culture is clearly linked to the people / human theme. The people concept dealt with the construction of the team; the work element that addressed the processes and extended to team dynamics. Culture was identified as having a bearing in respect of both business and national/country elements and a common element in an effective crisis management program is the presence of a responsive corporate culture that facilitates strong communication and develops internal support during a crisis (Smith, 1990). Breaking the concept of culture down, business culture encompassed vision, values, norms and language. With nationality or country, this incorporated the customs, social structure, practices and communication of a country, or in some cases within a country. In respect of the business culture, it was observed that adherence to processes, including reporting, was driven by the value that was placed in that culture on ensuring
that the correct crisis response existed. This involved ensuring, as part of the business values and the norms, that escalating incidents to ensure visibility was seen as a positive activity, not a negative. As noted by SME 3 (2016, p. 7), this required a culture of transparency within the business, one which encourages people to act on issues, and to report the issues knowing that there will be no retribution for the delivery of 'bad news'.

In regard to national culture, it was observed during the simulations that both process discipline and team dynamics can be influenced. As a general position, the SMEs noted that there are disciplined people and there are people that are less disciplined in their approach. This cultural discipline can contribute to process deviation and the cultural contrast was specifically evident between northern and southern Europe. It was observed that the further south one moved, structures ran a greater risk of becoming less formal, often with an *ad hoc* approach (Calori & Seidel, 1994). In respect of the team dynamics and interaction, the cultural element was noted in the findings as playing a significant role in whether or not members of a team voiced their opinion. This is particularly evident in some markets, such as Japan and Korea, where managers will defer to and not challenge those that are considered ‘older’ and ‘wiser’. This can impact decision making, for having an opinion and voicing it while on the crisis team is crucial in ensuring that processes are followed, and that innovation and opportunity are leveraged.

The reality is that culture will always be an influencer in cases where a business utilises a crisis model that leverages localised country crisis teams that are required to think globally while acting locally. These dynamics need to be understood, not necessarily to influence the construction of the crisis team, but in order to specifically re-design training to ensure it provides a culturally specific focus on the process requirements. This training would focus specifically on enhancing capabilities to minimise process deviation. This was tested in a southern European market where one on one training and coaching was provided to the crisis leader during a specific response. The results showed an enhancement in performance levels, particularly in regard to control of the team, and a minimisation of process deviation. In a separate space, there is also the need for the central teams that are remote from the countries to understand the
nuances, capabilities and cultural dynamics that exist in order to enable the most effective support to be provided to the local team.

### 5.4.4 Training and Rehearsals: The Art of Preparation

Preparation through the delivery of training and the testing of capabilities plays a crucial role in process deviation minimisation and ensures that crisis preparation is aligned with broader recovery mechanisms (Normandin & Therrien, 2016, p. 116). This importance is flagged within the extant literature and supported by the findings of this research. Referring again to figure 21, training can be seen as a bridge between the crisis team and the utilisation of the tools. This interconnectivity of themes was also observed in the manual coding exercise and method triangulation. This linked the importance and use of the tools with the specific capabilities of the crisis team. Smits and Ezzat (2003) contended that how well an action is implemented depends firstly on the quality of the plan and the supporting structures, including the artefacts, and then, perhaps more importantly, on the readiness of the crisis management team. Readiness can only be achieved through training and experience. Labas (2017, p. 8) confirmed this by concluding that “lots of firms are crisis prone and a few were really crisis prepared, the results obtained stress the importance of adequately implementing organizational crisis preparedness.” This built on the position of Robert and Lajtha (2002, p. 187), who argued the need for a structured and continuous learning process.

Training in the routines and the use of the processes and procedures forms one dynamic in this space. The second dynamic relates to the practice or rehearsals that occur via the utilisation of crisis simulation exercises. This second stage provides an evaluation of what has been learned by the crisis team in the course of the training. This evaluation enables the crisis team to gain awareness of associated pressures of crisis management and awareness of decision making and the potential implications of their decisions (Sommer & Pearson, 2007). As Pearson (1997, p. 53) concluded, while practice does not necessarily make perfect “it does seem to lead to clearer thinking and smoother action under duress”. While agreeing with the importance of training, the frequency is in fact a critical element. Low frequency of training coupled with a low rate of real case activations creates the risk of knowledge loss by the team. This can result in a team
performing well in a simulation and then forgetting what they have learnt. Then, when
the real case occurs, the team can lapse into old habits and throw the 'script' out of the
window. Therefore, a business must make the critical call to invest in capability
development. By creating a well-practised team, the value of the processes and the
artefacts are reinforced, and process adherence becomes second nature.

Focusing on minimising process deviation, SME18 (2016, p. 3) stated succinctly that
“training is the key”. Other SMEs argued that training is second only to ensuring that the
composition of the team, including its leadership, is correct (SME2, 2016; SME10, 2016).
This was because without the right team, training may not necessarily be effective. It
was also argued that a lack of training contributes to the occurrence of process
deviation. Individuals were being placed into unfamiliar environments, outside their
comfort zone, and dealing with the complexity of a situation to which they had limited
exposure and experience. As SME 10 (2016, p. 5) noted, frequency of training equals the
creation of experience. If a business does not take this aspect seriously, teams miss out
on gaining pre-crisis experience with the use of the artefacts and with low frequency of
utilisation, subsequently forget their application when it comes to the real-life
activation.

Training within TCCS is currently focused on the development of the team. Conflicting
views exist as to whether there should be a continuation of equal weighting on the
delivery of training to the full crisis management team or whether there should there be
a shift that brings greater focus to the crisis leader. Surugiu and Surugiu (2012, p. 305)
formed the view that there should be specific training for the crisis manager due to the
specialist nature of the leadership role as this focus and would enhance overall
performance. (SME11, 2017). A move to provide specialised training to the crisis leader,
to enhance their specific capabilities, would require a mind shift in respect of the nature
of training content and its manner of delivery. That said, there were views that this shift
would enable a specific focus to be applied to the elements that contribute to a crisis
leader allowing process deviation to occur. Therefore, it was important to focus on the
skills that the crisis leader must apply to minimise this deviation. This process and its
value was highlighted and discussed earlier, with the example of the transformation of
the crisis leader in a southern European market.
Irrespective of the direction that the training and simulation take, in development of the program there must be a focus maintained on ensuring simulation realism by aligning the scenarios to real-life experiences. To enable this there is an ongoing requirement to capture data from crisis response activations and this involves a detailed evaluation of what worked and what did not work. From this the development of training and simulation scenarios that are based on actual occurrences results. This removes the possibility for a crisis team to argue that the scenario is unrealistic and/or the belief that this ‘could not happen here’. The creation of realistic simulations requires all crisis teams to embrace the post crisis activation review process. The issue is complicated by the fact that generally, once a crisis is resolved, the team members simply want to return to their ‘day job’. This is because “everyone is so busy in the business that once something is resolved, there is no real opportunity or really an appetite to get together” (SME1, 2017) and conduct the review. Therefore, before the team is allowed to return to the norm, it is critical that the organisational learning process be undertaken. This knowledge, in addition to integration into the development of scenarios, can be shared with stakeholders to enable prevention of similar cases, or, in the event of a case, enables an evaluation of the previous responses in order to evaluate applicability in the new case.

The importance of the routine of learning post a crisis can be traced back to the early work of Turner where he noted that “when the immediate effects [of a disaster] have subsided, it becomes possible to move toward something like a full cultural readjustment . . . of beliefs, norms and precautions, making them compatible with the newly gained understanding of the world” (Turner, 1976 p. 382). Despite this importance and the fact that a crisis creates a context in which challenges to existing thinking and routines may be made, full cultural readjustment is an ideal that is rarely achieved (Smith & Elliott, 2007). There are multiple barriers to learning including beliefs that catastrophic events are unique and restricted in both space and time together with organisational cultures which may give rise to single loop learning. In this case while some learning occurs “it tends to occur within the dominant organizational paradigm which may well have given rise to the conditions for the failure in the first place” (Smith & Elliott, 2007, p. 532).
The learning loop should therefore form part of the ostensive crisis management routines, as sensemaking is a central part of returning to normality post the crisis and the climate must be created to facilitate effective crisis reviews and learning (Broekema et al., 2017). As with any other part of the routines, deviation at this point must also be avoided, or at the very least minimised. There is a value in self-assessment, and effective teams embrace this concept as the developmental tool that it is. Ultimately, it enables the crisis team to form closure in respect of the issue that they were managing. Embracing organisational learning is highly conditional and can be linked to elements such as the business culture and climate (Bundy et al., 2016, p. 1678; Margaryan et al., 2018) and the associated dynamics need to be understood by the leader and managed. It is through self-assessment that capabilities and skills are enhanced, thereby preparing a CMT for the management of future crisis scenarios. This has a linkage to the position on enhancement of routines based on the learning process as discussed by Pentland et al. (2010) and the view that enacted sensemaking can establish the basis for the prevention of future crisis as individuals think about and highlight their own actions (Maitlis & Sonenshein, 2010). It is also noted that not all resolutions will be successful and failures will occur yet these failures “do not need to be catastrophic after all most organisational learning is achieved on a trial and error basis” (Fischbacher-Smith, 2014a, p. 344). This would also tie into the ways that organizational learning around crisis can be constrained due to a range of barriers to learning (Smith & Elliott, 2007).

Lastly, feedback from the SMEs confirmed the importance of keeping training fresh and relevant and looking for ways to further utilise technology in this space (SME21, 2016). This goes beyond simply ensuring that simulation scenarios are based on replicating true events. In recent years social media has been embedded into training, with live engagement that places real time pressure on participants to respond correctly to the dynamics created in this space. As technology solutions continue to evolve, additional avenues to training and testing of capabilities must be pursued. For example, Abertay University in Scotland recently designed a computer game for Interpol that is focused on enhancing and then testing investigator capability in the area of intellectual property crime. In fact, as a direct consequence from this research a project is currently underway with that university, with the researcher working with third year undergraduates to develop a prototype computer game. This will enable evaluation of this learning
technique as a way of enhancing crisis leader and CMT member capabilities and performance. It is proposed that this element could become the focus of future research.

In conclusion, this research confirms the extant literature regarding the importance of ongoing crisis training and practice through realistic simulations.

5.5 Chapter Summary

The aim of this chapter was to present a discussion of the findings of this research and how they link to, and/or differ from, the existing body of literature. The discussion merged the theoretical framework and literature review outlined in Section 2 of this thesis with the research data. Building on the derived concepts outlined in the literature review, cross referencing was undertaken to evaluate the findings, including those derived from the Leximancer output and the supplementary manual coding, in respect of that literature. Sections 5.2 to 5.4 presented a range of concepts linked with the literature review. The concepts addressed business resilience and risk management before moving on to processes and routines. Lastly, the chapter examined in detail team composition and leadership, focusing on the sub-concepts in respect of team composition, the role of the team leader, the elements of culture and personality, and finally the role of training. In this respect, the discussion supports the development of the theory depicted below to explain the deviation. From here strategies to address the process deviation can be created.

As noted at the outset of this chapter, the research has derived empirical data and evidence from the case study research to address the question of how the ostensive and performative routines interact in a crisis management situation, and what factors contribute to deviations from the routines. By answering this question, a theory was developed to explain the deviation. That is:

“Ostensive crisis routines and their related artefacts are robust. The process deviation from the ostensive routines during a crisis response occurs due to human dynamics which incorporate the behaviours of the members of the crisis team and
the crisis leader. The core causes of deviation are ineffective crisis leadership and weaknesses in the crisis team structure.”

The next chapter will provide the concluding comments for this research. It will contain a summary of the main points of this thesis and articulate how the objectives were achieved, the way the findings contribute to the body of knowledge and concludes by outlining limitations together with recommendations for future research.
Chapter 6 – CONCLUSIONS, LIMITATIONS AND FUTURE RESEARCH

6.1 Summary of the Thesis

The research stemmed from observed behaviours during crisis responses in a business context, whereby the actors within a crisis team deviated from their scripts, these being the ostensive routines and associated artefacts. Such deviations had, on numerous occasions, created additional complexities in the crisis response by derailing a team's strategies. This research set out to address the question of how the ostensive and performative routines interact in a crisis management situation and explore the potential factors that contribute to deviations from the routines. The thesis addresses a research gap in the existing narratives as it directly relates to the lack of specificity in respect to crisis management deviation in a business context and leadership. These elements are critical areas for business as today, more than ever, businesses need to be prepared to respond to crisis in a world in which managing uncertainty is the new norm.

This thesis commenced by linking together the literature of the interrelated concepts. It began with a discussion on the core theme of crisis management with a specific focus on teams and the way they respond to a crisis before examining the literature in the sub-stream of ostensive and performative routines. Lastly, it delved into the literature as it related to the linked concepts in respect of ERM and business resilience.

Reviewing the existing crisis management theories as they relate to these core themes enabled the researcher to validate the appropriate approach for the research journey. It was identified that the development of a conceptual framework combining these three
concepts supported the development of the theory to explain process deviation via a deep dive analysis of the empirical data collected within the two strands. Adopting an acting metaphor, the first strand in broad terms examined the script. In this context, the focus was on the ostensive routines and the artefacts that supported these routines. The task was to evaluate the artefacts, their relevance, and whether they were the cause of the deviation. The second strand, in broad terms, focused on the actors, or those cast to act out the script. The task was to test whether the actors, their level of skill, and their leadership were a contributing factor. Through an understanding of the deviation, potential solutions could be designed to mitigate and minimise the potential for deviation in the future.

Through this research the question of how the ostensive and performative routines interact in a crisis management situation and the factors that contribute to deviations from the routines was addressed. This led to the following theory being developed to explain the causes of the process deviation. It has been concluded that:

“Ostensive crisis routines and their related artefacts are robust. The process deviation from the ostensive routines during a crisis response occurs due to human dynamics which incorporate the behaviours of the members of the crisis team and the crisis leader. The core causes of deviation are ineffective crisis leadership and weaknesses in the crisis team structure.”

In order to establish this theory, the research adopted a multiple case study approach. It cited historical cases such as TCCS’s Belgium crisis of 1999, which not only established the importance of a robust crisis management program, but also the source of the ostensive routines currently guiding TCCS’s response. Through observation, it evaluated crisis teams responding in ‘real-life’ situations and contrasted these with crisis teams during simulations. Lastly, through interviews with SMEs it elicited critical views on crisis team performance against the ostensive routines that were articulated in crisis plans and the value of the associated artefacts. These are the tools and checklists that support a crisis team. This multiple observational approach provided the researcher with access to a wide spectrum of empirical data.
It is noted that TCCS created a compelling research context for several reasons. These included the global reach of the company and its bottling partners with operations in over two hundred (200) countries; its high brand profile; an employee base of over seven hundred thousand (700,000); owning twenty (20) brands each generating a billion-dollars; and delivering 1.9 billion servings of their products globally daily (TCCC, 2018). As a leader in the fast-moving consumer goods (FMCG) field the system’s product quality and brand reputation is of critical importance. Intentional product tampering or threats or accidental product quality issues, have the potential to erode consumer trust and damage brand equity. Within this overall context, the role of a major franchise bottling partner, who has been actively engaged in enhancing business resilience capabilities is critical. These multi dynamics ensure that the case study context as it relates to TCCS and CCHBC is compelling at multiple levels and was highly relevant as a mechanism for investigating the research question.

The simulation observations were undertaken over a twelve-month period (1 February 2016 to 31 January 2017). The live cases were observed over a fourteen-month period (1 January 2016 to 28 February 2017) and the SME interviews over a seventeen-month period (1 February 2016 to 30 June 2017). This breadth of data collection enabled the creation of a rich data set, including: vignettes from the researcher’s observations; records from the simulation sessions; and transcripts from the interviews. These were firstly reviewed and evaluated by the researcher during the collection process and then subjected to ‘unbiased’ qualitative analysis using the Leximancer software tool. Subsequently, building on critical feedback on an earlier iteration of this thesis, manual coding was undertaken to validate the Leximancer outputs. This was based on feedback that the use of Leximancer alone had the potential to suppress the researcher’s interpretation of the data. Through this method triangulation exercise, it was observed that while the resulting manual codes were not an exact match to the automated findings from Leximancer, there was sufficient commonality in the thematic outputs to validate that the manual coding process provided a realistic supportive interpretation of the data. This resulted in a further strengthening of the initial findings.

Addressing firstly the Leximancer output, by adopting the arguments of Rynes and Gephart (2004), the Leximancer software tool played an integral role as it is a computer-
aided computer textual analysis tool. This allowed for a systematic, comprehensive and unbiased analysis of the data sources. Through the creation of the concept maps the research established links between the core themes through the identification and validation of interrelated concepts and themes. These themes aligned to the literature review in overarching terms while driving a focus on various sub-elements. These were categorised, and the following areas examined:

I. Business Resilience
   a. risk management
   b. crisis response

II. Processes and Routines
   a. role of the artefacts (e.g. tools, plans, checklists)
   b. reasons for process deviation

III. Crisis Teams and Crisis Leadership
   a. crisis team composition
   b. role of the crisis Leader
   c. the influence of culture and personality
   d. rehearsals and training to support artefact utilisation

Overall, there was a range of strong, moderate and minor linkages identified among the theoretical concepts. Strong links appeared between the concepts of tools, checklists and training, which have an operational alignment to organisational learning. The links were also strong within the concepts of teams and personalities, and role sorts and culture, with a more moderate commentary in respect of crisis and risk management. What this analysis proved was that the ostensive artefacts played a crucial role in enabling a crisis team to perform their duties and formulate the appropriate responses. The artefacts were clearly identified as being appropriate and, when correctly utilised, contributed to sustainable outcomes. This therefore shifted the thinking from the creation of a theory that would perceive the process deviation as being driven by the nature of the routines and the associated artefacts to one that is influenced by human dynamics.
The data analysis and concept clustering validated that this human factor is the critical influencer in respect of process deviation. This stemmed from two elements. The first was the construction of the crisis team itself, so in this respect the choice of actors. The second, and perhaps the more critical, was the performance of the crisis team leader, or in an acting metaphor, the director. The director has the critical responsibility of keeping the cast on track, following the script, allowing creativity and innovation where relevant, but always being there to steer the cast in the right direction in the live performance.

The data was also subject to detailed triangulation in that supplementary manual coding was performed as part of the thematic analysis. This established that while the output of the thematic analysis, while not an exact match to the Leximancer material, had strong commonalities with the Leximancer results. It was noted that the 1st order codes showed a similar linkage to the importance of both the selection of the crisis leader and the composition of the crisis team. This included the role that culture could play in respect of team performance together with the perceived value in undertaking personality testing. The 1st order codes also illustrated strong support relating to the effectiveness of the ostensive routines and the fact that a positive perception as to their value drives utilisation. The artefacts were also seen as being robust and additionally the importance of reviewing the lessons post incident and the role of training were strong sentiments that rolled up into the overarching aggregated themes.

The finding in respect of the human dynamic validated the creation of a theory that focused on the crisis team and the crisis leader. From here, potential solutions to develop both the crisis team and the crisis leader, to effectively minimise process deviation, have been identified.

6.2 Achievement of Objectives

As described at the outset, the objective of the research was straightforward and was directed at understanding how the ostensive and performative routines interact in a crisis management situation in a business context and the factors that contribute to deviations from the routines. The observed behaviour was the deviation during
performance by a crisis team from the ostensive routines applicable to crisis activation. While the literature review indicated that there was significant research regarding the interrelated themes of business resilience and risk management, processes and routines, and crisis management, no research existed that addressed this specific phenomenon within a business. This would in part link to the observations of Bundy et al (2016) in respect of the fragmented nature of crisis management research.

The project was qualitative in nature and was designed to collect empirical data from which to understand how ostensive and performative routines interact in a crisis management situation, what factors contribute to deviations from routines and to formulate a theory to explain the process deviation. The secondary objective was, through understanding the core contributors to the deviation, to formulate recommendations to minimise the deviation, and for areas of future research in this area. Through the comprehensive and systematic review of the literature across the interrelated themes, a theoretical framework was developed to guide the research thinking. By deep diving into the concepts it was possible to understand the deviation.

The theoretical framework depicted in figure two illustrated the interaction of the various elements existing within an organisation relevant to this study. It illustrated the interconnectivity between the ostensive and performative routines together with the business resilience linkages with a focus on risk management and crisis response. From there the examination of how the ostensive and performative routines interact in a crisis management situation and what factors contribute to deviations from the routines was established. The framework depicted the time bound nature of organisational events and the influence created by the organisation’s dynamic external and internal environment on resilience, risk and crisis management which are influenced by time. In the context of this research real time was utilised as a reference point against which activities are mapped. It was from this theoretical framework and the literature review that the research derived the critical sub-streams for further evaluation.

The analysis determined that the appropriate research methodology involved adopting a critical realist approach leveraging a multiple case study review that incorporated interviewing subject matter experts in the field of crisis management focused on their perceptions and experience relating to routines and the deviation from routines during a
crisis response. This was coupled with observations by the researcher of real case responses and simulations that were integrated into vignettes for analysis. The rationale for researching the phenomenon within the context of TCCS was also provided.

This multi-case study approach enabled the collection of a wealth of qualitative information that was extracted from historical research; real time incident simulation observations; vignettes from the researcher’s observations of crisis response during the period of the research; and from structure interviews with identified subject matter experts. The collected data was then subjected to detailed analysis, firstly by the researcher as the data collection process occurred. To remove researcher bias from the equation, the use of a computer-aided textual analysis tool then allowed systematic, comprehensive and unbiased analysis of the data to occur. The identified tool was Leximancer. Leximancer utilised machine learning to derive concepts to identify relationships between the concepts. This in turn eliminated the human bias that can occur through a researcher’s manual coding of the data. This way of analysing data provided greater rigour and a robust approach, enabling unbiased answers to the research questions. Building on the automated analysis and adopting a recommendation from an earlier review of the thesis manual coding was undertaken providing thematic analysis which was aimed at validating the accuracy of the Leximancer data. While it is evident that the resulting codes from the thematic analysis were not an exact match to the Leximancer findings, there was sufficient commonality in the outputs to validate that this additional coding process provided a realistic supportive interpretation to the initial data thereby strengthening the findings.

This overall methodology and approach to analysing the data was outlined in detail in the methodology (Chapter 3).

The findings from the collected data have been outlined in Chapter 4. Moving to the discussion section of the thesis, this section involved interpreting the findings against the theoretical synthesis and constructing a theory. This entailed interpreting the findings through data triangulation utilising the outputs from the Leximancer analysis and supplementary manual coding exercise and analysing this through the lens of the literature review. From this, further literature was sought to validate the extant
literature against the empirical findings. This element of the process was explained in
detail in the discussion which is contained in Chapter 5. From the analysis of these
findings and the associated discussion, the research identified the elements that
influenced the process deviation. From these findings the strategies that could
potentially be applied to minimise the process deviation were articulated. This
facilitated a review of the original theoretical framework and challenged the way that
the findings might influence the overall model, concepts and theories as depicted in the
theoretical framework. The next section will delve into the specific contributions to the
theory and the body of research in respect of crisis management.

6.3 Research Contributions

6.3.1 Contributions to Theory

The research has confirmed the critical role and the high level of accountability that is
placed on the effective performance of a crisis management team within a business
context. It has confirmed that core contributors to deviation from the ostensive routines
during their performance are weakness in crisis management team’s construction and
cohesion; their level of experience; and the capabilities of the crisis leader. The ostensive
routines and the associated artefacts used in a business context have been evaluated as
appropriate and value adding, and it is confirmed that human intervention,
interpretation and behaviour creates the deviations. Capabilities of the crisis
management team and the crisis leader can be built through rehearsals, with a central
requirement being that these simulated rehearsals are realistic and occur on a regular
basis. Training is therefore paramount in building a team’s capability in the use of the
artefacts and confidence in their contribution to the crisis response (see section 6.3.4).

Having a direct relationship to the team cohesion is the trust that is established during
the performance of ‘live’ situations. Through experience and crisis exposure, teams
come to appreciate the value of the ostensive routines and the supporting artefacts. This
experience enables a team to leverage the process even in instances where the
coordinator, or crisis leader, is ineffective in their guidance. A risk arises when teams
lack experience and trust, driving ineffective cohesion which, when coupled with poor crisis leadership, creates a situation that is conducive to process deviation.

Therefore, the key contribution from this research into the understanding of how ostensive and performative routines interact in a crisis management situation and what factors contribute to deviations from routines is the development of the theory to explain the deviation and thereby enable responses to be developed. The finalised theory to explain the process deviation is that:

“Ostensive crisis routines and their related artefacts are robust. The process deviation from the ostensive routines during a crisis response occurs due to human dynamics which incorporate the behaviours of the members of the crisis team and the crisis leader. The core causes of deviation are ineffective crisis leadership and weaknesses in the crisis team structure.”

6.3.2 Validating ostensive routines and use of artefacts

The research has validated the role played by the ostensive routines and the importance of the minimisation of process deviation during the performative stages. It has examined a stream of data that evaluated the effectiveness of the ostensive routines and the associated artefacts and concludes that, in the context of crisis management, the ostensive routines that encapsulate the crisis plans, together with the artefacts such as tools and checklists, are robust. It has concluded that the reason for process deviation does not rest with the routines and associated artefacts due to either a negative perception as to their effectiveness or any evidence of deficiencies in their construction. Rather, the deviation results from the human dynamics, be that from the team composition or the leadership of the crisis team.

6.3.3 The composition and skill of the CMT

Acknowledging the value of the ostensive routines, the research has confirmed that deficiencies in a business crisis team’s structure and the capabilities of the crisis leader lead to the deviation. It confirms that the composition of the crisis management team and the skills that they possess need to be leveraged in order to minimise process deviation. Within this element, it is noted that further research in relation to the
personality traits of crisis team members would be beneficial. This is not necessarily in relation to using the results of the data for the specific construction of the team but would be of particular relevance to the crisis team leader in order to most effectively leverage the team’s capabilities during the crisis response activation. As a next step, there is an opportunity to confirm the criteria for driving the selection of the crisis team members and thereby shift from appointments based on both the position/role held and seniority.

**6.3.4 The role of leadership in crisis management**

The research has confirmed the importance of effective leadership for the crisis management team within a business. Within this context, it has identified and confirmed multiple traits that can be leveraged in the selection of the crisis team leader. It also concludes that nomination of a crisis leader on the basis of functional experience is inadequate. There is a necessity for businesses to formalise the process of the identification and selection of the crisis team leader. This key position cannot be based on position or seniority but rather on experience and exposure to crisis situations. This process should consider the listed attributes together with demonstrated experience in the successful management of crisis teams. It is important to note that ‘successful management’ may not necessarily equate to successful resolution, for this may be outside the crisis leader’s control. What is evaluated is the manner in which the crisis leader approached the response and the strategies adopted to minimise process deviation. Within this space of crisis leader selection, there is a role to play for personality assessments and this should be incorporated into the selection process. As previously noted, a personality assessment should not in itself be the sole determining factor, rather, it needs to be leveraged as an additional tool in the selection process. The personality assessment can also be leveraged from the perspective of enabling a crisis leader to understand their team and effectively utilise their capabilities.

**6.3.5 Contribution to methodology**

The management of a research investigator’s bias during the undertaking of qualitative research remains an ongoing challenge and a conventional shortcoming in this field. The utilisation of Leximancer largely offset this shortcoming and further validated the
value of the program in qualitative research. This approach effectively enabled researcher bias to be countered through the lexicographic analysis of data based on words and synonyms existing within the theoretically defined concepts. This further validation of the software’s applicability in qualitative analysis is considered, while small in nature, an important contribution for future study in qualitative research. These points aside, feedback on an earlier iteration of this thesis recommended that manual coding also be utilised to enable and support method triangulation and enable further validation of the findings as produced by Leximancer.

6.3.6 Contributions to business

The conclusions of the research have been consolidated and are being applied in the refinement of the crisis management system within CCHBC. These refinements are in three areas. The first is with the artefacts, for while they were evaluated as robust, it was acknowledged that their enhancement by leveraging technology would be beneficial and potentially aid a crisis leader in minimising deviation. The second is strengthening the process for the selection of members of the crisis team through confirming the required skills and attributes. Ostensive routines have been developed in this area and are being rolled out in the first half of 2019. The third is using these findings to examine mechanisms to enhance training for both the crisis team and its leader. This has commenced with the researcher working with students at Abertay University, Scotland, in the development of a computer game prototype as the major project work for the 2018/2019 third year students. It is anticipated that this program will step change the approach to crisis training and enable enhanced evaluations of crisis decision making within a business context.

6.4 Limitations

While the context for focusing TCCS has been discussed and confirmed, the main limitation of this research stems from the fact that the focus of the source data is from within the FMCG sector. This posed the question as to whether the results would be replicated across other industry streams. The choice of a multifaceted case study
approach that involved observations and interviews within one sector was guided by Yin’s (2009, pp. 47-50) identification of two important rationales; the industry was perceived to be typical or representative of a broader environment, and could be studied longitudinally. This is the case, as it is understood and accepted that businesses have similar ostensive routines in place to manage crisis situations and are exposed to the same concerns in respect to deviation. A difference will be driven by the sector and the nature of the risks that they are responding to.

Another limitation existed in respect to the volume of cases that could be observed and the number of SMEs that were accessible during the research period. Despite this, it is argued that the balance achieved by the multi-case approach of interviewing the range of SMEs together with vignette creation mitigates this limitation. Linked to this element was the timeframe, with an expanded observational period potentially enriching the empirical data.

In addition, it can be argued that the initial chosen methodology had limitations. For example, while the Leximancer software identified references in the concepts and concepts in the references, the researcher played a pivotal role in the analysis and interpretation of the data at their disposal. This analysis and interpretation extended to the supplementary manual coding process.

Within the methodology, the utilisation of MBTI as the personality assessment tool can be considered a limitation. This is for a number of reasons, including that it was used in its base format, together with the conflicting opinions as to its capability to effectively evaluate personality. That limitation aside, the MBTI assessment provided a sound initial construct for future research into the aspect of personality as it relates to the creation and operation of crisis teams.
6.5 Future Research

This research validated the applicability of the multiple case study approach for qualitative research of this nature and illustrated the richness of data that can be sourced. Additional future value would be derived by undertaking further observational research of business crisis team and crisis leader dynamics. A line of inquiry would involve creating sample variants of the research subjects. The first sample pool would comprise business crisis teams that are required to adopt the improvements as detailed in this thesis. That is, the recommended selection criteria involving personality and cultural analysis would be used in the team construction and, more importantly, in the selection of the crisis leader. This team would also utilise redesigned artefacts. The second team would maintain the status quo. A comparative analysis would then be undertaken between the two subject teams, over a nominated period of time, to validate the conclusions that were drawn in this research.

The research was undertaken within a limited time span. Observations of simulations and ‘real-life’ activations took place over a twelve to fourteen-month period. This time frame could be expanded to capture additional rich data for vignette creation. The field covered by the pool of SMEs could be expanded across different industry sectors, incorporating additional cultures and countries to validate the applicability of the findings on a broader global scale. Here the sourcing of additional vignettes would also be beneficial.

The lessons learned from a crisis response directly contribute to organisational knowledge and learning. A validation of how organisational learning in crisis management contributes to the resilience of the business would be appropriate and would support the ongoing investment in crisis team development. Whilst some authorities have rebelled against the need for further research in organisational learning (Gavetti, Levinthal, & Ocasio, 2007), further research into the link between organisational learning and strategic flexibility, particularly in respect of business resilience, would be beneficial due to the increased uncertainty and volatility of the environment in which businesses operate.
Additionally, there is the opportunity to deep dive further into the construction of the crisis team in a business and the role that personality assessments can play. This is both in respect of the selection of the crisis leader and more generically to understand the personality types of the crisis team members. In this space this would include selecting and utilising a different personality tool, such as NEO PI to deep dive further into this aspect.

Lastly, future researchers may benefit through exploring the additional analytical opportunities available in the lexicographical analysis capabilities of Leximancer. For example, further in-depth utilisation of Leximancer’s ‘discovery’ mode may offer additional insights in relation to the extracted data.

### 6.6. Closing Observations

The complex nature of the global business environment, driven by volatility, ambiguity and uncertainty, is such that businesses will continue to face a growing number of crisis situations and the way that a company responds to these will influence its viability. This means that the ability of a crisis team to effectively respond to a business crisis situation, irrespective of its nature, is even more critical than ever before. To address this important topic, this thesis set out to understand a specific observed behaviour within crisis teams. This was the deviation from the ostensive routines during the application of the performative routines. Within this context it set out to address the question of how the ostensive and performative routines interact in a crisis management situation and what factors contribute to deviations from the routines.

Ostensive routines and the nature of their performance form the foundation of guiding a crisis team to an effective response in a crisis situation. The crisis leader is essentially the director of a production and plays a pivotal role in guiding the response. What has been concluded is that the scripts themselves provide a strong foundation and do not themselves create the deviation. This research, having addressed the question of how the ostensive and performative routines interact in a crisis management situation and
what factors contribute to deviations from the routines, has resulted in the development
of a specific theory to explain the deviation. It is concluded that this theory is:

“Ostensive crisis routines and their related artefacts are robust. The process
deviation from the ostensive routines during a crisis response occurs due to human
dynamics which incorporate the behaviours of the members of the crisis team and
the crisis leader. The core causes of deviation are ineffective crisis leadership and
weaknesses in the crisis team structure.”

Therefore, as concluded in this thesis, the focus in a business must be on the correct
casting of the actors (the team composition) and the choice of the director (the crisis
leader). Team composition and its leadership can be driven by confirmation of the skills
and attributes required, together with the role that personality plays, and by building a
selection model that moves from appointment by role and seniority. Then, through the
 provision of ongoing training together with exposure to real life experience, enhanced
capabilities can be developed

By drawing all these elements together, process deviation can be minimised, thereby
strengthening a response that in turn contributes to an organisation's resilience. While
it will take time, the importance cannot be underplayed, and through dedication by
those crisis leaders in the field the process deviation from routines can be minimised
and the resilience of a business strengthened.
APPENDICES
Appendix A: Full Case Study – 1999 Belgium Crisis

Introduction

The value of a well-designed crisis management program is that it brings to a company the ability to prepare and respond to any contingency. As Pourkomailian (SME14, 2016) notes, when an incident does occur, success results when the business can prevent panic and chaos, and stops the incident from becoming a crisis. The basic doctrine of crisis management is that there exists a link to effective planning through establishing processes and procedures, preparation and response, including an understanding of the problem at hand and the sensitivities of the market, which can influence the response.

In establishing the context of this research, which examines incident response within The Coca-Cola Systems (TCCS) with a focus on deviation between ostensive and performative routines, it important to understand the source of the current crisis management program. It was created because of TCCS’s ineffective response to the Belgium recall of 1999. This case study examines that recall, which was the most significant in the history of TCCS. This was a case that illustrated key program deficiencies and in effect was the catalyst for reengineering the systems crisis response methodology.

This study illustrates a number of key dynamics that are central to this research and in developing an understanding of the dynamics that contribute to process deviation. These include: the importance of having the right people in place at the right time; ensuring that processes and procedures exist and are understood and followed; the provision of training that ensures the CMT is prepared to respond to the crisis; and lastly, the importance of understanding and responding within the context of the local environment. This case study examines the event, the market sensitivities leading up to the incident occurring, the nature of TCCS’s response, and the lessons that were learnt which drove the development of a more effective crisis management model for the system.
The Incident

The Coca-Cola Belgium tainting crisis began on June 8, 1999, when reports were received that a number of school children at a middle school in Bornem had fallen ill after consuming Coca-Cola. "Their main symptoms consisted of abdominal discomfort, headache, nausea, malaise, respiratory problems, trembling, and dizziness (SME21, 2016)." As John Parker (2013) from Coca-Cola Enterprises (CCE) recounts, "the children experiencing the symptoms reported that they had drunk Coca-Cola during their break. The school made an announcement to see if others were affected. The news spread quickly, first throughout the school, and then, after ambulances came racing to the schoolhouse doors, throughout the community". While it is a fact that TCCS took initial basic actions, complications arose when two days later school children in Bruges reported illness after consuming Coca-Cola products.

This expansion of the impacted area exacerbated the issue, with the resulting publicity driving the expected increase in consumer complaints. On 14 June 1999, the Belgian government intervened and took decisive action by directing the withdrawal of all Coca-Cola products and prohibiting their distribution until further notice (Nemery et al., 2002, p. 1658). The directive was driven by a perception within the government that TCCS was slow in its response, which had the effect of removing control of the management of the crisis from the team. This was linked to a failure by TCCS to articulate the nature of the issue or the cause of the illness (two probable scenarios emerged) or satisfy stakeholders as to the safety of their products, and to what was perceived by key stakeholders (government and consumers) as a lack of urgency in their response. As Nemery et al (2002) contend, the company appeared to have been caught by surprise, their explanations appeared confused, and their spokespersons in the media and press conferences did not correspond to the brand’s image of youth and energy. Moreover, they were very casual in providing data from the chemical analyses of their products, which in effect broke the trust of the stakeholders in a market already the subject of an earlier food scandal. On 15 June, the crisis expanded further when the governments of Spain and France accused the company of selling tainted products, which created a multi-jurisdictional expansion of the issue that further complicated the crisis response.
The result was that "approximately 17 million-unit cases of Coca-Cola and other soft drinks were recalled, and existing stocks were destroyed, at an estimated cost of US$103 million." (Johnson & Peppas, 2003; Mitroff, 2002; Parker, 2004) The initial phase of the crisis concluded on 23 June, when the authorities allowed the sale of Coca-Cola products again, having been satisfied that the alleged causes had been remedied, and that the production sites involved had been cleaned up and were operating according to normal standards. What was most concerning in this instance was that TCCS failed to effectively protect their brand and ultimately “brands are the most valuable assets in business today. They drive demand, motivate staff, secure business partners and reassure financial markets” (Nemery et al., 2002, p. 1665).

Various aspects of the response failed and, while there were multiple dynamics at play, some specific elements stand out. These include: the failure to identify the nature of the illness and communicate this effectively; the inability of the team to understand the market sensitivities; and the application of a US-centric crisis communication approach in a European market, which failed to address cultural nuances.

**The Cause of the Illness**

The failure to understand the illness and to convey a message of product safety to the stakeholders was central to the inability of TCCS to exercise control of the situation. This was linked to the fact that there were two possible technical explanations for the contamination incident. As Philippe Lefant, General Manager of Coca-Cola Belgium, later communicated to the media, separate errors occurred at two Coca-Cola plants, one in Dunkirk, France, just across the Belgian border, and the other in the northern Belgian city of Antwerp (Nemery et al., 2002, p. 1657). Firstly, initial tests indicated that the outside of the beverage containers had been in contact with a fungicide (parachlorometacresol) that had been applied to the wooden pallets used to transport the product. The pesticide treatment of the pallets occurred in the Dunkirk operation and the consumers who drank from these cans probably fell ill after inhaling the substance. Lefant insisted the pesticide had not leaked into drinks, but had been

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4 Ultimately, for TCC, the valuation and brand trust was restored. In the Brand Finance report for 2012 Coca-Cola was ranked at 8th, up from 16th in 2011, and the only FMCG manufacturer in the top ten.
absorbed by an anticorrosive lacquer painted on the bottom of the cans (Haigh, 2012, p. 1). This resulted in the authorities in France directing TCCS to shut down its plant in Dunkirk until the situation could be rectified and confirmation of product safety validated.

A second explanation was that at the other plant in Antwerp, a tainted supply of carbon dioxide, the gas that produces the carbonation in soft drinks, probably caused the ‘off’ smell as reported by some of the children in Belgium and this may have contributed to the children feeling ill (Hays, 1999). While there were two potential explanations for the source of the illness, neither was communicated effectively to the stakeholders, leaving an information vacuum.

Ultimately, a third scenario emerged to explain the high illness/complaint ratio across multiple locations as experienced in this case. This related to mass sociogenic illness being a potential explanation for the majority of the cases (Hays, 1999). The research indicated that something was undoubtedly wrong with the bottled Coca-Cola, and it is plausible that the presence of CO₂ contaminated by carbonyl sulphide (COS), which hydrolyses to form the odorous hydrogen sulphide (H₂S), triggered various bodily reactions without gravity in the children (Gallay et al., 2002; Taylor, 2000). However, this did not explain the broader expansion of the complaints and the research of Gallay et al focused on the aspect of mass sociogenic illness. Mass sociogenic or psychogenic illness, which is sometimes also wrongly labelled mass hysteria, has been defined as “a constellation of symptoms suggestive of an organic illness, but without identifiable cause, which occurs among two or more persons who share beliefs related to those symptoms” (Gallay et al., 2002; Nemery, Fischler, Boogaerts, & Lison, 1999; Nemery et al., 2002). The high level of media coverage, the visual impact of seeing ambulances and sick children in hospital, and the complexity of the market sensitivity on food safety contributed to creating an atmosphere conducive to this scenario. This explanation, however, came out post event through specific research and, while it is likely that it may have been a factor in consideration by the CMT at the time, it is a factor that would not normally be factored into their response methodology. Even if this was factual at the time, the team had to manage stakeholder perception, and that was that the product was
unsafe. To do otherwise was to apportion blame to the consumer, a strategy to be avoided.

**The Crisis Response: What Went Wrong?**

What ultimately went wrong with the response? The purpose here is not to extensively deep dive, as this case has been subjected to extensive previous research. Rather, this case study seeks to analyse the process failures most relevant to the topic of ostensive processes and performatives deviations. As Mitroff (2002) noted, “how Coke responded to the crisis not only revealed how deeply flawed Coke’s understanding of crisis management was, but it also revealed how easily and quickly Coke became trapped into solving the wrong problem.”

While Mitroff noted the company was focused on the wrong problem, there were broader issues with TCCS’s response in that they failed to follow the basic concepts of crisis management response including well prepared local teams (as illustrated by their ineffective response) and effective early warning indicators, as displayed in the inability to correctly understand the problem and the manner in which the incident would be perceived based on local market sensitivities. Perpetuating this may have been the perspective of the CEO of TCCC Doug Ivester. Known as a CEO who thrived on ensuring he had all the right information, he “had all the data but missed their larger meaning. He determined that what had made the schoolchildren sick was that Coca-Cola had been made with a bad batch of carbon dioxide. It was a minor problem, hardly a health hazard, he judged. By the time he addressed the issue publicly, it was a full-blown crisis” (Philen, Kilbourne, McKinley, & Parrish, 1989). This aspect may also have been reflected locally, where the severity of the children’s illness was potentially downplayed, creating the apparent lack of empathy and thus the environment for an unstructured and inadequate crisis response.

In relation to the understanding of the problem, TCCS reacted in a way that saw them discounting the claims of product contamination. This lack of acceptance of responsibility for the creation of the incident suggested to the public that they did not care and were blaming the resultant hysteria on the consumers. While testing was being carried out, no reassurance was provided. When the results were known it was
concluded that the documentation of the findings was very poor, since the sampling conditions, analytical procedures and other essential quality control criteria were at no point provided for scrutiny. Specific evidence of the CO₂ being out of specification was also not provided at any time (Mitroff, 2002). Ultimately, the information that came from the company to fill the void was too little and too late. Ultimately it was in the form of a press release in which “Coca-Cola admitted some problems with product quality and stated that although there was no health risk, the possibility existed that consumption of their product could cause headaches, nausea and abdominal cramps” (Morris & Sellers, 2000). Certainly not a reassuring message to convey to the stakeholders and just one of the many communication failures.

Building on this was TCCS’s inability to respond correctly within the context of the market sensitivities and it seems certain that its management, and in particular its top management, did not appreciate and interpret the potential seriousness of the situation in the wake of the ongoing dioxin crisis. A CMT needs to be aware of the prevailing market sensitivities as these contextualise the event from the perspective of the stakeholders. Market sensitivity relates to the climate that is present in the market at the time and which if not understood can impact the successful resolution of the event. This includes the Government’s position, since they as a specific stakeholder are influential in the successful resolution of any crisis. The CMT needs to be cognisant of the fact that consumers are faced with a wide range of competitively priced food products of consistently high quality. Each food item must be safe, aesthetically pleasing, good tasting, and consistent with the product image. Variations within the same batch or between batches of a product must be kept to a minimum since consumers interpret them as an indication of production faults. A further relevant factor is that the literature indicates “that, overall, consumer attitudes towards food safety in general differ according to demographic and socio-economic factors such as gender, age, educational level and economic status” (Nemery et al., 2002, p. 1663). This is an important concept in regard to understanding existing market sensitivities.

This crisis was playing out in a country that had already been plagued by an ongoing major food crisis. A crisis involving dioxin contamination of animal feed that had erupted earlier in the year and was gripping Belgian society played a pivotal role in
heightening the anxiety of the population, including adolescents, about the quality of modern food. Political dynamics were at play and the Coke crisis emerged at a pivotal time in the dioxin case and in the lead up to the national elections. During this period a number of key ministers had resigned over the dioxin scandal and “the 13 June election toppled the center-left Christian-Democrat/Socialist coalition after 12 years in power and brought in the center-right Liberals and the Green Party as the main winners” (Nemery et al., 2002, p. 1658). This was a critical turning point in the crisis and one that the CMT should have identified as a key risk and worked to mitigate accordingly. Unfortunately, TCCS failed to acknowledge the criticality of this shift in political dynamics, and the next day the incoming Government took immediate action on the incident involving Coca-Cola. As Nemery (Nemery et al., 2002) correctly states within this context, it cannot be due to chance that it was Coca-Cola that became the very target—some might say the sacrificial victim or scapegoat of this food scare.

As an interesting addendum concerning market sensitivity, it was noted that during the dioxin crisis

“any Belgian poultry or egg was suspected to be contaminated. In contrast, risk perceptions were only triggered for the Coca-Cola soft drink brand during the Coca-Cola crisis in 1999, while other soft drink brands maintained their ‘safe’ image. Furthermore, newness, believability and uncertainty heightened the panic value of the crises at hand” (Lok & Powell, 2000).

For the Coca-Cola system, it was their own crisis response that created the focus on their brand, and theirs alone, rather than a broader issue that could have impacted any beverage manufacturer.

The problems were of course exacerbated by the company’s public relations response, which is described by Taylor (2002, p. 1663) as foot dragging and a poor attempt at damage control. She noted that Coca-Cola’s communication strategy was based on American cultural norms rather than those of the host nation and failed to meet the needs of its international stakeholders. “When an organization lacks competence in understanding the cultural norms of host nations, then unfortunate incidents can become enormous crises that damage the relationship between an organization and its
publics” (Verbeke, Frewer, Scholderer, & De Braban, 2007). This of course raises the question as to where the CMT control lay: locally or within the headquarters in Atlanta. Overall communications were fragmented and ineffective rather than structured and consistent with a desired stakeholder management objective. Ultimately “the Chairman of The Coca-Cola Company published full-page apologies in the newspapers. The new bottles and cans of Coca-Cola products received green caps and lids, and all Belgian families received a voucher for a free bottle of Coke” (Taylor, 2000).

The Lessons Learned

This was indeed a dark hour for TCCS, and the ramifications were wide ranging. In addition to the financial cost of the recall (including destruction of product), TCCS experienced a 5% decline in the bottlers’ revenues and a 6% decline in cash operating profit. The event resulted in disenfranchised consumers who no longer trusted the brand. Ultimately, it was a factor that had a bearing on the CEO's ability to retain his role. Doug Daft, who replaced Doug Ivester as TCCC’s CEO in early 2000, implemented a new global strategy, to ensure that while the company was thinking globally it acted locally. In an interview with The New York Times, he summed up the Belgian situation and the US-centric nature of the response by saying that “maybe there was no one there who understood the environment. Or, if we had people who understood the environment, we didn’t listen to them” (Taylor, 2000, p. 278). Ultimately, either position was a failing for the system, and Daft went on to initiate a full review of the crisis response program. In an interesting contrast as to the perceived effectiveness of the response, the cited perspective of Parker (Nemery et al., 2002) is of note. He concluded that “because of extensive pre-crisis preparation, we handled many aspects of the crisis extremely well.” This is certainly an observation that is in contrast to the end result. The lessons learned led to a reshaping of the crisis response program and can be captured under the headings of processes and procedures, teams and their development and communications.

Process and Procedures:

Hays (2000) noted that Parker stated that predetermined and clearly defined procedures are core to effective crisis management and argued that this was indeed the
case in CCE. While a plan existed, the questions were whether it was the correct one and whether it was followed. The lesson arising is that there is a necessity for a well-designed crisis management plan to firstly exist. This plan should provide the framework, checklist and tools that effectively guide the CMT in understanding the fundamental issues that they are dealing with and the risks that are emerging, and to drive their thinking as to the appropriate ways in which to manage those risks. The processes and procedures need to be standardised across the business to ensure that all managers working on a CMT speak the same language and understand the same concepts. As a subset of this, business continuity plans need to exist and these can address various aspects including product recall. Tools need to exist to guide the thinking on the nature of the problem, the market sensitivities, and stakeholder management, with the tools being important to enable calm thinking during the stress of the crisis response.

From an enterprise risk management perspective, understanding the areas that could create a crisis need to be understood through risk assessment. For FMCG companies, quality is a critical concern and Robb (2004) recommends that all firms develop quality management plans covering quality control and crisis handling – from recalls to communication. He believes that at any point before, during, and after a crisis there is always at least one way to do what is right – a way that both complies with regulations and is consistent with the brand.

**People:**

Irrespective of how good the processes and procedures are they are reliant on the CMT firstly to use the plans and secondly to ensure that deviation from the process is minimised. Therefore, having the right people, representing the right areas of the business and at the correct management level, are central to effective crisis management. In the case of a complex system such as that which exists with Coca-Cola, it is vital that there is local bottling representation together with members of TCCC as the brand owner. This local understanding of the market is crucial and enables the team to avoid bringing a US-centric crisis response into a market that may have unique sensitivities. So, correct team composition is the start, and in the case of TCCS this is
based on a defined number of roles, which are focused on the position versus the skill set of the person holding that position. Once the team is identified and in place, it is important to ensure that the team is crisis prepared. This preparedness needs to be supported through investment in regular training, including the conduct of realistic exercises. Ideally these exercises are conducted in a ‘dawn raid’ style, where no warning is given to CMTs beforehand, therefore increasing the pressure and experience. So, reinforcing the central theme here is the importance of team structure and taking the time to plan and prepare.

**Communications:**

Effective and timely communication is critical to the successful resolution of a crisis. A central requirement is to ensure that the company is being transparent and honest. This requires the communication team to ensure that messaging is correct and that an information vacuum does not occur. The communication needs to be consistent and delivered through one voice to avoid inaccurate or inconsistent information dissemination. As Parker acknowledges (2004)

> “we hesitated to say what we knew – there was nothing harmful to health in our products – because we feared the public reaction. If you do not talk, somebody will talk for you, and having the government, the media, a competitor or anyone other than you as the source of information is highly risky.”

This requires the correct communication response plan to be in place, a situation that – while complex in 1999 – is even more complex and important in these days of social media. Linked to this is the importance of developing relationships with stakeholders before a crisis occurs. The middle of the crisis should not be first time you engage with key stakeholders, as trust has not previously been established. So, it is important to build the relationships early and then not to be afraid to ask for help during the course of a crisis response.
Conclusion

This was indeed a crisis of immense magnitude for TCCS and one that highlighted multiple process and system deficiencies in the manner in which crisis management concepts were applied. Ultimately, from this event a new program emerged, one that provided the framework and support tools to assist in the successful resolution of crisis situations. As noted in the literature review, the plans, tools and frameworks provide the ostensive routines that the CMT should follow in order to effectively manage the event. There is little doubt that while routines existed at the time, deviation occurred, deviation that impacted the ability of the CMT to respond effectively. It is within the context of this new framework against which incidents are now managed that the structure of the teams is examined, asking the questions: do we have the right teams in the right place and if the tools exist, what influences the deviation from the ostensive routine?
Appendix B: CMT Subject Matter Experts Interviewed

The research included conducting ‘one on one’ recorded interviews with subject matter experts (SMEs) in the field of crisis management. The participants came from both inside and outside TCCS. Each SME had significant experience and perspectives gained from private or public-sector exposure to crisis management. The following data details background and experience referenced numerically. The master file with full identities is retained by the researcher.

Table 11 – Subject matter expert key data

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Appendix C: Subject Matter Expert Interview Example

TRANSCRIPT

INTERVIEW WITH SUBJECT MATTER EXPERT SME2

UNEDITED RAW TRANSCRIPT

Date: Saturday, 16 July 2016
Type: Interview – iPhone recorded
Consent Form: On File

GK: This is a research interview with SME2 from the Coca-Cola Company in Uithoorn in the Netherlands. Thanks for participating in the research, you know the background from our chat and having seen the material. If I could just go through and get some basic details, what is your highest level of education?

SME: That would be a PhD Doctorate.

GK: How long have you been in the Coke system?

SME: Seven years.

GK: And over that time how many crisis management cases do you think you have been involved in?

SME: Wide involvement I would say about 30.

GK: Have you during that time been the actual coordinator on the IMCR?

SME: Yeap, probably I would say about a dozen.

GK: And that was over the seven years?

SME: Yes, about a dozen out of that thirty over the seven years I had a principal role to play.

GK: If you had to present a specific function, of the subject matter expertise that you brought to the crisis team, is in which field?

SME: In security.

GK: What was your previous work experience?

SME: I spent 32 years as a police officer in London.

GK: Obviously you would have attended crisis situations in that role?

SME: Many of those, yeap.

GK: Can you give me a number?

SME: I would probably say that you are looking at in the hundreds. I certainly did twenty-three murder investigations probably around thirty extortion kidnaps...
and then many other types of crisis. But I was mainly as a detective, so they were operational based.

GK: Trainings attended for IMCR – have you attended any of the trainings? I know provided a lot.

SME: Yeah, I probably provided fifteen trainings of either one on one through to whole groups but have never formally been trained. I sat in, when I first joined the system, I sat in the first couple as an observer and watched other SSD colleagues and then took it from there. I have never actually undergone a validation.

GK: So total years doing crisis response?

SME: Probably I would say through my police career and into this role, about 20 years.

GK: During your time in the system, what kind of cases have you been involved in?

SME: Quite varied, the ones I tend to be most involved in and have more of a lead position have been around contaminations or extortions, I would say I have been involved in five extortions, and probably double that, say ten to twelve contaminations where we have never actually had a formal demand made of us and sometimes the motivation for the contamination is unknown.

GK: As you know in the system we have designed a number of tools, academically we are calling them artefacts as you know, that help to guide the response of a crisis team. What value do you think that they bring to the table?

SME: From my actual use in the field and particularly from my perspective of doing probably thirty validations and trainings, I actually feel that the use of the tool gives a very good tried and tested structure to the team of any make up of experience. Even the most experienced teams benefit from actually going through the tools with the known information and as importantly the unknown information. What do we know, what don’t we know and what are our strategies to find out and the stronger teams to me are the ones that go back to it as further information becomes available, just to check that the decisions that were made at an early stage are still valid as more information comes through. The reverse of that is that I have seen weaker teams either not apply the tools at all or pay lips service to them. They may at the initial onset use the tools and then never revisit and that can end up with them going off on a tangent, so for me, the tools that we offer and are there, give a structure to a team, whether that team is inexperienced or actually very experienced.
Often it has been observed that when a team forms they actually don’t adhere to the routines. Have you observed that and if you have why do you think the deviation in the process occurs?

Yes, I have seen that happen many times, people will work through when you do a validation they will work through the tools, some teams better than others, in real life sometimes the tools are not evident, they are never produced or if they are they are not really applied to the thinking and the decision making. Personally, I think that that is partly to do with culture. When I first joined the company, I noticed that some teams, particularly experienced teams, had the attitude that this is what we do as a management team. Things go wrong, we put them right and we are very good at it and indeed they were. There are other ways of solving issues and crisis situations but you need a structure of some sort. Now we have labelled our structure within the Coca-Cola system in a certain way, there are many other types of crisis management structures, but I still feel strongly that a team benefits from having a structure to follow, because it keeps the thinking and the decision making honest. So, I kind of think partly its culture and personality stroke experience of people on the team. Sometimes they do a very good job without intensively going through a system but I think that quite honestly, using the system would always add some benefit to a team.

We have a number of tools, problem solving, market sensitivities, etc, if you look at their structure would you consider them to be a checklist?

They can be misconstrued as a checklist and I have seen that happen in validations where people feel that they have to have an answer for every piece of it. For me the tools will not solve a problem. If I pull my previous detective experience it won’t solve the investigation however they are steps and instructions, and literally I think tools is a very good word, because you bring them out of your tool box as you need and quite honestly I think having them there gives you almost a route map to go through, but it is the experiences in that room of that group that will resolve an issue and we should use the pieces of the tools that help guide our thinking and not try to come up with there has to be an answer for every one of these boxes. That was never really the intention of the system as a whole.
GK  Perfectly agree with that one. Obviously, you have seen a lot of teams perform well is there a case you can take me through that illustrates a team working well and if so, why do you think that they worked well?

SME  I think one that really stuck with me of the team coming together in a difficult time for a number of reasons is [case identifiers removed] So, for a number of reasons this was difficult, because people were away. Where I thought it worked really well is that the general manager in the [location removed] office and the general manager in the [location removed] office led by example. They both physically turned up when we went out to collect the product from the street and we got a tremendous assistance from staff who were actually on their holidays. Over one hundred people gave up their holiday time to come in and assist but they were lead from the front and I felt that that sent a very strong message. In terms of management we broke the work down into six sections and it helped for in the early calls we would meander through the information and get to an outcome, over two and a half hours. We delegated work into six operational teams, each of those teams gave and update and it became a far more concise forty to forty-five-minute call. That was one of the big strengths that came from it. A number of things worked really well, the relationship [case identifiers removed] We had a very open relationship with them and we had a very poor relationship with the food standards agency, but in this case, we were, we managed to convince them that we were a victim and not the cause of the problem which our relationship with them in a slightly different position. That relationship actually benefited from going through here. So, there was a number of things that were put into place during a very difficult and demanding time that I think led the way in which other countries teams could respond.

GK  Where a team hasn’t performed well why do you think that has happened?

SME  Partly for the reverse of that where they haven’t used the tools to give the investigation any form of structure. Quite often I have come across it where we have very dominant personalities within the IMCR team who don’t give due credit and air time to others. Or one of the problems also seen is if the issue we are dealing with is a common recurring one, we sometimes jump to the solution. We have this happen time and time again. We know exactly what causes it, we known what to do, let’s just do that and get on and back to normal business. I feel
that is one of the pits that we fall into when we look at a business solution and sometimes totally miss the outside emotion that surrounds the actual issue and we could be trying to trip the wrong thing, for example if we have a report that some children are sick following drinking a product that may be less than a perfect serve, some mould etc. which sometimes happens with some of the products and we know about the mould, we know what causes the mould, we know how to cure it, we often forget that the real issue is the emotion around sick kids. The potential concern if not fear in our consumers, is it safe for me to drink. Also of course it’s our workforce because they are our consumers. So sometimes I think we fall into the trap of going to the business solution, particularly in a common recurring problem. So, weaker teams, sometimes it is the makeup, there is not clear strong leadership, sometimes there is over bearing leadership and other people can’t actually get their ideas onto the table which are necessary. Then sometimes it is generally lack of structure, and again I think that underpins why the tools are very useful to help guide us through in various stages.

GK You mentioned culture earlier, what role do you think culture plays?

SME When I first joined I think it play a very strong culture not only in the way we dealt with an IMCR type situation but also the reporting of an IMCR situation. I encountered a belief in certain country teams and tended to be more established that this incident isn’t something that we need to tell Atlanta about. In manufacturing things go wrong from time to time that’s why we are here to deal with these, we don’t have to go and tell people and the reverse side was put to me that it we tell people we then have a whole host of extra work to do as people are coming in demanding things where they should just let us get on and deal with this. We are good at this. So, part of it was the culture around we know what we are doing and we can get on and deal with it and I can understand it to a certain degree. The problem comes is they are very isolative and if they were to step back and think is this an issue that has just happened in this country, could it be happening in other countries. When I first joined we had a case I can give of [case identifier removed] and it is something that is a recurring issue. I came across it in the [location removed] and it hadn’t been reported as an IMCR and I am still very new but I had to go to [location removed] and I picked up the fact that they had a problem that hadn’t been reported and it was a very similar problem. But
because it hadn’t been reported in the system by either country we hadn’t picked up the fact that this was. When we actually started to get the reports in was affecting [locations removed], none of which had reported back to Atlanta and none had been reported around the actual business unit so everything was being dealt with in isolation. So, I can understand that sometimes there is a case that this really isn’t something that needs to be reported, it is an everyday occurrence and we deal with it, but I equally can see from the point of view that from a global perspective if you keep everything localised you really are blind from a global perspective or even a European region perspective.

GK That is very much focused on business culture, flip it now to national culture. Having seen a lot of different countries at play. Does the cultural dynamic in your view impact the approach to the response?

SME I think the country that stands out for me when I first joined for not reporting IMCR incidents and not using the process was [location removed]. Having said that they were a very experienced team and they dealt very efficiently with things. They had this reluctance to put it in. I worked with that team quite a lot and I was impressed by the abilities on the team but the case was that ultimately no one else was learning from this. You have dealt with this very effectively but if the country next door is having the same problem and does not have such an experienced team they can’t look to you to give that guidance because we don’t know and the argument I put forward was, if you are not reporting things in and up and it comes to knowledge in another way, maybe through media and Atlanta come back there is a natural suspicion. What are you hiding? So ultimately if we do have something happen and you are dealing with it effectively I think you are missing the opportunity as a management team not telling your bosses, this is what has happened, this is what we are doing, don’t worry you have your best team dealing with it. Control the message. I think that certainly in working [location removed] that has helped change some of the culture and thinking that we should be telling people and we should be telling them just how good we are at how we are dealing with things.

GK Funny you should mention [location removed] as anecdotally heard when I was talking to [name removed] last week and when they were running a system up there, and if you compare them to the [country removed], and we know that
there is quite a dominant leader up there. I would say extremely dominant everyone had to put their hand up before they could speak. Go back to last week we are running the validation in [country removed], the level of white noise was such that I did not, I could not work out how they could understand what was going on with the level of what sounds like arguments, but what the [country removed] told me, it sounds like we are arguing but we are not, but your ability to concentrate and have structure it is questionable and I think that was quite evident with the way they were scored last week. I thought they did actually quite a good job and with our scoring system it was quite interesting to see the deviation in the scores, from having sat there and there in the noise, from the people who were inputting, seeing a different level of communication, let’s put it that way, so the role of coordinator plays is very important. Now I don’t know if having to put your hand up before you make a comment is quite the best way of doing it but people yelling all the time is definitely not a good thing.

SME My personal experience and I link back to the earlier question about what were the positives that I saw in a good case I had actually validated the [location removed] team, the joint bottler KO team in November and we had this issue in December Christmas time. The early calls were that monkey type with everyone talking across each other and things ran on for two and half hours, in the end we were getting concise meetings of forty-five minutes because we had actually sub divided the work, we had given a lead, we had agendas for the meetings. So Gerold, tell us where we are now from yesterday, John tell me on the security side, the structure came. The [location removed] became very good at using it. They actually felt, and one of the things I took away is I believe that the [location removed] team grew into this issue and this incident. At first it was a little bit loose, as we got a grip and went forward, I saw the team and certainly the leaders of the team, grow in confidence, you know what, we can do this. We are actually doing quite a good job and I could actually see them physically grow and they went from a team of you know we have been validate and god forbid we get caught with one of these to we have a big issue here, it could go horrible but we are on top of it and doing a good job. So, they grew in stature all the way through.

GK Who was the IMCR coordinator for [location removed], do you remember? I know the GM was involved.
SME: It was you GM who just got promoted, the other GM was [name removed] who is gone, the coordinator is the CPAC lady who I can picture her face but cannot think of her name. She actually was on holiday and was phoning in.

GK: From your side?

SME: Yeah and the coordinator from your side was a gentleman who left your company.

GK: [Name removed]. Working for [Name removed].

SME: Yeah went pretty early into the New Year. I would say the dominant coordinator was the PAC director from [location removed] whose name escapes me.

GK: That is alright. One of the things we know in the Coke system is that people end up on a crisis team because of the role they have not necessarily their experience. What’s your thinking on that approach?

SME: I do feel that because crisis management is one part of a person’s role, you do need people who are good at dealing with crisis and to an extent it can be trained but otherwise in another way, there are people with certain natural abilities that lend themselves to being good crisis management managers. So, it is almost like, if people are just around the table because that’s the job they got, that doesn’t necessarily give you the best team. However, if we need people with that decision-making level we still need to have them plugged in. What we do need is to identify good crisis management people, because when we think about crisis management it’s not a rank structure in my view. There are two ways to look at this and one we need a level of expertise in the field of PAC and technical and the level of decision making but equally I think we need good crisis management as a discipline in its own right. So, I feel that there is benefit in identifying people, whatever their role is that are good crisis management to be brought together as a crisis management team and have then the experience of subject matter experts and others. I have seen it many times in my police career where irrespective of your rank the person who has the right abilities makes that decision or takes it forward. We see it particularly in firearms type incidents because people are there because they have the right training and the right experience to deal with that part of an overall operation and they are brought in to do that. I can see that there is the potential to radicalise the way we do IMCR training, and IMCRs in the field is to use dedicated people who are experience and have done many of these
and have built up a body of experience to actually pull it together. Then in amongst that you have if you like the decision makers the PAC leads etc. so you either have those technical leads, PAC leads, legal etc. and bring crisis management in as subject matter experts or you actually form the team around a crisis management team and then you bring the others in and almost as though, we are the crisis management team and we need the technical ability etc. to come through but we make the recommendations. Now they are then signed off and reviewed by the decision-making level. Rather than necessarily have the decision-making level being the crisis management team.

**GK** Just on that point and I don't know if you have seen it, there have been a number of cases where the decision maker has injected themselves into the team, for want of a better description, and suddenly the ability to think more broadly disappears because suddenly everyone thinks the boss is here we need to align what he or she is coming up with.

**SME** And that is where I believe we need clear water between the actual IMCR team doing the work, pulling it together and making recommendations, and the decision maker who they are then going to refer it to who is then going to consider it. For as you describe it if you have that person in they are a) too close to it - they play a very important role, sit back and not actually involved emotionally in this and where these decisions are grown from. So, you bring it to me and you state your case and I will be that third set of eyes. And then the other reason of course is by bringing someone of rank in it will have an effect on how open people will be prepared to be particularly if that person has a defined view it is going to be difficult for other, maybe lesser ranked people to challenge that because ultimately when we finish this we go back into our day jobs. So, I think there needs to be a clear water between the decision maker and the IMCR team.

**GK** If you had to pick a couple of characteristics that you would want to see in a good team, what would they be?

**SME** It would be experiences of the various component parts. Technical is very important to us, PAC is a very important thing because communications is an important part of going through internal external, the different types of communications, the different types of stakeholders, but also I think a legal, is quite often a main player there but I think also people who have the traits of a
good problem solver under pressure because a lot of people when the pressure comes on they are not used to it, they are not trained to deal with it, and then things can go array, the decision making can be off, so actually I actually see some benefit in actually investing in a cadre of people who come together whenever, when things are tough to deal with IMCRs. Rather than this one has happened in your country and you happen to be holding the chair for PAC, or you happen to be holding the chair, so you are catapulted forwarded to be on it, irrespective of the quality you bring to the team.

GK If you had to think back to an example of a person who was a really good crisis management coordinator within the Coke system, who would that be and why?

SME One for me that stood out and I am struggling for the name, and he is the coordinator in the [location removed]. I am going to go with [location removed], but it could be [location removed] I will double check. He is ex-military, he is very good, he has clearly had a background in dealing with crisis pressurised situations in his former trade or calling, he is a very calm headed person and he keeps the detached from the debates and the decision making. So, he works as a ringmaster and he brings the people in, subject matter experts, he frames the discussion so 'tell us what we know now, what's happened here, what don't we know, how can we find out, who's going to take that forward.' We have clear actions that fall out of it so I call him a ring master because of his slight detachment but his framework and structure he gives to his team and then allows the team to do the thinking through from their expertise. But he keeps them on track, he is the sheep dog that keeps the flock going till we get to the final result. And I have seen one or two of that ilk around. We have a very good one in London, [name removed], very experienced, different background, but he has been in the CPAC industry for a long time working for different companies, very calm very experienced, can manage a tam very well. So, there are a number of people I have come across but they are in the minority when I go and work with teams.

GK Myers Briggs, one of many tools to look at management and personality traits. Have you done Myers Briggs?

SME Yeah, I haven’t done it for a couple of years and I would have to actually have to dig out my results. I first did it when I went to Atlanta. For me the things that I do
recall is influencing and collaboration are two of the strong points that came out and certainly when you put it into an IMCR situation, they are absolutely key in my view. You have to find a way of making sure that team are collaborating and peoples experiences, and we don’t have excluded, and they may be the junior and I have seen this happen with my own eyes, quite recently during a validation ahead of the Euros, where this was the third global special event that this particular young lady had been involved in but she found herself on a table during a workshop with a number of fairly senior leaders and she was quite junior, and she was a female and they were men and they were almost leaning across her and excluding her out and I saw her sit back and her shoulders drop and you know, no one wanted to hear from her. I actually spoke to her afterwards and she said "I had so much to offer but they just didn't give me the opportunity. I am a woman and I am junior and they didn't recognise in me that this is the third time I have done this". So again, perhaps this takes us back to the cultural piece as well as a global company, do junior people, do women, do young people get the same level of opportunity and respect in these decision-making type forums.

GK It is a very valid point. One of the things I go back to goes to the level of experience, I remember one of the things I was told when I first joined the crisis response mechanism in the company, seventeen years ago, there are two ways you can get off the team, die or resign, and there was rationale for that because there was longevity and experience of the process so it sort of became automated. Now that shifts into my question around checklists because there is a book I have just read called 'The Checklist Manifesto' and its and excellent read, and it talks about the importance of the checklist versus what we currently have as the tools because if I look at most of our plans, they actually don’t contain a checklist of key activities, would that be a fair point.

SME Yeah.

GK So what do you think the value would be in designing a key prompting checklist that would guide the crisis coordinator?

SME Yeah, I think there is value because the nearest that I would say we have to that is the question summary the ten or twelve questions, I can’t remember exactly where there are, they are key questions and basically if we can sit down and we can answer each of these then we have the basis of what we need to report up etc.
it’s still not necessarily the basis of what’s going to solve it and the actions have to be taken. So, there is almost a checklist there, but with the tools we don’t have that and the tools as we touched on earlier, some people view the tools that you must go and answer ever box whereas each situation is different and for me you put your thinking across and say in these circumstances as we know it is this relevant. So, what’s the business solution, what’s the emotional thing, that is a really useful exercise because it maybe that we have got an incident here that’s happened, and it’s happened in a country where that is particularly sensitive because of what’s happened. Whereas if it’s in the next country along it would have different sensitivity level. So, I think addressing your mind as you go through the tools is a good thing, but equally I think that going through a checklist and I go back to my homicide time where we actually have, these types of checklists we go back and say right have we covered this bit. Not only have we covered it but is what we’ve got valid. The word checklist I think has a difficult connotation in people’s minds, they think it’s the case of you just have to go, just go over it. The checklist is, have we actually satisfactorily answered this question, do we have this. So, the checklist approach can have a very beneficial thing, particularly going back and making sure. Because like a murder, these incidents we have limited information at the start and we have to make some assumptions. Then we start building our actions through those assumptions and we gather more information. What we should do and better teams do is then go back to the system and say right, knowing what we know now, were those assumptions right, are they still valid, do we continue with them, do we change them. And if so let’s record why because a lot of that decision making is lost. We are not good at keeping records. We spoke about having decision logs, but coming back over now, good teams don’t have to spend a lot of time doing that and the checklist type approach may have a lot of benefit. A younger less experienced team may need to spend a little bit more time going through it as it is part of their learning curve as well. But definitely, I have come across it and I am sure you have Gerry, in validations where people are spending inordinate length of time trying to find information to answer a box which has no relevance in this really. Okay, address your mind to it, does it apply in this stage, if not let’s move on. It might when we
do a summary later, it might be quite an important thing, but at the outset we didn’t have the information that would suggest that that was in play.

GK Yes, and I think if we look at the tools, people use that as Gawande the author says, he calls them the Read and Do checklist which is the thing that pilots have, are the brakes off, whatever, so you read it and you do it, and I think people get fixated on what is the problem, is there a solution, and they see that as a check box, that they must tick before they move on versus a mechanism to help formulate thinking which I have always seen them as. It is a formula to guide, so it’s a routine and it’s there and it’s to guide you. The checklist is more of a confirmation, did we actually do this, so a) has public health risk changed, have the dynamics changed, and it’s yes or no. If it’s yes then it guides your thinking, and I think me miss that as a tool and an artefact that we can use.

SME One of the concerns that I have is that we rarely, even if they start off using the tools, we rarely go back to them. Either in a validation or in real life, and in real life, they are less likely to start with the tools anyway, the just start with what do we know okay, right, let’s start running around like headless chickens, rather than actually having a structured approach and the better teams actually have them up on the wall and look up and say right, okay, in this case is there something we are missing. It is there. We are focused on this part of the problem but is there actually an emotional reaction going on in the market place, that we should be concerning ourselves with over and above this, because ultimately didn’t someone say there were two sick kids in the hospital, isn’t that a concern at this time. So, I do think that having something, and the moment we have this and if that was taken away and replaced with something, as long as people used it. It is like anything, it’s having a crisis management system, but if you don’t take it out from the binder and use it when you have a crisis it is not going to assist you at all. The other thing I feel is that these things happen that often so practicing it, being comfortable with it, sitting down and that’s where I think this concept of should we select people that have, the natural traits to be good crisis managers, and then train them more and keep them at a level, exactly the same as if we are saying we are going to set up a firearms team. We don’t want to give everyone a gun, but certain people have the traits to use it. Now let’s pick those people and let’s keep them highly trained so train fewer people to deal with it.
Are there any other tools you would put into play. Because if I go back, we haven’t revisited this as a system since 2000, 2001, so we are fifteen years down the track, the worlds changed, any tools that you would think?

I personally think it’s overdue, a fundamental over haul, it has been tinkered with and stuff, but I think there is an overarching need to go back. One thing is I don’t see communication as a tool, communication is a function that runs throughout the process and I think we lose something by taking it and trying to box it in its own right. We have to communicate at every stage, there isn’t a single method of communication, we have to say what is most appropriate and it as to be doubled up with who we are communicating to, so your stakeholder identification and management and communication run together so I think that it is not helpful to make people think oh that is something that I got to go to, where that is something that should be thought throughout the process. I have not really given much thought to what other pieces could come in, but I do feel that it is overdue a review.

One of the tools that has been raised is potentially somehow bringing a structure on risk management into the thinking. So, we make a lot of recommendations and one of the key things we should be looking at is what are the risks associated with that. So, if we take direction a) where have to obviously understand the risks of unintended consequence for that action and the risks for the other part. It has been observed that there hasn’t been enough discussion around what is the risk that is being generated from our strategy so bringing risk management into the piece. Going back to 2000 risk management in its current form within ERM was in its infancy but some of the people I have spoken to have said that maybe it’s time to bring some of that language, so of that thinking around generation of opportunity into the discussion as a tool might be beneficial.

I think it is right because I think it would benefit by being formalised as I think there is some thought and discussion around risk when we are talking about well at this stage should we do nothing, but yeah, what if this happens, so the discussion sometimes goes on but it is not formal and they are not actually being applied to a tool in its own right, so I think that would be very beneficial because it brings it to the forefront of people’s minds. To say, well these are our options, but each come with its own set of risks and if you are identifying risks, then you
should in my view then take the other side of the coin and say, okay if we are
going to take that decision, we have identified these risks, what can we do to
mitigate them and who will own that. So, it’s just that next step, so okay, if we are
not going to do anything at the moment, when are we going to get to the stage
where we are going to do something because that could happen at three o’clock
in the morning and we will all be in bed. So are we going to get up and have
another meeting, or if we say well it’s at three at the moment, if it goes, and hits
five, these are the steps that will come in. So, I think to formalise bringing risk
mitigation into the structure would be a very positive thing because it gets it on
the table because I think at the moment its sometimes spoken about but it is not
captured and people don’t even realise sometimes that it is risk mitigation that
they are talking about. I hadn’t thought through how that would look in a tool but
it has to be as its going to be present in everything that we do, it’s just that we are
not consciously acknowledging it.

GK  Maybe it’s a construct of mapping risk and opportunities, so we say okay if we
take, this is the problem, we have used the tool and we understand the problem
and we say this is the risk that can potentially emerge if we do X but on the flip
side we also have an opportunity here to leverage Y. So, on the opportunity side
we also have to think about what do we have to implement in order to leverage
the opportunity. I don’t think that formal discussion...sometimes we do it
intuitively but I don’t see that as being the centre piece.

SME  You know the way you described it there, that is exactly how I was taught formal
risk management at the British Government University. It is actually about risk
management, preventing the harmful things from happening, and having the
mitigation plans should it happen, but the other side was to maximise the
opportunities that doing this project is going to bring, so if we say, we are
embarking on a project that is going to bring us this benefit, what’s in place to
make sure that this benefit happens. So not that the project becomes the
outcome, so that was part of it. I have seen it happen but not captured in that type
of thinking, and I go back to the [location removed] case where we had a really
bad relationship with the health authority but this occasion, cause normally we
are the people that has done something wrong that has caused the issue, this time
we are the innocent victim so we sat in a different light with them. I hadn’t
appreciated just how bad things were and we were invited along and we were in the office with them with their new chairman, and they actually let us work with them in the wording of their statement. We didn't want a statement to go out and the Police support us, but they wanted to cover themselves, their role, they wanted to put something out, but they allowed us to help word smith and when we came out, it was only then that I was told that we have never actually been in and sat down with them. That is a massive step forward, so what I identified as the opportunity of coming out of this negative, was well when this finishes, why don't you make sure we keep this relationship going. In fact, the suggestion was that they don't really appreciate what we go through when we come with our plan to them, so why don't you invite them to come and see a training, a validation. Bring the team together, put the scenarios up let's practice it, we want to look good, but invite the police and invite the partners. We do it in global special events, we invite the organising committee, we invite key people from the police, and its warts and all but in this case they would probably be able to say hang on you are probably the only company that has ever done this, A - we didn’t know that you had this system B - we didn’t know it was so extensive, so that when you come to my building with your file, this is the process that you have gone through, I now appreciate it. Certainly, it helped us in the London Olympics when we did that with the organising committee because they realised we hadn’t got just a five-minute process to get to the point where we are coming to them. So again, opportunities throw themselves up and we don’t really have a mechanism to really seize them because what I tend to find happens is it’s over, we go back to our day job, we don’t properly review, we don’t properly tease out the learnings, and we don’t properly task people to follow up on where the benefits and the gains can be made. So, we walk away having gone through the negatives without actually gaining those positives that we have discussed.

GK Fair call. Anything else, any other thoughts?

SME The other thing that I think we are really bad at and I know organisationally we are going to try and get better at this, but, I don’t think we do enough by way of summarising, going back after the event, and picking through what worked and what didn't and capturing it and putting it into a system and then demanding of the system that we want to have this feedback because we have to get everybody
doing it, and then the volume of knowledge and learning will grow and we have to have regular feedbacks. So, if we are going deal with this situation, then go back to our job, then you want us to come back again and summarise and capture it into a cohesive document then there has got to be something in it for us, because we are all busy people and unless there is a tangible outcome to us why would we do it, so I kind of think that it’s a discipline that needs to be, if we are going through, the tools and the process, I think that there should be a post. It is really not well articulated, we need to have something there that says right, this is what we do when we are dealing, but when we are finished, what’s that procedure for stopping, at the moment it’s okay, right see you for the next one and we need to have a formalised close out from the point of view of what I call a tombstone log which is a full report from the start to the finish of what happened so the person who hasn’t dealt with this case, can pick it up. Read through and I understand what went wrong, I understand what cause it, I understand what you did, and I understand what worked and what didn’t and why it worked, why it didn’t work, and all of that learning and it is about putting that type of thing together in organisational knowledge and then having that logged with a central point who use that information to make a much bigger, and it might have to be statistical it might have to be case study, but something that can feedback.

GK Interesting cause there is now software, which I am going to use for the interviews, that can analyse words and commonalities, so if you take that approach, and in CCHBC we have implemented a process that every case must have a closure, a lessons learned, before you can actually close it down. For elevated incidents, there must be one facilitated by group, for incidents, it’s a self-assessment, go through the fifteen odd questions, but we are forcing people to now do that process. Now whether that is going to be reflected on the company system is a different aspect, but we acknowledge what you say that it is important about the lessons learned before we all pack up and move to the next case.

SME No I think that is very good, one thing that if you are going to use software, is that we have to do some work around data entry standards, because having worked in the intelligence industry in the police on many occasions the problem is we can have great intelligenes systems and you can put information in but you might never find it, if don’t put it in the same way. So, you know, if I am looking for
British Airways and you are looking for BA, it is not going to read that. So, I think that that is one of the key things that we have to have a simple system and we have to have some commonality of how we put things in. That could be as simple as a template, again we have that type of thing for what has been reported, this is what's happened, these are the steps we have taken, this is what we are going to do and this is what we are going to report back. It's an easy way to read through and I think that is the piece within the system that if we are going to have a root and branch over haul and think that we need to have that formalised in as well.

GK  Alright SME2, excellent. Thanks for participating, if I can think of anything else I will let you know.

INTERVIEW COMPLETED
Appendix D: Researcher Vignette Sample

UNEDITED RAW CASE DATA – EXTRACTED FROM CONTEMPORANEOUS NOTES

Vignette Observations 2016:
During the course of 2016, the business experienced one hundred and thirty-eight activations of the crisis teams across the group addressing a variety of issues of varying level of complexity.

The vignette in its full version documented in detail eleven (8%) of the activations. This section provides an abbreviated version of the vignette. It is designed to provide contextual insight into the observations and commentary recorded for five of the cases. It is presented with business sensitive and identification data removed.

These were cases in which the researcher provided crisis support which enabled direct observation of the team’s utilisation of the artefacts and the performance of the crisis leader (co-ordinator).

The comprehensive data set incorporating all eleven cases was utilised for the purpose of the researcher’s analysis and for input and analysis by Leximancer.

Case One: January 2016 Health and Safety: Process Observations Only

In this case the process and the artefacts assisted in the resolution of the case. It could be argued that there were some initial process deviations, which came about due to the requirement for the team members to initiate an immediate response due to the presence of police and media at the scene. Once the initial spike had been addressed the team reverted to the processes and routines and convened and focused on addressing the questions at hand. In this case, we had a very experienced and structured coordinator leading the process, so the tools were used; the questions in respect of emerging issues were raised. One of the shortcomings was the decision to not engage the Group Coordinator, as he was on leave in a different time zone for the actual meeting. So, while an immediate alert occurred, a lack of involvement in the meeting resulted in the Group Coordinator not being in a position to answer questions from the
Regional Director when he called. As an overall assessment, the structure of the coordinator assisted in guiding the team correctly in their response and evaluation of the implications of the case. The shortcoming was in the space of the investigation itself driven by the fact that the investigator/s were too close to the case. This emotion brought a level of bias to the investigation and ultimately the opportunity to delve more deeply into the root cause was missed. This highlighted an important point of third party investigation of the case, removing emotion, and thereby ensuring that the crisis team was presented with the correct data from which to draw their conclusions. Training and experience in complex investigations is critical for enhancing this process in the future.

**Case Two: February – Quality Non-Conformity: Process Observations Only**

This case was managed by the same IMCR coordinator [country removed] as per the first case. This coordinator was methodical, logical and structured in his approach to the response. The tools were utilised and a checklist approach was followed which ensured that key elements were examined at all time. This coordinator had over 10 years’ experience in the system, which provided the structured capability to respond. It was again illustrated that the tools played a very valuable role when used and leveraged correctly. The importance of a structured agenda was also shown, that is the team were familiar with the order in which the proceedings would be conducted and this provided for preparation, a structured response, and the ability for the coordinator to effectively control the flow of the meeting.

It also highlighted the importance of the coordinator in driving the team dynamics, ensuring that tasks were allocated and that activities and actions were completed. The other dynamic of this case was the emerging similar issue in [country removed], which had the potential to draw the team in a different direction. The case was given the relevant level of focus and attention from a cross-market perspective, and the response in [country removed] was somewhat less structured, with the team, as will be shown in other cases failing to have the same level of interaction and focus in respect to the utilisation of the tools. The observations in relation to [country removed] response versus the [country removed] response further brought into focus the aspect of culture.
and whether some cultures simply are not prone to following established routines, rather they drift and deviate from the process.

As a learning and for integration into the checklist it was note that testing conducted by local approved laboratories is often faster than the approved laboratories in [country removed] and provides equally good information. Being aware of issues in other operations through knowledge sharing, [country removed] in this case, helps the team focus on other possibilities for the reason of non-conformance. Having traceability and withdrawal plans ready before the lab test results arrive, ensures fast and efficient replacement of affected products on the market.

**Case Three: Quality Non-Conformity: Process Observations Only**

This again was a solid effort by the team in resolving the issue and utilising the artefacts to develop conclusions and validate the approaches. The [country removed] team was led at the time by a very experienced coordinator and again the tools were effectively used to analyse the nature of the incident, the risks, exposures, and core elements that had the potential for this case to evolve from a serious consumer complaint to a crisis. The complexity is always increased in cases [data removed].

A couple of elements stand out here, the first being the experience of the team with the core members having been in place for several years working together on a variety of cases. This bonding serves to ensure that there is a level of trust within the team, this trust ensuring that the members follow the instructions of the coordinator, by respecting the nature of her position. So, the team has trained closely together, worked closely in real cases, and this experience has enabled them to be in a position where they understand the importance of following the process. Again, it was evident that the team understood the purpose of the tools, the processes and leveraging stakeholders and engaging with key members in the Group when there was a benefit in doing so. The approach in summary was structured and disciplined and this was in my view driven by a culture dynamic and a level of trust, that came from the experience of the participants and the trust that they exhibited for one another. Being proactive in finding contact information of the affected customer, managing social media the right way, expressing empathy and dealing with the case systematically can prevent its escalation.
Case Four: Counterfeit Product – Process Observations Only

Anti-counterfeit efforts have to be aligned and systematic in order to be effective and managed under the umbrella of the crisis management program to ensure conformity in approach. Sales personnel in the field should be effectively leveraged to ensure that they could proactively identify potential outlets selling counterfeit. Security, Legal and TCCC should refresh the counterfeit strategy to clearly state what is the objective of the efforts, together with confirming the means and actions needed to achieve the ultimate goal of the strategy. This ensures timely activation of the crisis management procedures.

This case was managed in an extremely ad hoc manner, as there was a perception amongst the crisis team that this was not really a matter that required their focus, rather, it was one that was specialised in nature requiring the ongoing management focus of the specialised stream. This was an interesting direction for the team to take, for the reality is that if this topic is incorrectly managed there is the potential for the issue to grow rapidly and create significant reputation issues for the business. This therefore removed the opportunity for the artefacts to be effectively utilised and resulted in both the investigative and business responses being mismatched. It was explained to the team that managing under the crisis management umbrella did not mean, nor indicate, that the team did not have the situation under control, rather it brought with it the ability to ensure that a sound structure was in place.

As the structure was not in place, this meant that the processes were not followed, and therefore no deviation from process occurred, as there was no process. Later in the piece, crisis meetings were held, and these again were ad hoc, driven by the fact that there was no clear agenda. This was reinforced again during the simulation training provided in 2016 at which point the team acknowledged the importance of structure. It was evident that despite training and experience, there was more a few that reporting was a group requirement, yet when it came to the case itself it was okay to avoid the following of the full processes. This should not be the case as the team is relatively experienced; yet the deviation from the full activation of the process was evident. Training would obviously have a role to play here as the team had not been subject to an exercise for three years, hence, awareness of the importance of leveraging the artefacts,
checklist and overall ostensive routine may not have been imbedded into the response mechanism.

**Case Five: Health & Safety – Process Observations Only**

This was a case where the team clearly did not adhere to the processes and deviated from the utilisation of the tools. The basics were not followed and my conclusion is that this was because the team became focused on the injuries of the victim, rather than focusing on the root cause and the breaches that had occurred. While empathy is of course crucial, so is the ability of the crisis team to remain unbiased in their response and an approach. They have to remember the basics and they have to link back to the process.

Investigation of high visibility elevated incidents should be carried out by unbiased and independent team of personnel knowledgeable in fact gathering, analysis and interviewing, aligned with country IMCR team and the Group. The local team showed extraordinary empathy and care for the victim despite his negligence and decisions/actions that contributed to the situation occurring.

By not following the tools, the team fell into a trap of missing vital information, allowing personnel with a vested interest, that is the plant management to conduct the investigation, which failed to raise all issues of process failure and negligence as important in the first instance. Decisions were also made outside of the process, in that the team did not review the nature of the matter, and make the recommendation stemming from the meeting; rather they made the decision as a sub team, which was not best practice. Cultural perhaps was a variable at play in this case as it is observed the further south that one moves in the Balkan region that process often gives way to intuitive responses. The team also missed analysing the risks created by their actions. This was particularly evident in the area of victim response and the allocation of funds and the view that by being so supportive, we could then utilise the victim as a health and safety poster boy. This messaging and approach was contradictory to our zero tolerance to safety breaches and was rewarding the victim for creating the environment in which this incident was allowed to occur. A challenge was continually raised – if the off sider had received the burns, caused by the other party, what action would we be taking? The
answer likely terminate, so why is this then different. The breaches occurred yet no disciplinary action was proposed.

The team were reminded to revisit the tools, understand the position of each stakeholder, not just the position of the victim, rather than fall into the automatic focus that they adopted. The response in totally lacked structure and illustrated that training is central to ensuring practices are implemented. This team was relatively fragmented, new, and had continually postponed training, which resulted in a gap being created. Experience and practice – the two basic fundamentals.
Appendix E: Crisis Simulations Observed

The research included observing and monitoring ten crisis management teams during their crisis management training and simulation exercises during the period of March 2016 until January 2017. The observations covered ten Coca-Cola HBC territories and the program was undertaken with support from the members of the Central and Eastern Europe Business Unit of TCCC.

Approvals were attained from the Core Team and extended crisis team members. The following table details the location and timing of the simulations observed. A master file with the details and identities of the participants together with their authorisations to participate in the research are retained by the researcher.

<table>
<thead>
<tr>
<th>Business Unit and Location</th>
<th>Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>Switzerland (Zurich)</td>
<td>31 March 2016</td>
</tr>
<tr>
<td>Nigeria (Lagos)</td>
<td>12 May 2016</td>
</tr>
<tr>
<td>Isle of Ireland Business Unit (Belfast)</td>
<td>2 June 2016</td>
</tr>
<tr>
<td>The Baltics Business Unit (Tallinn)</td>
<td>15 June 2016</td>
</tr>
<tr>
<td>Greece (Athens)</td>
<td>13 July 2016</td>
</tr>
<tr>
<td>Poland (Warsaw)</td>
<td>24 August 2016</td>
</tr>
<tr>
<td>Serbia (Belgrade)</td>
<td>26 October 2016</td>
</tr>
<tr>
<td>Russia (Moscow)</td>
<td>16 November 2016</td>
</tr>
<tr>
<td>Austria (Vienna)</td>
<td>19 January 2017</td>
</tr>
<tr>
<td>Romania (Bucharest)</td>
<td>26 January 2017</td>
</tr>
</tbody>
</table>
Appendix F: Example of Simulation Observations

EXAMPLE 1 - MARKET 1 2016
UNEDITED RAW DATA

IMCR VALIDATION OBSERVATIONS
Market 1 – 2016: Researcher's Contemporaneous Notes

The IMCR coordinator for this simulation was the PAC Director of the country operations. This individual was an experienced crisis coordinator having worked on multiple cases with various dynamics over a system career in excess of ten years. As part of the core team two other highly experienced crisis team members supported her. One from legal and one from risk/strategy, members who have formed the core of the crisis team for over a decade. This was a team with longevity and structure which engendered a high degree of trust. Even with some new comers it was clear from the preparation that the team had gone through a series of pre-work activities.

On the initial input, which was a quality complaint, the approach was to assign the data to the quality team for their initial evaluation, rather than to simply jump into exercise mode and assume that because an exercise was taking place that this had to be an incident. After evaluation, it was concluded that this information needed to follow the protocol and was escalated to the Initial Assessment Team (IAT) where discussion was held as to the nature of the material, whether it meet the criteria of an incident and what actions would need to be taken. It was validated that this was an incident and would need to be managed under the process. It was noted that the team actually articulated their rationale for adopting the course of action that they took. When the team expanded to incorporate the broader IMCR components, the coordinator stepped back and took a guiding role, oversighting the tasking, the allocation of actions, and importantly ensuring that there was follow up.

In the course of the early stages of the exercise, there was a gravitation to the utilisation of the tools that had been placed on the walls and this saw a congregation of participants forming around the walls and this created a little white noise simply due to the proximity of the participants.
Processes and procedures were followed and information receipt and exchange was generally effective. However, despite the aide memoir being circulated there was no use of the checklist, it was what could be described as an automated process, driven by experience, but as was observed when things intensified, a couple of aspects feel by the wayside. This was a point that in the debrief was reinforced with the team.

In relation to the administrative side and log keeping, at first it was not clear who was maintaining the information. In fact, the assigned team member was carrying her laptop around so that she could be close to the discussions. From a log retention point of view this created complexities for her due to trying to listen to every aspect, and record every aspect rather than, be feed the key data, which would then be stored. This was also observed when the second simulation scenario commenced with this being mirrored by the second log keeper. This created a risk of confusion and poor recording. A quick chat was had to correct this, to ensure that the administrative team understood, that staying in one spot and having the data feed to them made their life easier. The other benefit here was that the core team had to focus on articulating the key elements that needed to be recorded. The other aspect in this area was while reviewing the logs and assigned actions it was clear that the key data was being captured, and there was a logical sequence, what was not always evident was the rationale for the decisions that were being made.

In this case, the tools themselves acted again as a magnet. The question for a post review was were tools a distraction in the form of wall charts, due to this gravitation to one location? The general consensus was no, and the team believed that the model ensured that they stayed in their frame of reference. It was evident that they were assisting in guiding thinking, and unlike some instances, this team did not become purely fixated on answer the question, but there is a danger here if the coordinator falls into a trap of making the tools the focal point is not guiding the overall response of the team.

On a couple of instances, the team did not remember their investigative logic, the ABC. Assume Nothing, Believe No One, Challenge Everything, and fell into making assumptions. This was particularly evident as we progressed into the second scenario, which was a fire incident with a health and safety element. While the team formed in a
timely manner and tasks were assigned, a number of assumptions were made, and this required clarification to be sort. Again, with the sub leadership, there tended to be an automated approach, no reference to the plan or the checklists, again there was a strong reliance on the expertise and experience an example of a team potentially thinking that they already knew the answer. So, while automatic and logical in approach, again with sound decisions being made, the team did not leverage checklists, but did focus on the tools. On the point of assumptions this was particularly relevant when it came to validating the effectiveness of the emergency response. The attitude was that the teams at the plant practice this regularly and therefore it must have occurred correctly on this occasion. The lesson reinforced with the team in the debrief was always to ask the question and to not simply assume. This was evident when they were required to provide me with a briefing on the status of the scenarios and the response. They were asked some hard questions, to which the assumptions were made, and on occasion members became a little defensive. I reminded them that the checklists may have prompted them to focus on additional elements. However, while these deviations were observed, it was ultimately picked up by the coordinator who was performing a helicopter view and this enabled the team to be steered back on track.

In respect of the briefings, these were an area of opportunity, ensuring that they avoid being ad-hoc in their approach. The coordinator assigned the briefing to her deputies and this was a good capability test for them. While most points were covered, the communications as they relate to a senior management briefing could have been more succinct. While the tools were referenced there was the possibility to use them to structure the messaging in relation to the ramifications. This is potentially where the 10Q summary could have come into play. This would have enabled the team to validate the further extensions of the implications of a product recall, which is what is the consumer expectation – for example it would be expected that a consumer would want to know how they should respond, versus the focus that they had on the regulator. This would have been picked up through a utilisation of the checklist.

Looking at the exercise in totality the team worked seamlessly together, there was no them and us between the two elements of TCCS. Commitment was excellent, engagement was of the highest order, and exhibited a team that was comfortable with
each other. It was evident that there was a good degree of trust present and that trust stemmed from team longevity. In discussions after the exercise, it was clear that this was stemming from the fact that they were familiar with each other’s skills and attributes, and were able to utilise the various skill sets. Logical and rational decision-making was present. They needed to ensure that when challenged by leadership that they do not see this as a defensive position, and become argumentative. Challenges will come and the task at hand is to illustrate that the strategy is sound and as is the logic behind it. As an observation it was there, in the articulation, there is a possibility to strengthen. Again, this was in English, and perhaps in [native language removed] the briefing may have differed, but as the GM is [nationality removed] and the company language is English, a little refinement here would be an opportunity.

The crisis plan, which created the ostensive routine was reviewed as part of the validation process. It followed the redesigned format, but as I looked at this plan and others I see the continued opportunity to refine and simplify. The need to draw the checklists out becomes clearer with every simulation and event. The preventative risk work was also solid and reflected in the document. However, it did contain old TCCC methodology and there is a need to pull this out, particularly as the plan custodians in the US have not reviewed the format to align the template with the new TCCC enterprise risk management approach.

In the post validation assessment, the team identified the following as having worked well.

- High engagement and focus.
- Collaboration between the teams ensuring that each sub group received full support.
- Clear role sort for each team member
- Clear Leadership
- Effective utilisation of the tools ensuring that the revisited the tools after each new development.
- Clear action plans executed in a timely manner
- System alignment. The team worked as one and the response was seamless.
• Smooth split and transition to two teams when the new cases started.
• Well maintained logs

The team identified the following as areas of improvement.

• Always confirm and double check that procedures are really followed
• Attention to detail is critical
• Ensure the right person, contacts the right stakeholders and in the right tone.
  They picked up the case that in one instance they thought the contact with the stakeholder was lacking empathy, so another person was assigned to follow up.

The validation team was generally aligned with the self-assessment of the team.

The validation team identified the following as positive areas:

• ABC – the concept was generally followed, although this appeared on the improvements list as well, and we were aligned with their finding to always go back and check.
• Team dynamic, just as they identified, they worked as a seamless team, excellent team dynamics.
• Leadership was strong. Consideration was given to pull out the coordinator due to strength, however, we were able to observe that there was depth in the team.
• Processes were followed and generally the followed the investigative questioning effectively.
• Media statements were strong, empathy was shown to the victims.
• Root cause analysis and all quality tasks were carried out effectively.

Areas of improvement from the training team were:

• ABC, as above, while generally good there were a couple of lapses, just need to go back and visit the process.
• Follow the process. Everyone had an aide memoir but it was not used as effectively as it could have been. Members gravitated to the tools on the wall.
Reminded that it is vital to double check things, even the smartest team can forget.

- Avoid being defensive. When challenged by ‘management’ on rational of decisions the team at times would go into defensive mode. Remember that the challenges will come, they needed to be factual and specific.
- Do not assume things, always challenge, reinforced the old adage, no matter how good you plan and respond, no plan survives first contact with the enemy.
Appendix G: Myers Briggs Background Data

(HomePage, 2017)

This appendix provides a summary of the Myers Briggs personality inventory as projected by the Myers Briggs foundation. They note that the objective is to make the theory of psychological types as described by C. G. Jung understandable and useful in people’s lives. The essence of the theory is that much seemingly random variation in the behaviour is actually quite orderly and consistent, being due to basic differences in the ways individuals prefer to use their perception and judgment "Perception involves all the ways of becoming aware of things, people, happenings, or ideas. Judgment involves all the ways of coming to conclusions about what has been perceived. If people differ systematically in what they perceive and in how they reach conclusions, then it is only reasonable for them to differ correspondingly in their interests, reactions, values, motivations, and skills."

In developing the Myers-Briggs Type Indicator the aim of Isabel Briggs Myers, and her mother, Katharine Briggs, was to make the insights of type theory accessible to individuals and groups. They addressed the two related goals in the developments and application of the MBTI instrument. They are the identification of basic preferences of each of the four dichotomies specified or implicit in Jung’s theory and the identification and description of the sixteen distinctive personality types that result from the interactions among the preferences. These are depicted below:

<table>
<thead>
<tr>
<th>PERSONALITY TYPE KEYS</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>E</strong></td>
</tr>
<tr>
<td>Extroverts</td>
</tr>
<tr>
<td>Energized by people, enjoy a variety of tasks, a quick pace, and are good at multi-tasking.</td>
</tr>
</tbody>
</table>

| **I**                 |
| Introverts            |
| Often like working alone or in small groups, prefer a more deliberate pace, and like to focus on one task at a time. |

| **T**                 |
| Thinkers              |
| Tend to make decisions using logical analysis objectively weigh pros and cons and value honesty, consistency and fairness. |

| **F**                 |
| Feelers               |
| Tend to be sensitive and cooperative and decide based on their own personal values and how others will be affected by their actions. |

| **S**                 |
| Sensors               |
| Are realistic people who like to focus on the facts and details and apply common sense and past experience to come up with solutions to problems. |

| **N**                 |
| Intuitives            |
| Prefer to focus on possibilities and the big picture, easily see patterns, value innovation, and seek creative solutions to problems. |

| **J**                 |
| Judgers               |
| Tend to be organized and prepared, like to make and stick to plans, and are comfortable following most rules. |

<p>| <strong>P</strong>                 |
| Perceivers            |
| Prefer to keep their options open, like to be able to act spontaneously, and like to be flexible with making plans. |</p>
<table>
<thead>
<tr>
<th>Type</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>ISTJ</td>
<td>Factual, organised, logical, detailed, analytical, conscientious, responsible, pragmatic, critical, conservative, decisive, stable, concrete, efficient.</td>
</tr>
<tr>
<td>ISFJ</td>
<td>Warm, factual, sympathetic, detailed, dependable, organised, thorough, systematic, conservative, realistic, caring, practical, stable, helpful.</td>
</tr>
<tr>
<td>INFJ</td>
<td>Vision &amp; meaning oriented, quietly intense, insightful, creative, sensitive, seeks harmony, growth, serious, persevering, inspiring, loves languages.</td>
</tr>
<tr>
<td>INTJ</td>
<td>Vision orientated, quietly innovative, insightful, conceptual, logical, critical, decisive, independent, determined, chases competence, improvement.</td>
</tr>
<tr>
<td>ISTP</td>
<td>Logical, quietly analytical, practical, adaptable, curious, cool, observer, problem solver, exact, realistic, trouble-shooter hands on, variety, adventurous, independent.</td>
</tr>
<tr>
<td>ISFP</td>
<td>Gentle, quietly caring, compassionate, adaptable, modest, aesthetic, idealistic, observant, loyal, helpful, realistic, spontaneous, patient with detail, enjoys action.</td>
</tr>
<tr>
<td>INFP</td>
<td>Deep felt values, quietly caring, compassionate, creative, idealistic, empathic helpers, inquisitive, enjoys ideas, language, writing, independent, adaptable.</td>
</tr>
<tr>
<td>INTP</td>
<td>Logical, conceptual, analytical, objective, detached, critical, ingenious, complex, intellectually curious, loves ideas, questioning, adaptable, independent.</td>
</tr>
<tr>
<td>ESTP</td>
<td>Seeks excitement, active, pragmatic, direct, easy-going, observant, realistic, adaptable, analytical, trouble-shooter, spontaneous, adventurous, experimental.</td>
</tr>
<tr>
<td>ESFP</td>
<td>Energetic, sociable, practical, friendly, caring, expressive, open, enthusiastic, seeks excitement, spontaneous, resourceful, adaptable, observant, generous, fun loving.</td>
</tr>
<tr>
<td>ENFP</td>
<td>Enthusiastic, imaginative, energetic, creative, warm, future-orientated, individualistic, insightful, caring, optimistic, possibility focused, open, seeks novelty, playful, spontaneous.</td>
</tr>
<tr>
<td>ENTP</td>
<td>Energetic, intensive, enthusiastic, abstract, logical, theoretical, analytical, complex, ingenious, verbal, seeks novelty, change orientated, global, independent, adaptable.</td>
</tr>
<tr>
<td>ESTJ</td>
<td>Active organiser, logical, assertive, factual, decisive, practical, analytical, systematic, concrete, critical, responsible, common sense, takes charge.</td>
</tr>
<tr>
<td>ESFJ</td>
<td>Actively sociable, warm, harmoniser, caring, enthusiastic, empathic, people oriented, practical, responsible, concrete, orderly, conscientious, cooperative, appreciative, loyal.</td>
</tr>
<tr>
<td>ENFJ</td>
<td>Actively sociable, enthusiastic, harmoniser, expressive, warm, idealistic, empathic, possibility oriented, insightful, cooperative, imaginative, conscientious, appreciative, tactful.</td>
</tr>
<tr>
<td>ENTJ</td>
<td>Driving organiser, planner, vision focused, decisive, initiating, conceptual, strategic, systematic, assertive, critical, logical, organised, pursues improvement and achievement.</td>
</tr>
</tbody>
</table>
Appendix H: Examples of Crisis Management Tools

Process and Decision Matrix

The Process and Decision Matrix is used to illustrate the core crisis processes to be undertaken by TCCS. It starts with the work of the 'Initial Assessment Team' (IAT), the composition of the 'Incident Management Team' (IMT) and ultimately the review of the crisis response once the incident is over. This ensures a learning loop is established.
Figure 27 – Crisis Tool: Problem Analysis

The Problem Analysis Tool is designed to focus a CMT’s thinking in relation to the true nature of the problem that they are managing. Through a structured questioning process, it focuses the investigation’s data collection and leads the CMT to a construction of the ‘best possible outcome’ and ‘worst case’ scenarios. Responses can be developed for either scenario and the potentially a third that sits in between. That is ‘the most likely outcome’.
Critical Ten Questions Tool

| 1 | What has gone wrong? Brief description as we know it. Early incident reporting is often inaccurate in important aspects. |
| 2 | Nature of the problem as viewed from outside. What is predicted speed of onset of the concern i.e. how much time do we have to react? Remember facts, perceptions and expectations are of equal importance when viewing from the outside. |
| 3 | What is the size and scope of the problem in terms of markets and products impacted? Today’s global media can cause an incident to expand to additional markets very quickly. |
| 4 | Are there any known market sensitivities that could exacerbate the situation? All incidents take place within a particular context that may adversely impact your ability to resolve the matter successfully. |
| 5 | Who are the key stakeholders with a specific interest in how you will respond to the incident? Do we understand stakeholder expectations and their likely mindsets? At a minimum consider the viewpoints of these stakeholders: government agencies, NGOs, employees and business partners. |
| 6 | Possible outcomes: What is the worst case scenario? Remember we must manage with the worst case scenario in mind in order not to close off options and have to do an “about face” or “eat our words” later should the situation deteriorate further. |
| 7 | Do we have an effective business solution? How soon can we implement it? Are we reasonably confident that we have sufficient information to take this action? Incident management necessarily involves making decisions without all of the desired information, but early enough to make an impact. |
| 8 | Incident management strategy: The long term viability of the Coca-Cola system depends on our image and reputation. This is greatly dependent on our ability to meet stakeholder expectations of doing the “right thing”.

9 | Public communications strategy: Will we be proactive or reactive? Health and safety of people is foremost. Statements must be truthful based on verifiable facts. We will fully cooperate with appropriate authorities and we will take responsibility for our actions.

10 | Coordination with business units: Does the business unit need additional assistance or advice? Caution: A coordinated approach to communicating with the business unit is essential to eliminate confusing or duplicate requests. |

Figure 28 – Crisis Tool: Critical Ten Questions Checklist

The Ten Questions Checklist provides the CMT with a mechanism to structure their executive reporting. A team that can comprehensively answer these ten questions can illustrate to an Executive Leadership team or a Board of Directors both that the nature of the issue is clearly understood and that an effective command and control structure exists to manage the crisis to its resolution.
Appendix I: Leximancer Raw Data

This appendix provides an illustration of, and additional insight into, various elements of the data as produced by Leximancer. It outlines the data created and highlights the purpose of the creation of the concept cloud and the concept threads.

Figure 29 – Leximancer concept cloud

The Concept Cloud Explained

The project results were also presented in the form of a ‘concept cloud’. The concept cloud provided the researcher with an alternative visual. This visual resembles a tag cloud on the Internet. Similar to the concept map, the concept cloud is heat mapped in that colours integrate and illustrate the intensities of the themes. As an additional variable, the font size of each concept’s label denotes its frequency in the text (Leximancer, 2016).
Figure 30 – Leximancer concept threads: Personality

Figure 31 – Leximancer concept threads: Risk

Figure 32 – Leximancer concept threads: Tools
Explanation of Figures 29 - 32

These figures are examples of the output and analysis for three of the concept threads examined in the research being the themes of ‘personality’, ‘risk’ and ‘tools’. In the initial modelling the concepts are clustered into the high-level themes. Concepts that appear together often in the same pieces of text attract one another, and so they tend to settle near one another in the map space. The themes aid interpretation by grouping the clusters of concepts and portraying them in the coloured circles within the maps. The information and themes were selected with the brightness of the ray indicating the strength and co-occurrence between the concepts. A ranked list of the related name and word-like concepts is displayed on the right side of the panel (Leximancer, 2016, pp. 12-24).

This modelling was used across the core concepts and themes of the research. The benefits of this detailed examination included the ability to browse locations in the documents where the concepts co-occur. This enabled additional data analysis to be undertaken on the themes and for linkages to be reviewed.
REFERENCES


