Learning from Policy Fiascos in the Public Sector

The role of interpretation by top management in the Civil Service

Thesis submitted for Degree of Doctorate in Social Sciences at the University of Leicester

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May 2007

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Abstract

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The role of interpretation by top management in the Civil Service

Thesis submitted To Centre for Labour Market Studies, University of Leicester for degree of Doctorate in Social Sciences

Brian Cawley, May 2007

This is a study of policy fiascos in the public sector, how they are interpreted, and how we learn from them. 'Policy fiasco' is a term that has been coined by policy analysts to describe high profile events arising from certain actions or inactions of public agencies that have been negatively evaluated by the public and other stakeholders. Despite the frequently serious consequences of such events it would appear that frequently in their aftermath learning is limited or ineffective, and there is evidence that similar problems recur with costly consequences. From an academic perspective this research study will shed further light on the process of learning from policy fiasco, an issue that is of increasing importance, and yet has received relatively little attention in the research literature to date. It is my thesis that policy fiascos are primarily socially and politically constructed events, and that there are multiple interpretations of what occurred. Therefore learning from such events is critically dependent on how key stakeholders, in this case top civil servants in Ireland, interpret the events, and interpret the lessons to be drawn from them. The study will demonstrate the limitations of rational, objective approaches to analysis of, and learning from, policy fiascos, and in particular the limitations of approaches typically adopted by official inquiries into these events. It adds to our knowledge by providing new insights into the process of learning from policy fiasco by adopting an interpretative framework, and through the use of a recent 'iconic' case study of policy fiasco and interviews with the group of top civil servants in Ireland, sheds new light on the reasons why learning in the aftermath of policy fiascos is particularly complex and difficult.

Chapter 1

Introduction to the world of policy fiascos

This is a study of policy fiascos in the public sector, how they are interpreted, and how we learn from them. 'Policy fiasco' is a term that has been coined by policy analysts (see Mc Connell 1987) to describe high profile events arising from certain actions or inactions of public agencies that have been negatively evaluated by the public and other stakeholders. They are frequently labelled as 'fiascos' as a political act, or as an act of blaming, because policy fiascos are often highly political. However the term itself does not reflect a value judgment on the extent, or even the fact, of failure, for these issues are frequently contested. Policy fiascos typically grab the headlines, and the attention of the public, for a relatively short period of time. The financial, human, social, or environmental costs can be serious, but not necessarily as serious as the publicity might suggest. In their aftermath, public servants are typically called to account, and there are demands for corrective action.

Policy fiascos are not new. The reader will no doubt recognise them as those high profile events that regularly hit the headlines and are portrayed as failures of government agencies. One of the earliest events to be branded a policy fiasco occurred 30 years ago in November 1976. This was the Swine Flu Fiasco, where on the basis of a mistaken diagnosis in the case of one soldier, the Ford Administration in Washington decided to immunize the whole population of America against swine flu. There never was an epidemic, and the policy fiasco resulted from a combination of media

hysteria about the threat of infectious disease, political miscalculation, administrative bungling, and simple human error (Neustadt & Fineberg 1978: 91).

Despite the frequently serious consequences of such events it would appear that frequently the corrective action taken in their aftermath is limited or ineffective, and there is evidence that similar problems can recur with costly consequences. For example, many authors (see, for example, Garrett 1995) have noted the parallels between the mistakes made in handling the Swine Flu fiasco and the subsequent mishandling by successive US administrations of the HIV/Aids issue. The question therefore arises as to what, if anything, we learn from policy fiascos.

From an academic perspective this research study will shed further light on the process of learning from policy fiasco, an issue that is of increasing importance, and yet has received relatively little attention in the research literature to date. Most of the research to date on disasters, crises, and failures in the public sector has been based on a rationalist model (see Fortune & Peters 1995) that assumes a unitary reality out there to be discovered. In such a model, failure is assumed to derive from a misperception of reality, the consequence of a discrepancy between how people think the world operates and the way it really does. However as a basis for understanding and explaining policy fiascos, and learning from them, the rationalist model is inadequate. It is my thesis that policy fiascos are primarily socially and politically constructed events, and that there are multiple interpretations of what happened. Therefore learning from such events is critically dependent on how key stakeholders interpret the events, and interpret the lessons to be drawn from them. According to Maitlis (2005: 46) 'the scientific neglect of differential constructions of reality by different groups must be superseded by examination and understanding of these divergent views'. Therefore this study proceeds on the theoretical assumption that in the contested world of policy fiascos, reality is interpreted and learning is constructed on the basis of this interpretation. It will add to knowledge by providing new insights into the process of learning from

policy fiasco by adopting an interpretative framework (based, inter alia, on the work of Weick 1995, Milliken & Starbuck 1988a), and in particular shed new light on the reasons why learning in the aftermath of policy fiascos is particularly complex and difficult. It will demonstrate that the complexity of the phenomenon, its causes and context, lead to multiple interpretations.

The study will add to our understanding or organizational learning by supplementing the grand theories that have dominated the literature with empirical data that provides a deeper understanding of the micro- processes of learning that are at work. Much of the official learning from policy fiascos emanates from a formal review of organizational practice. However in this study my contention is that an individual level of analysis provides a richer perspective on learning in these circumstances. As we shall see, the findings suggest that when faced with empirical reality we must recognize complexity and interaction at a variety of levels, and from a research perspective not be satisfied with theoretical positions that may promise clarity, but ultimately fail to embrace the subtlety of experience. The study will demonstrate the limitations of rational, objective approaches at the organizational level to the analysis of policy fiascos, and in particular the limitations of the approaches adopted by official inquiries. I will show that by working from the individual level of analysis we can achieve real insight into the processes of learning from policy fiasco, and how interpretation by individual managers is the result of interactions with the organizational and societal levels, and in turn informs practice at those levels.

From a practical perspective, the question of whether and how we learn from policy fiascos is an important one, not least because of the serious financial or other consequences that frequently arise. Official inquiries typically provide the official, and often the only, basis for learning and for preventing similar incidents in the future. They also typically rely on a retrospective, rational, and sequential analysis of the events that led to the 'failure'. However my thesis is that such an analysis fails to take account of the complexity of these events, and fails to take account of multiple interpretations, particularly the interpretation by senior officials that has an

important bearing on any action that may be taken in the aftermath. It is my thesis that it is only by understanding how these key actors interpret and make sense of policy fiascos that we can understand what lessons are drawn and how, and what action is subsequently taken, if any. In a very practical way this study should suggest alternative approaches that increase the likelihood of learning from these events.

Learning from Success

Although as noted above there has been relatively little research interest in understanding the process of learning from policy fiasco, for the past two decades there has been considerable research interest in learning from success. Research into corporate success gained particular prominence with the publication of Peters and Waterman's (1982) text 'In Search of Excellence', which drew lessons from the experience of successful firms. Other authors focused on what they identified as critical contributors to corporate success such as leadership (Kanter 1983), core competence (Hamel & Prahalad 1990), quality management (Garvin 1988), customer care (Horovitz & Panak 1994), and continuous improvement (Suzaki 1987). The assumption underpinning much of this work is that if the secrets of successful firms can be identified and codified in terms of knowledge, behaviour, and process, then their success can be replicated.

Reform programmes in the public sector over the past decade have also been underpinned by a set of guiding principles which if followed, it has been proposed, will lead to better performance. Reforms based on the New Public Management (NPM), which were initiated in New Zealand and Australia, have been transferred to Ireland and Britain and include an emphasis on strategy and business plans, the creation of independent regulatory and delivery agencies, and the development of performance measures as a way of promoting better performance. Despite all of this interest in the concept of 'excellence' and how it might be achieved, there is little evidence to indicate that organizations can learn to become better performers by following the

example of others. Indeed Kaplan (2003), Bouckaert and Pollitt (2000), and others, have identified serious weaknesses in this approach.

While there has been considerable interest in learning from excellence, there has been much less interest shown in learning from failure, despite the fact that failure may hold greater potential for learning that is relevant to improving performance in organizations.

Learning from Failure

Organizational failure has not received nearly so much attention as organizational success. We still know relatively little about its causes or its prevention. Stories of success are easier to come by than are stories of failure, even though instances of organizational failure are at least as prevalent as instances of success. There are many reasons for this, not least the fact that in western culture it is the norm to celebrate success and to shun failure. Failure carries a stigma. It is more comfortable, if not necessarily more useful, for organizations and managers to focus on the lessons of success rather than the lessons of failure.

But more recently there has been evidence of an increasing interest in the study of organizational failure, particularly in the private sector, and to a lesser extent in the public sector. This interest has been at least partly fuelled by a number of high profile corporate failures that have led to a fairly fundamental re-evaluation of corporate practice, particularly at a time when corporations are being increasingly measured against a variety of economic, social, environmental, and regulatory benchmarks. For example the collapse of Enron in 2001 followed by the related collapse of Andersen Consulting, ushered in a new era of regulation and scrutiny in the private sector. In the public sector we have witnessed a series of high profile, and sometimes shocking, events blamed on public agencies and their officials, from the Dutroux paedophile affair in Belgium and the BSE debacle in the UK during the 1990s, to the more recent poor response of US agencies in the aftermath of Hurricane Katrina. These have led to much soul-searching about how such

apparently basic failures can still occur in sophisticated western societies with highly evolved systems of governance and public administration. These policy fiascos in the public sector have led to anxiety about a possible recurrence, and a concern that other problems lurk beneath the surface waiting for the 'right' combination of circumstances to trigger them. This has in turn led to a greater level of risk consciousness, and a new interest in how we can learn from failure, just as in the past we have tried to learn from success.

There is much to be gained from studying organizational failure, not least the possibility of avoiding further failures that carry significant human, financial, and other costs. In the public sector it is a basic requirement for maintaining trust between citizen and state that governments should learn from failure. Yet there is troubling evidence that the lessons of past failures are not being learned. The process of learning from failure is complex, particularly so in the public sector, and certainly more complex than is implied in the 'Lessons to be learned' section that is invariably to be found in the reports of official inquiries established in the aftermath of public policy fiascos. Yet research into learning from failure is in its infancy, and there has been little or no research into learning from policy fiascos in the public sector. The apparent ubiquity of policy fiascos in the public sector presents both a challenge and an opportunity for researchers and 'those proponents of social science who have traditionally claimed to seek to understand and help improve the practice of government and public policymaking' (Bovens & 'tHart 1996: 3). This is a challenge taken up in this research study.

Learning from Policy Fiasco: The Research Project

My approach to designing this research study was based on the understanding that the retrospective analysis of policy fiascos by key stakeholders involves interpretation, and the development of theories of cause and effect. It involves the development of a narrative at the level of the individual that makes sense to the interpreting party, and that can in turn be

rendered sensible to a wider audience. To date there has only been a limited body of research that has adopted an interpretative approach to the analysis of organizational failure, including that by Weick (1988), and Brown (2004). Most of the research has focused on the organization as the unit of analysis, and on the rational analysis of weaknesses in organizational systems and processes as the bass for learning. However there has been little or no attempt at using interpretative frameworks at the individual level to researching the process of learning from policy fiasco in the public sector, although as we have noted the constructed nature of policy fiascos makes such an approach particularly valid and useful.

Given the degree to which the events surrounding policy fiasco are open to a variety of interpretations, the process of learning in their aftermath is problematic and haphazard. Elliot and Smith (2000), in their discussion of barriers to learning from crisis noted that

> One of the key problems facing any study of organizational learning in the wake of crisis is the lack of empirical data concerning the manner in which the various learning processes occur. (Elliott & Smith 2000: 7)

In this study I seek to better understand how top civil servants interpret policy fiasco, and the implications of this for understanding the process of learning from fiascos. I concentrate on that key group of top civil servants who play a critical role on behalf of their organizations, and on behalf of the civil service generally, in interpreting fiascos and in drawing and applying lessons from them. In Ireland this is the group of seventeen Secretaries General who head up government departments.

Bovens & 'tHart (1996) argued that the primarily positivist, organizational-level perspectives that have dominated research in this area must be replaced, or at least complemented by, an individual, interpretivist approach which recognizes that social affairs are socially constructed. In adopting such an approach

> We may lose deductive rigour and parsimony, but gain understanding of how the principal actors interpreted and re-interpreted the evolving situation confronting them, and the behavioural imperatives they derived from these

> interpretations. Given the importance and uniqueness of the events under study, this should be well worth the effort. (Bovens & 'tHart 1996: 151)

This study is a contribution in that direction. It involves an analysis of the interpretation of policy fiascos and their consequences, and the lessons to be drawn from them, by the top tier of civil servants in Ireland.

Research Question

My Research Question is

'How do top civil service managers interpret policy fiascos, and how does this contribute to our understanding of learning in the aftermath of such fiascos?'

Some of the questions relating to the content of interpretation that must be addressed include:

How do they understand the concept of policy fiasco? Do they equate policy fiasco with failure?
What do they understand the causes of policy fiasco to have been? Are these the same as, or different to, the causes identified by the official inquiry?
What do they consider to be the relevance of context?
What do they understand to be the consequences and the lessons of policy fiasco?
What are the implications of the answers to the above questions for learning from policy fiasco?

Some of the questions relating to the process of interpretation that must be addressed include:

Which are the sources that Secretaries General look to when making sense of policy fiascos?
What aspects of policy fiasco grab their attention, and why?

To what extent is the interpretation of policy fiascos a collective and/or social process and to what extent an individual process?
What role does time play in the process of learning from policy fiasco?
What role, if any, does past experience, style, and interests of Secretaries General play in their interpretation?
What are the implications of the answers to these questions for understanding the process of interpretation of policy fiascos by senior civil servants?

I pursue the answers to these questions, and ultimately address the research problem, by first surveying the key debates in the literature relating to organization failure and policy fiasco, the process of interpretation and sensemaking at senior executive level, and the process of learning and lesson-drawing. I draw on, and combine, existing theory in these various fields to develop a theoretical framework for the study, and use a case study approach to explore the process of interpretation and learning from policy fiasco by the group of top civil servants in Ireland.

Major Theories reviewed

In this study I reviewed relevant theories from a number of diverse areas of the social sciences. Indeed one of the contributions of this research is that by combining current understanding and theory in such diverse areas as policy fiasco, sensemaking, and lesson-drawing, I was able to develop a unique theoretical framework for understanding and thereby gain new insight into the process of interpretation and learning from policy fiasco.

I explore the concept, the causes, and the consequences of policy fiasco. The concept of policy fiasco is distinguished from the more general concept of organizational failure by the fact that it is unique to public sector organizations, has political overtones, is typically time-bound, and is frequently contested. These are characteristics that make policy fiasco unique, fascinating, and particularly suited to the application of an interpretative research framework.

I explore the grand theories of organizational learning. I contrast those theories that are primarily based on formalized organizational-level perspectives on learning, with those that are based on informal and individual perspectives. In particular I am interested in how individual theories of learning can help explain the processes by which senior managers learn following policy fiasco, and how they in turn interact with organizational, and societal-level phenomena as part of this learning process, including how individual learning is transferred to the organization. I am also interested in whether such learning is necessarily associated with positive organizational outcomes, or whether learning can be 'negative' and even create further potential for failure.

I go on to explore the theory of interpretation and sensemaking. Weick (1995) and others have identified specific sub-processes used for sensemaking, and I explore their relevance to understanding the interpretation of, and learning from, policy fiasco. I also draw on the theory of lesson-drawing to understand how organisations may learn from each other. I argue that from a constructivist perspective on learning, the processes of interpretation and learning are inextricably linked and that this is vital to understanding the process of learning from policy fiasco. I contrast this perspective with the experiential, behaviourist and other perspectives on learning that have dominated the research, and how the adoption of a constructivist perspective can lead to different conclusions about how we learn from policy fiasco.

Overview of Methodology

Because of the research perspective adopted, I was conscious throughout of being myself an interpreter, and that my interpretation was rooted in my background, experience, and interests. Therefore before describing the research methodology in detail, I position myself within the research project. I proceed on the basis of a relativist ontology that questions the 'out there-ness of the world and emphasises the diversity of interpretations that can be applied to it' (Willig 2001: 13). The research methodology is based on a constructivist epistemology that assumes that various actors construct their

understanding of policy fiasco and the events surrounding them from different perspectives. This position is consistent with my own understanding of the social world, and in particular my understanding of the social phenomena at issue in this study.

I developed a theoretical framework for analysing the process of interpretation and learning from policy fiasco based on existing theory of policy fiasco, sensemaking and interpretation, learning and lesson-drawing. I used this framework to guide and structure the approach to data collection and coding. Consistent with the use of a theoretical framework, I converted the key elements of the framework into a coding scheme using template analysis. This provided the basis for organizing and analysing the data from interviews with Secretaries General, and also from media reports and the report of the official inquiry.

A case study approach was adopted, and a relatively recent and strong case of policy fiasco was used to explore the issues. While the interviews with Secretaries General provide the main source of data, supporting case study data was also gathered from media reports and from two official inquiries. While one specific instance of policy fiasco is used, the interview strategy was to invite the interviewees to move from the specific case to a more general discussion of policy fiascos, including where appropriate the discussion of other recent examples. Therefore the findings are valid in relation to the specific instance of policy fiasco, and while the main purpose of this research is to illuminate an area about which little is known, I argue that many of the findings are generalizable to policy fiascos in Ireland. I expect that the findings may also be valid in the case of fiascos in other countries, but this claim cannot be supported solely on the basis of the current study and must await confirmation or disconfirmation by other studies that adopt a broadly similar interpretative approach.

Overview of Structure

In Chapter 2, I review the literature for the major issues and debates relating to the concept, causes, and context of policy fiasco. Specifically I assess the

current state of research in the area, and establish a theoretical and practical basis for this research study. I establish that the contested nature of the concept, the complexity of cause, and the changing context in which policy fiascos occur, makes the adoption of an interpretative approach to understanding the process of learning particularly valuable.

In Chapter 3, I explore the relevant literature relating to organizational learning and interpretation in more detail. I explore the current state of research in the area of learning from failure in the public and private sector. I contrast those theories that proceed from an organizational-level of analysis with those that proceed from the perspective of the individual learner, and I show that individual theories of learning, in particular sensemaking and lesson-drawing, are particularly relevant to understanding the process of learning in the aftermath of policy fiascos. I finish by proposing a theoretical framework for the study that is based on an individual sensemaking perspective.

In Chapter 4, I set out my research strategy and methods. I position myself within the research project and also set out the epistemological and ontological assumptions upon which the study is based. The detailed theoretical framework is presented as the basis for collecting and analysing the data. Data collection methods are described in detail including some of the weaknesses and limitations identified in the methodology. There follows a detailed description of the case study that I used for the study. A template for coding the data is developed based on the theoretical framework, and this template is subsequently used for organising and classifying the data. The coding structure is presented. Some of the ethical issues that arose, and how these were managed, are also described.

In Chapter 5, I set out in detail the data collected from interviews relating to the content of interpretation, particularly the concept, causes, context, and consequences of policy fiasco. The data collected from interviews is presented using the template described above. This presentation is supported

in the appendices by detailed tables that provide detailed elements of the interviews in both unclassified and classified form.

In Chapter 6, I present the data gathered relating to the processes of interpretation. This includes how cues are extracted, the social process of interpretation, the relevance of individual experience and style, and the relevance of time. The data gathered from media reports and from witness statements to the Oireachtas Inquiry is also presented. Again the coded and classified data is presented in the appendices.

In Chapter 7, the findings and conclusions from the research are presented, including a detailed analysis to support these findings and conclusions. Finally some of the limitations of the study are discussed, as are the implications for theory and practice, with suggestions for further research.

Answering the Research Question

I conclude that the interpretation of policy fiasco by senior civil servants is very different from the official interpretation of events provided by the official inquiry. They contest both the fact of failure and the extent of it; they contest the issue of cause, and present an analysis that is deeply rooted in changing context and environment. The Secretaries General presented a realistic/pessimistic analysis of fiasco which suggests that policy fiascos are not only likely to happen, but perhaps increasingly so. This is in contrast to the optimistic analysis presented by the official inquiry, which proposed that weaknesses identified could be addressed and similar incidents avoided in the future. There is compelling evidence from this study that learning in the aftermath of policy fiascos is fragmented, uneven, and inconsistent across Departments, and heavily dependent on individual interpretations by Secretaries General and their Departmental management teams. There is little or no collective discussion or collective learning, and indeed there are political and structural barriers to such formal collective processes.

This interpretation of policy fiascos has significant implications for our understanding of the process of learning from such affairs, and this study

goes some way towards answering the question that has been repeatedly posed in the literature when it comes to policy fiascos: 'Why can we not seem to learn from the mistakes of the past?' The study reveals the complex processes of individual interpretation and learning that are at work in the aftermath of policy fiasco. It shows that some of the theoretical perspectives on organizational learning, particularly those that regard the organization as the primary unit of analysis and as the'collective' learning entity, need to be revisited so that more subtle, refined, and multilayered understandings of organizational learning that cross traditional theoretical boundaries can be developed. By adopting the interpretative approach we arrive at a better understanding of the way in which top civil servants make sense of policy fiascos, and identify barriers to learning that have implications for both theory and practice.

Conclusion

Policy fiascos in the public sector appear to be more common. The consequences of these fiascos for the taxpayer, the general public, or vulnerable groups within society can be significant. They are portrayed by the media as major failures of administration, and yet there is evidence that there is great difficulty in learning from them. The thesis set our here proposes that one of the main reasons for this relates to the inappropriate application of an exclusively rationalist, realist model to the analysis of policy fiascos and the subsequent drawing of lessons. Policy fiascos are socially and politically constructed events and open to multiple interpretations. The interpretation of the top civil servants, in this case the group of Secretaries General, is critical to the real learning that occurs in the system after these events, and how that learning is applied. It is therefore by adopting a relativist position within an interpretative research framework that we achieve a greater understanding of the process of interpretation by these senior managers, and thereby deepen out insight and understanding of the process of learning from these events.

From an academic perspective this study addresses a gap in the research related generally to learning from failure in the public sector, and

specifically in relation to learning from policy fiasco. It deepens our understanding of organizational learning in these circumstances. The role of the individual as interpreter and learner is critical. The study demonstrates that individual senior managers play a significant role in the post-fiasco phases of learning, and that this learning is frequently tacit, influenced by their own backgrounds and approaches but also their interaction with the wider world. Learning involves both acquisition and participation, and is sometimes facilitated by, and sometimes hindered by, organizational structure and process. Perhaps most significantly the study reveals a major gap between the processes and content of the learning by individual senior civil servants following policy fiasco, and the official learning from the public inquiry that is typically represented as 'the truth'.

From a practical perspective the study addresses the ongoing concern that lessons from policy fiascos in the public sector are not being learned, and that mistakes are being repeated. The study demonstrates that these concerns are valid, but goes some way to explaining the barriers to learning and the reasons why mistakes are repeated.

Chapter 2

Policy fiascos in the Public Sector: Opportunities to learn from failure or rituals in blaming? A Review of the Literature

Introduction

In this review of the literature on organizational failure and policy fiasco we will see that the research to date has been dominated by rationalist perspectives that fail to address key issues, and that fail to recognise or analyse the critical role of interpretation in the aftermath of policy fiascos. While rationalist perspectives have dominated the literature, this thesis proposes that an interpretivist perspective is more useful, and proposes a theoretical framework for understanding the process of learning from policy fiasco.

Concepts, causes, and context are the three critical pillars in constructing a retrospective narrative of policy fiasco. The concept of failure itself is frequently contested, and particularly so in the public sector. The definition of failure is not as straightforward in the public sector, because it is more difficult to agree measures of success and failure. Policy fiascos are distinguished from the more prosaic and generalized concept of organizational failure by the perceived extent of damage they cause, the media attention they attract, and the fact that they are usually highly politicised events (Bovens & 'Thart 1996). As we shall see, there is often a view that policy fiascos do not necessarily represent organizational failures at all, and that the very notion that they can provide opportunities for learning is largely spurious. Add to this the time factor, whereby policies or programs may have been initiated in quite different times and circumstances, and there is the potential for a wide variety of interpretations of policy fiascos. For these reasons rational perspectives are not sufficient for understanding policy fiascos in the public sector.

It was also necessary to establish what the literature reveals about the causes and context of failure. Inquiries into failures in the public sector typically identify causes that are internal to the organization. Others may point to environmental or institutional factors that are beyond the control of the organization. For example, the fact that the public service operates in a highly complex political, institutional, and social environment, and must balance the rights and needs of many different groups, has been cited as a defence in the aftermath of certain public sector fiascos. Therefore the causes of failure identified, the relevance attributed to contextual factors, and the relative weight attached to each of these, are critical factors in the interpretation of such events. But first let us turn to the concept of failure, and particularly to differences between the private and public sector. As we shall see, the highly contested nature of failure in the public sector renders a rationalist analysis as the basis for learning lessons from such events, highly problematical.

Organizational failure in the Private Sector

What exactly does 'failure' means in organizational terms? There is no consensus within the literature as to what it means, how it occurs, or what are its consequences (see Weitzel & Johnson 1989). In the research into organizational failure, which has been largely confined to the private sector, there has been remarkably little attention paid to defining 'failure', or to differentiating between types of failure. Mordaunt & Otto (2004: 60) noted that 'there is no clear, consistent use of the term. In the literature terms like 'failure', 'crisis', 'disaster', 'fiasco', and 'mistake' are frequently used interchangeably'. Many authors have simply taken the concept for granted, which is perhaps more reasonable in the private sector where success and failure have traditionally been measured by reference to the 'bottom line', and failure is often marked by the very public act of closure.

For private sector firms, success and failure are possible outcomes that are embedded in the market economy. The efficient operation of the market is

based on the survival of the fittest, and in this model of 'natural selection' the occurrence of corporate failure is not only unsurprising, it is inevitable (see Hannan, 1984). Clear signs and symptoms of impending failure can frequently be discerned from an early stage, and can include negative profitability (D'Aveni & Macmillan 1990), a shrinking market share (Harrigan 1982), a loss of legitimacy (Benson 1975), or exit from international markets (Burt et al. 2002). If not heeded and addressed, these minor problems can quickly escalate into major failures.

The opportunity for change and learning in the aftermath of failure in the private sector may be limited by its consequences. Anheier (1999) noted that there are two types of failure in the private sector: one that provides the opportunity for learning and transformation, and the other that leads to closure. Where the opportunity for learning is not grasped, closure may become inevitable. It is also noteworthy that in the private sector ongoing change and innovation are considered essential to survival and success, and to the avoidance of failure, because 'private sector firms are accountable to their shareholders, who have voluntarily entrusted the firm with their capital on the expectation of a reasonable profit return'(Vincent 1996 : 1). The concept of failure in the private sector is not only well accepted but also, because of the rules of the market, generally easy to identify and measure.

Organizational Failure in the Public Sector

In the public sector the issue of what exactly constitutes failure is more complex, contested, and contingent than in the private sector. This is not helped by the dearth of analysis and relevant case study material on the subject. Mordaunt and Otto (2004: 24) noted that 'almost all the literature on corporate failure relates to commercial sector organizations'. There has been a major emphasis on accountability and performance within public sector reform processes over the past decade or more, and this has been, at least in part, an attempt to counter the deficiencies in measuring performance: 'There has been a huge sea change over the period. There is now not a single area of the public sector untouched with an awareness of the need to encourage transparency' (Vinten 2004: 150). Despite this, the definition of

measures of success and failure in the public sector remains problematic. The reasons why it is more difficult to devise such measures in the public sector have been well documented (see for example Brignall & Modell 2000) and include the problem of goal conflict, the fact that policies must frequently meet the needs of different stakeholders, a lack of control over resources, and weak incentive systems. What constitutes a good measure for one set of stakeholders may constitute a poor one for another. Meyer & Zucker (1989) argued that public sector organizations, precisely because of this difficulty with measurement, could continue to operate at sub-optimal levels almost indefinitely. Unlike in the private sector there is usually no risk of closure, and therefore little incentive to change. The analysis of the causes of policy fiasco has frequently led to the conclusion that the event was the culmination of a series of mistakes, or the product of an ongoing 'organizational culture that provided normative support for wrongdoing' (Vaughan, 1999 : 292). But often there are no early warnings, at least none that can easily be discerned by the public.

Yet there is one very clear exception to the 'hidden' inefficiencies of the public sector, and that is the very public manifestation of problems through the dramatic and often traumatic events that constitute a policy fiasco. Seibel (1990: 45) observed that while public sector organizations may operate inefficiently on an ongoing basis, failure becomes evident through a set of circumstances that 'leads to a series of legal or rhetorical punch and counterpunch'. Indeed it is notable that much of the research into failure in the public sector has been prompted by the frequently disastrous and highly public consequences of perceived mal-administration or misjudgement by public agencies or their officials. This is partly due to their 'shock' factor, and the fact that the events that constitute the 'fiasco' frequently represent the first time a problem has come to public notice. Recent examples include the failure of the Scottish Qualification Agency (Clarence 2002), Britain's entry to and exit from ERM (Dunleavy 1995), the Hillsborough Stadium disaster (Jacobs & 'T Hart 1992), and the Challenger Space Shuttle disaster (Moore 1992). But in the public sector the question of what constitutes

success or failure is frequently not so much a matter of fact as of interpretation, and this is particularly true of policy fiascos.

Policy Fiascos

While at first sight policy fiascos may seem to represent extremely clear-cut examples of failure, and the inevitable consequence of a failure to deal with, and learn from, ongoing inefficiencies, the reality is more complex: 'policy fiascos do not stand out as readily recognizable phenomena' (Bovens & 'tHart, 1996: 9). Boin et al (2005: 2) referred to the confusion that surrounds the term 'crisis', 'which in popular culture is used to describe everything from hijacks and hostage takings to the break up of a pop group. This problem is compounded by the perceptual, constructed, and contingent nature of the phenomenon'. There are policy fiascos that are purely at the political level, and research in this area has typically involved the analysis of political miscalculation. Janis (1972) used political case studies to analyse the role of 'groupthink' in flawed political decision-making, while Shiels (1991) analysed the role of political miscalculation in Vietnam, post-Shah Iran, and the Cuban Missile Crisis. While this category of policy fiasco is tangential to the current study, it is worth noting that almost all policy fiascos have some political dimension. This political dimension, together with the modern propensity to portray all high-profile cases in the public sector as crises, further points to the difficulty in categorically classifying all policy fiascos as 'failures'.

The category of policy fiasco in which I am interested in this study relates to perceived failures in the administration or implementation of public policy or public projects by the public service, a number of which have already been cited. The main case study used in this research relates to the ruling as illegal by the Irish Attorney General of the practice by health boards of charging for long-stay care in public nursing homes which occurred in early 2005, which led to the resignation of the Secretary General of the Department of Health, and a bill to the Irish taxpayer of over €200billion. Since 2005 there have been several more policy fiascos in Ireland alone, a recent example being the

purchase of electronic voting machines that were subsequently judged to be not fit for purpose.

Policy fiascos are generally perceived to be the result of sins of omission or commission on the part of a public agency or its officials, and are deemed by the public at large, or by a large section of it, to have been avoidable (Dunleavy 1995). They have been defined by Bovens and 'tHart (1996: 15) as "a negative event that is perceived by a socially and politically significant group of people in the community to be at least partially caused by avoidable and blameworthy failures of public policymakers'. Tuchman (1985) argued that the mistakes are generally foreseeable and avoidable, but in practice this is very difficult to prove. According to Bovens et al (1999) for an incident to become a 'policy fiasco' four criteria must be met: the events must have transgressed normal zones of public tolerance; there must have been a perceived damage to the public interest; the negative events must have been perceived to be the result of the acts or omissions of responsible public officials or agencies and avoidable; and there is widespread feeling that blame has to be apportioned to those responsible, although there is also often disagreement about who should be blamed: 'When these four claims are made persuasively about a policy episode the key policy makers and agencies are in for trouble' (Bovens & 'tHart 1999:206). It is notable that 'perception' is an element in many of the definitions.

The term 'policy fiasco' is deliberately used instead of the more straightforward 'policy failure' because the extent to which the event, or set of events, actually constitutes a failure is often hotly contested by the various stakeholders. Opposition parties may actively seek to label some government program, policy, or project as a failure in order to score political points, or as Bovens and 'tHart (1996: 134) argued: 'incumbent policy elites may experience the emergence of judgments of their actions as a fiasco as highly threatening, while other individuals, groups or organizations will harbour the exact opposite interpretation'. The term reflects the framing of an event as a failure: 'a policy fiasco, like all news developments, is a creation of the language used to depict it; its identification is a political act, not a

recognition of a fact' (Edelman 1977: 44). Perception and interpretation are indeed critical to the framing of a set of events as a policy fiasco, and the media plays a critical role in determining how these events are perceived and interpreted:

> In western societies the role of the media in framing policy disasters is pivotal. The role of the media has changed from one of deferential lapdog to one of vigilant watchdog or roaming 'junkyard' dog. The institutional and personal drama of government scandal now has high entertainment value. (Bovens, 1998: 210)

However, for some the media itself may be seen as the problem, and as the creator of fiascos. There is little doubt that the public sector has been much less adept at managing the publicity fallout from crises than their counterparts in the private sector: 'whether they like it or not elites have to become more proactive in their crisis communication and more in line with the private sector which has always viewed crises primarily as public relations problems'(Boin & 't Hart 2003: 25).

The fiasco refers to the framing of events, but it also refers to their interpretation, and it is impossible to keep these separate: 'From an interpretivist point of view the former is not knowable in any other way than through a version of the latter' (Bovens & 'tHart 1996: 10). While the official interpretation of policy fiasco based on a rational, retrospective analysis frequently becomes synonymous with the 'truth', the evidence from the literature presented above shows that policy fiascos are open to many, and sometimes widely differing, interpretations. What this review of policy fiascos also demonstrates is that they are common, and continue to impact on countries with well-established and relatively sophisticated systems of governance. From both an academic and practical perspective, this makes the need to understand how we interpret and learn from these events all the more urgent.

Causes of Organizational Failure

Clarke and Perrow (1999: 9) lamented that 'the social sciences offer little by way of explaining the sources of organizational failure'. In the literature the analysis of cause comes primarily from an organisational psychology or a structural and systems perspective.

In the organizational psychology literature there is a fair degree of consensus that cognitive processes frequently do play some part in causing failures in both the private and public sectors. Defective decision- making is a frequently cited cause of failure. Janis (1972: 9) used the concept of 'groupthink' to describe how 'group members striving for unanimity override their motivation to realistically appraise alternative courses of action'. Shukla (1994) found that the mental models used by managers led to an ignoring, or filtering, of relevant information that would have helped them to anticipate problems. Habit, slavishly following the rules, stasis from routine, skilled incompetence (Argyris et al 1985), have all been cited as causes of organizational failure, particularly in large bureaucratic organizations. Dysfunctional culture causes organizations to 'fall into the competency trap, doing the same thing even when an alternative approach would be preferable. If you know how to use a hammer, everything looks like a nail' (Amburgey & Hayagreeva 1996:6). Amy Edmondson (1996) has conducted research into mistakes and error in the field of medicine and concluded that:

> Given that human error will never disappear from organizational life, an important management issue thus becomes the design and nurturance of work environments in which it is possible to learn from mistakes and collectively to avoid making the same ones in the future (Edmondson 1996: 87).

There has been a particular focus on the culpability of management. Some proponents of human cognition theories argue that managers are the principal decision makers and consequently their action or inaction is the fundamental cause of organizational failure. For example, Barnard (1938) argued that ruling elites in organizations establish routines that encourage

rule-mindedness and habit rather than optimal decision-making, a state of affairs that becomes particularly problematic when the organization faces some novel set of circumstances. Barmash (1973: 299) noted that 'corporations are managed by men; and men, never forget, manage organizations to suit themselves. Thus corporate calamities are calamities created by men'. Weick (1999 : 14) also emphasized the subjective understanding upon which the manager's interpretation of a situation and subsequent action is based, and that 'rationality is only bestowed in retrospect'. March & Simon (1958) argued the concept of 'bounded rationality' which states that managers do not, and indeed cannot, make decisions based on a complete and accurate picture of reality. Argyris & Schon (1978: 14) contended that managers' unwillingness to acknowledge unpalatable truths, and their willingness to adopt defensive reasoning in order to save face, leads to escalating error and an inability to learn from what has gone wrong in the past. However, while the organisation psychology perspective on failure is useful, and frequently a perspective adopted by post-fiasco inquiries, on its own is it is inadequate to address the full complexity of issues involved in policy fiascos and it is erroneous to think that it can do so.

The structural perspective on failure emphasises the inherent tendencies towards failure that exist within organizations, and the view that failure is a normal part of organizational life. From this perspective it is not the event of failure that is remarkable or interesting, but rather those tendencies or weaknesses, such as inter-departmental conflicts or power imbalances, that led to the event. This perspective is partly based on Durkheims' thesis (1966) that the pathological is an inextricable part of every system or, as Vaughan (1999: 275) put it, 'the same characteristics of a system that produce the bright side will also provoke the dark side from time to time'. Clarke & Perrow (1999: 2) also regarded errors as 'a routine and systematic part of daily organizational life that only occasionally become visible to outsiders. The public only learns about the most egregious of these'. Closely related to the structural perspective is the theory that in the private sector not just organizations, but whole sectors and industries, are subject to

patterns of growth and decline, and that failure must be seen as a part of this natural cycle. The firms that survive and prosper are those that best adapt to the changing environment (see Shukla 1994).

The systems perspective on failure suggests that it is fruitless, indeed misleading, to analyze the causes of organizational failure through a process of deconstruction. Systems are complex, and the causes of failure are to be found in the inter-related and dynamic processes of organization and environment. Chapman (1999: 12) argued that systems approaches to the analysis of failure are particularly appropriate in the public sector and that while 'a mechanistic, linear approach may help to understand where a rock may fall after it is thrown, it is useless for predicting the trajectory of a birds flight'.

While organizational psychology perspectives generally take the more optimistic view that human error is the cause of failure, and the remedy is to build competency and contingency, structural and systems approaches take a more pessimistic view insofar as failure is viewed as complex, and part of the way that we set things up in organizations. All of these perspectives become important for the interpretation of policy fiascos, because while none on their own can fully explain the causes of the phenomenon, they become powerful interpretative frameworks for different stakeholders.

Causes of Policy Fiasco

To what extent then are these general perspectives on organizational failure useful for understanding the causes of policy fiasco? Public sector organization do not typically suffer the same catastrophic consequences of failure as do firms in the private sector. However the absence of serious consequences makes public sector organizations particularly prone to policy fiasco because it renders them less vigilant of change, and more prone to atrophy: 'there is something about political and bureaucratic life that subdues the functioning of intellect in favour of working the levers' (Tuchman 1985: 7). The New Public Management (NPM) model of public sector reform was enthusiastically embraced in Britain and Ireland, partly at least to combat

some of the deficiencies arising from the protected position of the public service and to bring about a situation where 'bureaucratic padding has been displaced by an administrative 'permanent revolution' (Dunleavy 1995: 52). NPM reforms led to the creation of new executive and regulatory agencies that could, so the theory goes, operate unfettered by the cumbersome bureaucracy that traditionally constrained government departments. Yet despite these reforms, or perhaps because of them, 'there have been large scale and repeated policy failures' (Dunleavy 1995: 53). It is reasonable then to ask whether this cycle of public sector reform has, far from reducing the risk, actually created the conditions for more policy fiascos to occur. For example, Vincent (1996 :116)has suggested that the creation of new agencies and the increased emphasis on compliance may have created the potential to achieve better results, but simultaneously increased the risk of making mistakes. Gregory (1998) too has raised concerns about the extent to which NPM reforms may have actually caused more confusion in the accountability roles of senior civil servants.

The 'structural deficiencies' perspective on failure discussed above finds particular resonance in a public sector environment. The making and execution of public policy often involves multiple processes, agencies, and people: 'Complex organizations are surrounded by paper walls -actions rarely bear a personal stamp. Policies pass though committees and individuals before they are put into effect' (Bovens 1998: 47). Morgan (1997: 89) asserted that 'bureaucratisation tends to create fragmented patterns of thought and action. The multiplicity of organizations and agencies now involved in developing and delivering public policy, and the complexity of the society they serve, makes the identification of cause and the attribution of blame in the aftermath of policy fiasco much more complex:

> The systemic interdependence of the highly specialized agents of modernization in business, agriculture, law and politics correspond to the absence of single isolable causes and responsibilities. Who will take the hot potato (Beck 1992:33).

Human cognition theories of policy fiasco are popular, partly because finding someone to blame is frequently an important part of the post-fiasco process of 'framing and blaming' (Bovens 1998:131). Cognitive or behavioural failings on the part of public servants, including faulty analysis and the filtering out of unwelcome data, have been identified as causal factors by inquiries into fiascos ranging from the investigation of the Palme murder in Sweden (see Dekker & Hansen 2004), to the Rijn-Schelde-Verolme ship building scandal in Netherlands 'which led to multi-million loss for government, and was the result of decisions by many actors over many years' (Bovens 1998: 46). Dunleavy (1995: 142) partially attributed policy fiascos to the 'arrogance of Whitehall, the unwarranted confidence of senior public service managers that the Departmental view is right'.

In the aftermath of fiascos, Chief Executives or other senior managers are frequently held accountable, if not always the ones specifically to blame. For example, the Chief Executive of the London Ambulance Service was forced to resign in the aftermath of the IT fiasco in 1992 (Dunleavy 1995). Brown (2000 : 75) also described how the Allitt Inquiry into attacks on children in Grantham & Kesteven Hospital, ascribed the failure to 'a lack of leadership and effective communication from the top'. However, Bovens (1998: 45) cited the 'problem of many hands', the fact that policies and decisions often pass through many officials, and perhaps through many agencies, as a reason why it is extremely difficult to pinpoint individual responsibilities and accountabilities in public sector organizations. Allied to this is the unique time trajectory associated with many public policies, policies that were initiated at a time and in circumstances that were very different: 'the conduct of an organization over time is the result of the interplay between fatherless traditions and orphaned decisions' (Bovens 1998: 47). This renders human cognition theories of policy fiasco difficult to sustain on their own. Yet the tendency to focus on cognitive or behavioural causes of failure, and to lay blame on individuals, is part of the process of re-legitimising government and restoring confidence in the body politic. It demands an 'optimistic' analysis of policy fiasco by suggesting that errors can be eliminated and

future fiascos avoided. However, according to Gregory (1998: 20) 'assigning blame and focusing on an individuals error avoids dealing with the systemic causes of failure and thus blocks learning'.

While organizational life cycles of growth and decline do not impact on the public sector in the same way as the private sector, the literature suggests that the public sector too is subject to phases of change. If organizational failure is related to an inability, or unwillingness, to adapt to changes in the environment, it has been argued that public bureaucracies by their very nature are less adaptable (see for example Crozier 1964). The tendency towards inertia is stronger than in the private sector. Unlike in the private sector, there is frequently little or no pressure from outside for change: 'the day-to-day practice of public administration and management tends to engender political indifference– until something goes wrong'(Gregory 1998: 7). Not only have politicians frequently been indifferent to reform in the public sector, they have even been hostile: 'public sector reform has very little upside potential, but can pose a tremendous downside threat. In other words, it might not help, but it can certainly hurt' (Jones & Kettle 2003:10).

The theory of 'new institutionalism' suggests that policy fiascos represent a failure by the public service to embody the changing values and norms of the society it is seeking to serve. Ironically, it may be the traditionally unchallenged authority position of the public service that has made it so difficult for it to adapt:

> For the public sector its power and role in society has reinforced its isolation from the forces in society that might prevent policy disasters. Public sector organizations restrict the sources of information to which they attend -for a more comfortable life. (Boin et al. 2005:202).

But while public sector organizations may not as a rule be as adaptable or flexible as private sector organisations, that is not to say that they can, or do, completely ignore changes in their environment. The need to survive, let alone prosper, makes such a stance impossible. However, Gabris et al (1998:

5) argued that dysfunctional public sector organizations will change only when they have to, and in the most minimal way consistent with survival: 'they maintain the status quo, and when they adapt, they do so incrementally and with an interest in the short term. These patterns facilitate a kind of subsistence level of survival'. So while policy fiascos may represent a 'window of opportunity' for change and reform, the evidence of the research also suggests that the response to such events may be to limit the 'fallout' and adopt a minimalist approach to learning and change.

Bovens and 'tHart (1996) have used philosophies of governance to describe a theoretical framework that adapts the perspectives on the causes of failure described above to the specific circumstances of policy fiasco. Within this framework an optimistic perspective on policy fiasco regards the public administration as fundamentally well meaning and competent, and failure as an aberration, caused by some unusual and unforeseeable set of events, for example some limited instance of cognitive failure. This, for example, was the perspective adopted in the Inquiry into the Arms to Iraq affair (Brown & Jones 2000) and the study of the poll tax fiasco by Butler et al (1994). A realist perspective regards the various stakeholders involved in policy development and implementation to be utilitarian and vying for power, control and resources. From a realist perspective, failure is primarily caused by competition and power games between the main stakeholders. Pressman and Wildavsky (1973) provided one of the earliest analyses of failure from a realist perspective in their study of the Oakland Federal Program. They noted that the seeds of failure were laid early 'when the program was characterised by many contradictory criteria, antagonistic relationships, and a high level of uncertainty ' (Pressman & Wildavsky 1973:90). A pessimistic perspective regards failure as being deeply embedded within the system.

Douglas (1992) argued that the interpretation of policy fiascos invariably involves a process of accusing and excusing. Policy fiascos are by definition usually highly political events, and efforts to shift or avoid blame become an important part of the aftermath: 'Many of the officials and agencies involved will engage in impression management, blame shifting, and political

manoeuvring. Their reputations are at stake' (Bovens & "tHart, 1996: 130). Thus different interpretative frameworks may be adopted by different players, to provide a post-hoc rationalisation of the causes of policy fiasco. However they are interpretative frameworks, and this is why interpretation and not rationality, is critical to understanding and learning from, policy fiascos.

While post-fiasco inquiries have generally adopted an optimistic perspective, it is clear from this discussion that identifying the causes of policy fiasco is much more complex than in the private sector. Organisational psychology explanations that emphasise cognitive and behavioural causes are useful, but because of the complexity of agency in the public sector, are insufficient. Structural perspectives that emphasise internal organizational dynamics as the root causes of failure are helpful, but fail to account for some key aspects of policy fiasco, such as the wider political context of public administration. Institutional adaptation arguments are useful for understanding the tendency towards minimalist change in the public sector, but fail to take adequate account of the role of the media, or indeed public sector reform processes. What this discussion of cause demonstrates is that all of the major theories of failure are based on an objective and realist philosophy that assumes that organizational failure, and policy fiasco specifically, can be retrospectively defined, analysed, and explained according to some set of objective measures. But I argue that no one of these theories is sufficient to explain policy fiascos, and that because of the complex and contested nature of these events, an objective and rational analysis of cause cannot explain how in practice policy fiascos are interpreted and how lessons are drawn.

The Context of Policy Fiascos

Closely related to cause is the context of policy fiasco. The extent to which failure is ascribed to internal organizational causes as described above, or to external factors, will not only influence the analysis, but also the nature of the response. If policy fiasco is interpreted as inevitable and outside of executive control, then the response may be fatalistic. If policy fiasco is perceived to have been triggered by some unique set of circumstances in the environment

that are unlikely to be repeated, or are unique to a single organization, then the response may be sanguine, and the events regarded as having little potential for learning. On the other hand, policy fiascos that are interpreted as being due to some significant change in the environment can potentially impact on all organizations in the sector, and having much greater learning potential. For example, Cook (1989) suggested a link between high profile disasters such as Zeebrugge and Piper Alpha and the dominant influence of market economics on political thought during the 1980s.

The interpretation of context also influences the lessons that senior managers will draw. For example in a public sector climate dominated by accountability and risk minimisation, senior managers may be more likely to interpret policy fiasco as a cue for more defensive strategies and risk avoidance, rather than as a cue for innovation. So the relevance and significance attached to context is an important factor in how managers explain and interpret policy fiasco. It is useful therefore to consider some of the trends and changes in the environment of the public sector that may influence their interpretation.

The Changing Public Service Environment

There is ample evidence to suggest that the context within which success or failure is evaluated in the public service is changing in some important ways. The demands on, and expectations of, public sector organizations have changed just as the needs and expectations of citizens and stakeholders have changed. These changes are reflected in the nature of policy fiascos now arising. Boin et al (2001) argued that 'traditional' crises are now being supplemented by 'post-industrial and post-national' crises such as Chernoybyl, Mad Cow Disease, the German Currency Union Crisis of 1990, and the Arms to Iraq affair. Their argument is that as the world becomes more complex, with this complexity come new types of problems. This is similar to the argument put forward by Beck (1986) and Lagadec (1981) that we now live in a 'risk society', which is a society where 'the commonality of anxiety takes the place of the commonality of need' (Beck 1986: 49). We have created new risks, the consequences of which are manifesting themselves with ever- greater frequency: 'the latency phase of risky threats

is coming to an end and the invisible hazards are becoming visible' (Beck 1986: 55). As we seek to achieve greater levels of control over technology and nature, and hence greater security, we paradoxically achieve the opposite, or, as Wildavsky (1977: 220) put it, 'doing better, feeling worse'.

Increasingly there is a public expectation that risk can be controlled and that adverse events can always be explained: 'in a secularised culture such as our own it is important to be able to explain things by reference to people-this means that an event can be controlled' (Brunnson 1989: 147). The burden of managing the residual risk falls largely to the public sector, and any perceived failure to do so incurs public wrath. Citizens and stakeholders 'expect to be safeguarded by their state' (Boin &'tHart 2003: 14). In the aftermath of fiasco finding someone to blame, typically some public official, provides the comfort that fault lies in the incompetence of public officials rather than in forces that are less easily explained or controlled. Consequently there is an increased willingness, perhaps a need, to apportion blame, and a sense of outrage that problems were not foreseen. Hood (2004: 4) referred to ' an increasing disposition in law and politics to treat adverse outcomes as a product of avoidable and culpable errors in human agency rather than fate', and one of the consequences is a contemporary public management that 'combines low trust in established institutions and officeholders with a political disposition to respond far more dramatically to negative than to positive outcomes' (Hood, 2004: 4). Indeed the growing citizen distrust of the public administration makes it more likely that they will interpret events malignly rather than benignly, and attribute blame to public servants: 'Victims seem to find it easier to bear their misfortune if they can see injustice as well as bad luck' (Shklar 1990: 64). This in itself makes policy fiascos ever more likely.

What this discussion shows is that as the public have come to expect more of the state, and expect the agencies of state to guarantee their safety in what they increasingly experience to be an unsafe world, the actions of public officials are subject to increasing scrutiny. This creates the conditions where any perceived failure on the part of public agencies or officials is regarded as

a serious breach of trust, and the potential for policy fiasco is thus greater. This makes policy- making and policy implementation increasingly difficult. Where 'nothing is proven until there is scientific proof- and where citizens form themselves into coalitions of 'pseudo-experts' to draw attention to the risks' (Beck 1986: 75) every perceived flaw or weakness is pounced upon as further evidence of official incompetence. As a consequence, the incentives for public servants to avoid worst or bad outcomes outweigh those to achieve the best or good ones, or as Lucas (1976: 45) has argued, 'ensuring that we avoid the really bad means that we have to be prepared to forego the really good'.

As well as a growing distrust between citizens and their governments, there is a growing distrust between public servants and their political bosses:

> Now departmental chief executives are more personally exposed to public scrutiny and criticism than before, and are more likely than before to be found answering in public in lieu of their ministers (James 2002: 4).

At the same time, politicians are engaged in what Dunleavy (1995: 61) described as 'political hyperactivism', compulsively engaging in new initiatives, responding to the latest media criticism rather than looking to implement existing policies more efficiently. Bovens and 'tHart (1996: 39) noted the paradox of democratic politics whereby politicians 'are engaged in raising expectations and espousing myths of rational, just, and omnipotent government that help to create the conditions for their own political failure'. The willingness by politicians to forego best practice and evidence-based approaches to policy making in favour of politically advantageous initiatives creates an inevitable tension between them and their senior civil servants. Partly for this reason, the past decade has seen a steady growth in the use of political advisers (see Gregory & Painter, 2003). At the same time the civil service has also become increasingly 'professionalized', and at senior levels salaries are increasingly on a par with the private sector. However this too has come at a cost:

> One price they have paid for substantial increases in personal remuneration is that they have also been required to carry more of the political risk attached to negative outcomes. One consequence of this changing Schafferian bargain has been a generally less trusting relationship between ministers and public service chief executives (Gregory 1998: 22).

The ubiquity of risk in our complex modern societies and the expectation of citizens that the public service will manage this risk, has certainly created the conditions conducive to policy fiasco. The increased willingness for politicians to push public servants to the fore when something goes wrong, and the changing nature of the relationship between the political and administrative systems, makes it more difficult to separate political from administrative failure. The need for the public service to demonstrate conclusively that nothing can, or will, go wrong makes 'successful' implementation of public projects less and less likely. However against this background, the possibility of being able to categorise policy fiascos as 'failures' of the public service, let alone identify the causes of these 'failures', is becoming more remote.

Conclusions

In this Chapter I have explored some of the major debates in the literature on organizational failure and their relevance to the interpretation of policy fiasco. While organizational failure in the private sector is relatively easy to recognize and measure, this is not the case in the public sector. Failure in the public sector frequently comes in a complex package of media hype, political recrimination, the search for culprits, and denials of responsibility. These are the affairs known as 'policy fiasco' and whether or not they represent a failure, or the extent of the failure involved, is usually hotly contested. The events and what caused them are open to many interpretations. The official inquiries into these affairs frequently represent the only opportunity for systematically drawing lessons, and yet their interpretation is often based on a rational, sequential logic that is not well suited to the circumstances. Such inquiries tend towards the optimistic

conclusion that policy fiascos were an aberration and can be avoided in future by addressing identified weaknesses. However other interpretations are not so benign, and conclude that such problems are endemic in the system.

The complexity of the concept, causes, and context of policy fiascos evident from the above discussion means that they invite multiple interpretations and that rational, objective frameworks of analysis cannot alone provide the basis for learning from such events. It is now time to turn our attention to reviewing the processes of interpreting, and learning from, policy fiascos.

Chapter 3

Organizational learning, learning from policy fiasco, and the process of interpretation

Organizational failure represents both a problem and an opportunity. According to Birkland (1997) failures create opportunities for learning about the weaknesses as well as the strengths of the social system. Because, as we have seen from Chapter 2, there are not the same incentives for change in the public sector as in the private sector, difficulties and crises in that sector may represent unique opportunities for learning. Weaver and Rockman (1993: 464), on the basis of data from multiple public sector case studies, went so far as to argue that 'the most obvious route to institutional change is a massive failure in governance'. Capitalizing on this opportunity for learning assumes that the feedback from the negative experience will be used positively for learning, that the 'right' lessons will be drawn, and ultimately that the chances of a recurrence of the negative events will be minimized, if not eliminated. Indeed in a democracy a basic tenet of good governance is that the public can have confidence and trust that public sector organizations will learn in the wake of policy failure: 'it is part of the democratic trust by citizens in enlightened, responsive and accountable governance based on consent' (Olsen & Peters 1996: 2).

Before discussing in more detail some of the more specific issues and processes associated with learning from failure, it is first important to position this overall research project within the theory of organizational learning. In particular it is important to establish the basis for my own theoretical position and the implications of this for my research methodology.

The theory of organizational learning and its relevance to learning from policy fiasco.

In the literature widely differing positions have been adopted both in relation to the concept of organizational learning, and the processes that underpin learning in organizations. To bring some order to a field of theory that has been described as a 'conceptual minefield', Shipton (2006) developed a typology that distinguished prescriptive from explanatory theories, and theories that emphasize individual learning from those that emphasize learning at the collective, organizational level. Theories at the collective organizational level tend to emphasize rules, processes, and structures as the enablers and repositories of learning. (Shipton 2006: 244). By contrast the individual perspective focuses on the role of the individual as the critical agent of organizational learning. A prescriptive/normative perspective emphasizes the positive relationship between learning and performance, and the various actions or processes required to achieve these positive outcomes. On the other hand, the explanatory/descriptive perspective "is concerned more with understanding how organizational learning happens, and identifying barriers and inhibiting factors" (Shipton 2006: 246). This framework allowed Shipton to position the key theoretical contributions along individual/collective and prescriptive/explanatory axes, and my research study proceeds generally on the basis of an individual and explanatory perspective on organizational learning

However while extremely useful for helping to make sense of a frequently confusing field of theory, which is at least partly due to the dearth of empirical data, typologies such as this can also serve to mask the real complexity of the processes involved in organizational learning. My thesis is that understanding individual interpretation of policy fiascos is critical, but that this interpretation relies also on engagement with the organization and with wider society. Therefore in order to position my own research more specifically within this overall framework of organizational learning, but still honour the complexity of the processes involved, I discuss below the typology developed by Shipton (2006) whilst also pointing to some of the more complex and less easily classifiable aspects of the relationship between individual and organizational learning.

Oganizational-level perspectives on organizational learning

In an early, and seminal, contribution, Cyert & March (1964) proposed that organizations can learn in ways that are independent of the individual, which lay the foundations for a theory that emphasizes process, structure, and strategy as the critical determinants of the quality of learning in organizations. From this normative perspective the links between learning and improving organizational performance are emphasized and there is a heavy emphasis on the transfer of explicit, objectified knowledge that contributes to the learning organization (see for example Watkins & Marsnick 1993). However there is an alternative view that organizational learning is based primarily on the transfer and storage of tacit knowledge, and that learning may sometimes be dysfunctional and not necessarily contribute to achieving organizational goals.

Both schools tend to adopt the view that organization can be conceived of as 'collective mind'. This perspective has been criticized by those who argue that adopting such a position involves the reification of learning and the anthromorphization of organization (see Berends et al, 2003). Further, a number of authors have pointed out that there is little empirical data to back up this position: "such research ideas, despite offering interesting insights, provide little if any empirical justification". (Shipton)

Structuration theory also provides some valuable insights for understanding learning at the orgaizational level, and for overcoming the dualism traditionally associated with individual and organizational perspectives on organizational learning. Structuration theory proposes that organizational structure and process can be a resource for learning, but may also act as a constraint on that learning. Emphasising the critical role of individuals, Giddens (1984) noted that nothing happens in organizations without human agency. But for individual learning to become orgaizational learning, for practices to change,

one needs to have authority and this is why there needs to be a particular focus on the learning of managers (see Berends et al, 2003: 18).

Individual-level perspectives on organizational learning

While undoubtedly there are relevant institutional dimensions to organizational learning, these perspectives generally have failed to take adequate account of the critical role that individuals play in the learning process. Indeed Atoncopoulou (2006) has proposed that "it is now commonly agreed that organizational learning is the product of individuals learning" (2006: 456). Those who argue that the individual is the critical agent of learning in organizations can be divided between those who use the 'acquisition' metaphor of learning (for example March & Simon 1958), and those who use the 'participation' metaphor (for example Brown and Duguid, 1991). The acquisition metaphor reflects a traditional cognitive view of learning as a process of adding substance to mind. However the acquisition metaphor has difficulty explaining how individual learning is transferred to the organization. Indeed this has been a problem generally for theories that emphasize the individual role in organizational learning. Nicolini & Meznar (1995) noted that the relationship between individual and organizational learning is very unclear and that more empirical and theoretical work is necessary to understand how this relationship works. Berends et al (2003) have also argued that one of the reasons why it has proved so difficult to understand the relationship between individual and organizational learning is that much of the research to date has been based on theories of individual learning, and that on their own these fail to capture the social nature of organizational learning. For there to be organizational learning there has to be more than this.

Learning as participation

The participation metaphor proposes that the 'more than this' has to do with the individuals participation in organizational communities. In the 'learning as participation' model, learning takes place within the everyday settings of work and social life (see Elkjaer 2004). Learning is a social activity, embedded

within, and inseparable from, organizational practice. However the social constructivist view of learning frequently emphasizes collective learning without adequately explaining in any detail how individual learning leads to learning in organizations. Tolman (1991) pointed out that those social constructivists who emphasize group learning processes have been rightly criticized because " a psychology that deals with averages in the hope of achieving generality through abstraction can never become relevant to the particular individual" (Tolman 1991: 5). Richter (1998) also argued that the "current literature on organizational learning does not adequately explore the micro-relationships or linkages between individual and organizational learning and, as a result, may be obscuring some of the most powerful potential value of organizational learning theory" (1998: 300). Lee & Roth (2006) also made the important point that it is unwise, from an epistemological and ontological viewpoint, to try to separate the individual and the collective when researching organizational learning, because all individual action presupposes an orientation towards organization, otherwise it makes no sense. Addressing this precise issue of how to bridge the gap between the individual level and the organizational level, Dimovski & Skerlavaj (2007) proposed that we need to move from the 'why' to the 'how' of organizational learning and, while acknowledging that "learning processes cannot be observed as visibly as chemical processes in a laboratory", they argued that the key was to gather more empirical data in order to learn more about the actual processes involved.

In this research study, by analyzing the role of interpretation by senior managers in the aftermath of policy fiasco I am seeking not only to understand the role of the individual learner, but also to understand more about the dynamic relationship between the individual learner and the wider organizational and societal environment as part of the learning process, and the implications for organizational learning.

Exploring the relationship between theories of organizational learning and learning from policy fiasco

In this research project I am therefore interested, within the explanatory paradigm described above, to achieve a better understanding of individual learning from adverse events, so-called 'policy fiascos', but also to understand better how this individual learning relates to learning in the organization. In order to better understand the links between real-life events in organizations and learning from these events, we must better understand both the process by which individuals learn from events, and how this learning may become institutionalized within the organization. Nicolini & Meznar (1995) have pointed out that in the aftermath of organizational crisis "the identity of the organization is different than before" and that the process of change involves the abstraction by individuals of knowledge from various sources in order to form cognitive schema that represent their interpretation of an event.

However this process of interpretation is frequently not regarded as learning at all because it does not necessarily involve conscious reflection, but is frequently an unconscious and ongoing process. Indeed in the West there is a bias towards only regarding learning as legitimate if it involves a formalized, separated and rational process of abstracting knowledge, rather than an ongoing, informal and embedded process of cognition in practice. However the very formality of the process in the aftermath of policy fiasco may be primarily symbolic and political. In the aftermath of adverse events many authors (see for example Hedberg 1981) have emphasized the need for coherent interpretation at the official level. However achieving coherence under pressure may create a barrier to learning, because it is often the very disequilibrium and discontinuity caused by unexpected events that create the fertile conditions for learning. Seeking to heal this breach in the 'natural order' too quickly can lead to an over-reliance on an objective, rational and organizational level analysis, and neglect the relevance of individual interpretations by key stakeholders.. Indeed some authors (see Argyris & Schon 1978) have also argued that lessons drawn just to provide coherence and a sense of stability may fail to help the organization align with the new reality that the crisis embodies.

However the emphasis on formalized processes of learning in the aftermath of fiasco may occur precisely because they promise rationality and coherence, and

because informal learning presents significant challenges in practice. Bourdieu (1990), commenting on post-crisis learning, made an important distinction between 'on the ground' learning related to a task or strategy as it unfolds over time, with all its twists and turns, and the 'finished view', which takes account only of the destination arrived at. This is similar to the difference between participating on a journey and later looking at a map of that journey. In post-crisis situations retrospective sensemaking typically involves creating the map that describes the journey. To do this "learners must construct their understanding from a wide range of materials that include ambient social and physical circumstances" (Brown & Duguid 1991: 41). However not only are those creating the maps frequently different from the people who undertook the journey, but as we shall see, the maps they create depend on their particular perspective.

Yet in the aftermath of policy fiasco the official learning process, typically adopted by Inquiries, frequently rests on the assumption that "complex tasks can be successfully mapped onto a set of simple, Tayloristic, canonical steps" (Brown & Duguid. 1991: 45). However Orr (1990) and others have demonstrated that organizations work precisely because organizational members are willing to step outside, or bypass, canonical practice. Therefore retrospective sensemaking of complex events must take account of the fact that the participants in those events may have stepped outside standard procedures and guidelines, and recognize that the key to avoiding similar problems in the future does not necessarily lie in re-asserting formalized procedures and guidelines. Indeed such a course of action could lead to more, rather than less problems. However this is frequently the basis of lessons drawn by official inquiries.

Therefore we see that the application of organizational and individual levels of analysis in the context of understanding and learning from policy fiascos rests on very different sets of assumptions about cause, about learning, and about the purpose of learning. Organizational-level perspectives frequently look to the organization as represented by its structures, processes, and roles of its members as the primary causes of failure. However in so doing they may

frequently be relying on processes that are primarily political and symbolic, and that promise to restore confidence and order because they are rational and objective. On the other hand there is considerable evidence to suggest that in practice organizations rely heavily on non-canonical practice, and that individual managers make sense of events through an informal process of interpretation that involves drawing on a wide range of personal, organizational, and societal-level phenomena. It is therefore on the assumption that individual sensemaking by senior managers is critical to understanding learning from policy fiasco, and can help further explain how individual learning is linked to organizational learning, that I now proceed to explore the sensemaking perspective on learning.

Learning Theory and Sensemaking

Because of the relative and contingent nature of policy fiascos, it becomes essential from a research perspective that in order to understand learning from policy fiasco, the researcher must gain access to the maps created in the minds of the sensemakers. This involves understanding the processes whereby cognitive schema are developed by individuals in response to organizational crises, and the extent to which they involve formalized processes that simply represent political and symbolic rationalizations, or their own unique 'take' on a set of complex events.

In contrast to cognitive, behavioural, and experiential models of learning that are based on a stable and rational cycle of learning, a sensemaking model of learning emphasizes the dynamic interaction between the individual, and other people in the organization, but also with the wider economic, social, and political environment. In this model learning is more equivocal and relative to a variety of factors, including the dynamic nature of the organizational environment, the background and experience of the learner, and the time available for learning. Shipton (2006) noted that because organizational learning within the individual, explanatory tradition is highly contingent and context-dependent, from a research perspective there is not so much emphasis on searching for generalizing principles as there is on understanding the specific processes of organizational learning in specific domains and situations.

Learners are regarded as 'learners in context transactions' where agency and structure are inseparable. Individual actions are both responses to, and triggers for, changes in environment.

As noted above, learning can be both conscious and unconscious, reflected both in changes in behaviour and action, but also in tacit and unseen changes in knowledge and attitude. This means that it is important from a research perspective to provide opportunities for individual managers to articulate what is internal and sometimes unconscious, because this allows the researcher to explore how managers attach meaning to various events and how this may in turn be reflected in changes in behaviours, actions, knowledge or attitudes at individual or organizational level.

However if understanding the processes by which individuals' cognitive schema are developed in the wake of crisis is difficult, understanding the processes by which these schema may become institutionalized within organizational life is equally, if not more, challenging. This connection between individual and organizational learning is partly determined by the extent to which meaning is developed as part of social and shared processes of sensemaking. Elkjaer (2004) addressed the relationship between individual and organizational learning by suggesting that learning takes place at both an individual cognitive, and at a group participation level. He argued that in order to understand organizational learning it is important to understand those processes and transactions that occur between individuals and organizational communities as part of the learning process. For example, Huber (1991) argued that more learning occurs in organizations when there are a variety of interpretations available to organizational members. Sensemaking theory is useful therefore because it embraces not only the individual aspects of interpretation but also social aspects.

But before considering in detail the processes of sensemaking theory that may be relevant to this study it is first necessary to consider some of the specific issues related to learning from failure, and in particular some of the barriers to such learning.

Learning from failure

There is substantial evidence that learning in the aftermath of organizational failure is difficult. In their study of learning from past crises, Elliott & Smith (2000:3) ask 'why, after the history of warnings, have organisations shown an inability to learn?' Criticizing the ongoing failure to learn lessons from past mistakes in the field of healthcare, Shorthell and Walshe (2004: 207) noted that 'in each case it seems that little or nothing has been learned from similar events elsewhere'. The Bradford Football ground fire in 1985, the Taunton train fire in 1978, the case of suicides by mental health patients at a UK hospital, and the case of a hospital where urinary tract investigations led to a number of unnecessary deaths, have all been cited as examples of costly failures that had precedents (Department of Health 2000). In the arena of public policy, May (1992: 26) argued that based on an analysis of a range of cases 'in practice, policy learning does not follow from policy failure'. There are many more examples where the failure to learn from experience has led to a costly recurrence of the problem at the same, or a different, site. A perceived failure to learn from past negative experience results in further public unease, and further loss of confidence in the system: 'public unease stems not just from the failure itself, but from the feeling that collectively we have not learnt from failure, leaving us not only as poor, but as puzzled as before' (Pressman & Wildavsky 1973: 128). Why then is there such apparent difficulty in learning in the aftermath of mistakes and failures?

Barriers to learning from failure

The literature on organizational failure describes a number of barriers to learning in these circumstances. Failure is threatening to organizations, to reputations, and sometimes even to careers, leading to a situation where

> The need to be perceived as successful may produce a tendency to declare victory despite actual results, so that any learning process will be severely truncated (Elliott & Smith 2000: 9).

Argyris et al (1985: 291) argued that the need to save face leads to 'defensive strategies' such as blame avoidance and cover-up on the part of managers. Shukla (1994) too noted that failure is frequently experienced as threatening and leads to rigidity and defensiveness within organizations, and that this inhibits the ability of organizations to learn from what has gone wrong. In the West there is also a cultural antipathy to failure: 'in our culture failure is anathema. We rarely hear about it, we never dwell upon it, and most of us do our best never to admit to it' (Sitkin 1992: 232). Failure is frequently equated with incompetence. Edmonsdon (1996) noted that

> There is a widely held view in society of error as indicative of incompetence that leads people in organizational hierarchies to systematically suppress mistakes and deny responsibility (1996: 26).

A number of authors, including Othman and Hashim (2004), have pointed to the problems of integrating and codifying new learning, and that over time organizations 'forget'. This problem is particularly acute in the public sector where there are generally high levels of mobility, and the hierarchical and 'silo-based' structure makes learning difficult 'where responsibility for taking action is fragmented across so many people' (Shorthell & Walshe, 2004: 109).

There is much evidence that in the aftermath of failure organizations default to tried and tested routines: 'when the organization experiences a shock, the tactic for disposing of this shock is the reliance on a habitual routine' (Amburgey et al., 1993: 55). Senior managers will frequently be content with single loop learning, defined by Argyris (1980: 15) as 'the detection and correction of error that does not require change to the governing values', because reflection on the deeper learning issues is dangerous and threatening.

The research across all sectors suggests that there are substantial barriers to learning from adverse events in organizations. But according to Edmonson (1996: 22) the research in this area "suffers from a lack of empirical evidence". In this study we seek to further test, and understand, the theoretical

perspectives on learning from failure, and further contribute to the empirical base.

Learning from Policy fiasco

Whatever the barriers to learning from failure that have been identified generally, the process of learning from policy fiasco poses some unique problems and challenges. The public can be particularly critical of incompetence when it comes to the public sector. Unlike the private sector, the public sector cannot afford to be seen to make mistakes, a situation that can lead public servants to 'suppress mistakes and deny responsibility' (Edmondson 2004: 69). In his review of foreign policy disasters, Etheredge (1985: 205) referred to the culture of fear that dominated decision-making at the time of the Bay of Pigs: 'collective learning was inhibited because subordinates were at personal risk if they told the truth.' For public servants, particularly at a time when there is such a major emphasis on accountability, the costs of admitting error can be high. Mistakes may be suppressed or ignored, until the acknowledgment that something has gone seriously wrong becomes unavoidable.

As we have already noted, by their very nature policy fiascos grab the headlines for just a short while. The immediate aftermath is frequently characterized by high drama and emotion, conditions not conducive to reflection and learning. Part of the urgency in setting up official inquiries is to restore confidence in the system. However in the post-crisis period senior public servants 'are caught between showing willingness to learn through reforms, and on the other providing reassurance that the system is in general robust as it stands' (Olsen & Peters, 1996: 11). The 'event' nature of policy fiascos can therefore inhibit reflection on what went wrong and why, and the systematic embedding of new practices and approaches. The desire to get early closure can be a powerful inhibitor to learning.

Once the media attention has shifted elsewhere, and the public inquiry packed up, there is little further incentive for public sector organizations to

learn from what has occurred. Indeed for those organizations or individuals seeking to avoid real change, the best strategy may be to 'weather the storm' until business as usual has resumed. This need not always be simply a case of perverse or cynical behaviour on the part of public servants. It can also reflect an unconscious adherence to deep-rooted governing values, part of a 'conduct that is programmed, part by written directives, but more by learning processes that implant behaviour patterns firmly in their nervous systems' (Kaufman, 1981:108). Gephart (1984: 222), argued that the only changes that are likely to occur 'involve the formalization of procedures already shown to be inadequate', and that in the aftermath of failure public servants adapt their beliefs to the expectation that such happenings are routine and normal.

The highly political nature of policy fiascoes inhibits learning because governments are frequently unwilling to admit failure or accept blame, but seek 'to limit evaluation, fearing that explanations of program failure may implicate them' (May 1992:92). While the political rhetoric in the aftermath of failure may refer to 'learning lessons for the future', and avoiding a recurrence, political practice leans heavily towards maintaining the status quo. In such instances 'power can be defined as the ability to talk instead of listen, the ability to afford not to learn' (Rose 1993: 56). From both a political and administrative perspective the outcry that follows policy fiasco makes action imperative. This action must be seen to be quick and decisive, but for these very reasons may also be frequently ineffective:

> When dissatisfaction is high the pressure to act is great even if what is done has a high probability of failure. The action taken may be hurried, without any theoretical or empirical justification (Rose 1993:63).

This decisive and speedy action, even if it fails to address the real causes of the problem, allows those in the 'line of fire' to draw a line under the affair: 'official discourse can be used to bring closure to controversial incidents and signal a break from the past'(Gilligan & Pratt 2004: 2). The demand for an instant response in the wake of policy fiascos raises the intriguing possibility

that these responses may create the conditions for further policy fiascos, rather than reduce them.

So if learning from organizational failure is difficult, it is considerably more difficult and problematic in the case of policy fiasco for the reasons outlined above. While we know something about the barriers to learning, little is known about the informal processes of learning in the aftermath of policy fiasco. The only significant formal process for learning that is typically put in place is the official inquiry. Because official inquiries are such an important part of the aftermath of fiascos, and often provide the only formal process for learning from these events, it is worth exploring their role and function in more detail.

The role of Inquiries

Because the facts are frequently contested, and causes and context variously interpreted, inquiries are established in the aftermath of policy fiascos to bring clarity, closure, and hopefully learning for the future. According to Lord Justice Clarke (2000), there are two purposes of a public inquiry: 'ascertaining the facts and learning lessons for the future'(2000: 7). The objective is to 'clear the mystery and speculation surrounding the crisis, replacing them with impartiality and rigour' (Boin et al. 2005:5). The public inquiry is officially constructed as an impartial means of getting at the facts, and a basis for achieving rationally based organizational or sectoral adaptation in the wake of failure. The process adopted, and referred to earlier, frequently involve a rational, objective analysis at the organizational level based on positivist and Tayloristic assumptions. Indeed Inquiries generally present their findings in a way that makes the process appear highly rational: 'reformers construct accounts which impose order and meaning upon the world around them' (Olsen & Peters 1996: 5).

However these inquiries and their findings are often politically charged and contested. Indeed Inquiries have frequently been criticized on the basis that 'their purpose is not to understand and remedy, but to blame and find scapegoats' (March & Olsen 1975:6) and that their assessment of the role of

individual public servants may highlight their negative contribution in one area but not their positive contribution in others.

Inquiries frequently rely on rational process tracing techniques, such as backward-mapping, which starts with the events and works backwards, or forward-mapping which works in the opposite direction, reflecting an assumption that a sequential logic is the most appropriate and useful way to understand these events. But rational approaches can lead to very different conclusions. In describing the inquiry into escapes from UK prisons, Gray and 'tHart (1996) noted that

> The inquiry used backward mapping techniques and focused mainly on service delivery. Management were identified as the main culprits and the Head of the Prison Service forced to resign. The opposition also used backward mapping but identified the origins of the failure in the policy initiative itself, thus seeking to lay primary blame with the Minister. The Minister used a forward-mapping approach to go from policy intention to implementation, thus thrusting the blame back on the officials (1996: 12) .

Another weakness of a purely retrospective and sequential analysis of policy fiascos is that while everything seems clear with hindsight, the analysis frequently fails to take full account of the real difficulty of identifying warning signs when many items may have been competing for the time and attention of senior officials. According to Starbuck & Milliken (1988: 38), 'people seem to see past events as much more rationally ordered than current or future events, because retrospective sensemaking erases many of the factors that complicate and obscure the present and future'. The rational, sequential, and retrospective approaches adopted by Inquiries tend to 'edit out' context as background noise, and foreground action and agency.

Such a framing of events emphasises the individual decision makers. Inquiry reports attempt to provide a rational and coherent analysis and 'are interesting attempts to present a univocal and coherent view on what are generally acknowledged to be complex and uncertain events' (Brown 2000 : 96). There is the additional problem, in the case of some policy fiascos at least, that there may be multiple investigations and inquiries. However, far from providing a deeper or more effective analysis to support learning,

'multiple investigations making different and sometimes conflicting recommendations can inhibit learning' (Boin et al. 2005:11).

However the rational and authoritative tone typically adopted in Inquiry Reports cannot disguise the fact that they are just another interpretation of events, and not a statement of uncontested fact: 'public inquiries are officially sanctioned interpreters of the meaning of the state in society.' (Brown 2000: 19). As noted earlier, Inquiries tend to focus on the formalized processes within organization while often ignoring non-canonical practice. This, together with the real differences in the interpretation of causes, context, and even the fact of failure among various stakeholders, makes the exclusive use of an objective, rational analysis a flimsy basis for understanding the process of learning in the aftermath of policy fiasco. My view is that in order to better understand learning from policy fiasco we must understand the processes by which managers develop those cognitive schema that represent their 'map of reality' and their basis for future behaviour and action. . Therefore we turn our attention now to establishing how interpretation and sensemaking may contribute to better understanding this learning process.

The Role of senior managers in interpreting policy fiasco

The process by which senior managers interpret and learn from policy fiasco is little understood and is not dealt with in any systematic or formal way in the literature. As already noted, policy fiascos are highly political phenomena and retrospective explanations of failure are frequently as much about power as about rationality: 'in the post-event legitimation phase, the social construction of reality is often achieved by looking through the 'lens of the powerful' (Elliott & Smith 2000:43). This suggests that senior public sector managers have a particularly important role in interpreting policy fiascos on behalf of their organization and the system more generally, and in influencing the learning outcomes.

Indeed many authors have argued the critical role of senior managers in interpreting change on behalf of their organization, and translating these interpretations into new ways of working. For example, Heclo (1977: 25)

argued that the key group of people who influence change are those 'top executives who have access to information, ideas, and positions outside the normal run of organizational actors'. Maitlis (2005: 36) also referred to the important role of Chief Executives in creating narratives for their organization, not only making sense of events but also 'giving sense'. Senge (1990) has emphasised the role of senior managers as interpreters of learning for the organization as a whole, and that new learning occurs as a result of a dynamic interplay and exchange of ideas within a community of practice. So there is significant evidence that senior managers have a particularly critical role in interpreting events on behalf of their organization and in helping the organization learn.

In the politically charged and confused aftermath of policy fiasco, the interpretative role of top civil servants is even more critical. They must make sense of a complex and confusing experience, and 'give sense' that establishes the basis for action:

> 'The CEO occupies a prominent place and following a crisis is frequently called on to explain and interpret what happened. The CEO begins to construct a singular and coherent organizational discourse that contributes to the development of a new shared meaning' (Seeger et al., 1998: 240).

Their interpretation is critical in determining what becomes the 'civil service' view of events. How then do senior civil servants interpret events, and how do they draw lessons from experience?

The Process of Interpretation

As noted earlier, this is a process that is little understood and has been neglected in the literature. Kearney and Kaplan (1997: 205) noted that there have only been 'limited attempts to link top management mental models to strategic choice and action in the face of dynamic, discontinuous events'. From the perspective of learning theory, constructivism offers some useful insights for this study. Constructivism assumes the social construction of reality, unlike behaviourist approaches that assume an objective reality. Von Glasersfeld (1995: 14) argued that: 'from a constructivist perspective,

learning is not a stimulus-response phenomenon. It requires self-regulation and the building of conceptual structures through reflection and abstraction'. Constructivism assumes knowledge to be subjective and organized according to experience:

> Organizational realities are not external to human consciousness, out there waiting to be recorded. Instead the world as humans know it is constituted intersubjectively. The facts of this world are things made. They are neither subjective nor objective in the usual sense (Brown, 2000: 48).

From an ontological and epistemological perspective, constructivist theory provides a useful basis for understanding the process of interpretation and learning in the wake of policy fiasco. It is aligned with the view that organizational learning is fundamentally related to how organizational members, and in particular senior managers, interpret critical events. Knowledge is not organized on a rational basis for distribution to passive learners, but rather the learner actively makes sense of his world through engagement with it. Senior civil servants retrospectively construct a theory of policy fiasco because 'every managerial act rests upon assumptions about what has happened and conjectures about what will happen: that is to say it rests on theory' (Gill & Johnson 1991:34). Constructivism is particularly relevant to this study insofar as it helps us understand how managers create theories of policy fiasco, and I shall draw on this perspective when developing the methodology for the study. Yet the process of interpreting policy fiascos is still more complex than this would suggest. It is part subjective and based on experience, and part socially constructed, the result of an ongoing engagement with public inquiries, peers, politicians, and the media. It is therefore to the theory of sensemaking that we next turn to further deepen our understanding of these processes.

Sensemaking

As noted earlier, in this study sensemaking theory provides a particularly useful basis for accessing the cognitive maps developed by senior managers in the aftermath of policy fiasco, and exploring the role of personal,

organizational and societal-level phenomena in informing interpretation, and also for exploring the links between individual and organizational learning. Sensemaking is a concept that is similar to, and frequently conflated with, interpretation. Boland and Yoo (2002) contrasted sensemaking with the traditional, rational model of decision-making where managers process information, evaluate options, and select a response:

> Sensemaking turns this view of the manager on its head. Most of the time managers are confronted by an environment they do not understand clearly enough to know the alternatives, or to decide among them. Sensemaking, not decision-making, is the primary way that managers spend their time. (Boland & Yoo 2002:2).

Sensemaking is literally about making sense of what is happening or what has happened, and is frequently occasioned by incidents or events that are out of the ordinary and that 'violate perceptual frameworks' (Starbuck & Milliken 1988: 52). Schwandt (2005) proposed sensemaking as another orientation to adult learning to be added to behaviourism, cognitivism, and constructivism, and suggested that it incorporates elements of all of these.

A number of studies have been conducted into the process of interpretation by senior managers using a sensemaking methodology. These include the work of Mezias and Starbuck (1996) on the perceptual filters used by senior executives in interpreting events; Coopey et al (1997) on innovation as sensemaking; and Parry (2003) on executive sensemaking in the NHS. There has been a more limited, but still relevant, application of the sensemaking methodology to understanding disasters and crises. These include Weick (1993) on the 'collapse of sensemaking' in the Mann Gulch Disaster, and Gephardt (1984) on sensemaking in the wake of environmental disasters. Sensemaking is particularly relevant to understanding the interpretation of, and learning from, policy fiascos given the inadequacy of positivist approaches: 'the sensemaking construct has added an interpretative dimension to a field in the grasp of rational models' (Schwandt 2005: 183). However despite its obvious potential, sensemaking has not been applied specifically to researching managerial interpretation of, and learning from,

policy fiasco. However, there are a number of properties of sensemaking proposed by Weick (1995) that are highly relevant to this study.

Selective Attention

From a sensemaking perspective, managers only attend to certain cues from among many, perceive reality through an interpretative lens, and create new meaning from these events. Sensemaking theory refers to the 'construction and bracketing of the cues that are to be interpreted' (Weick 1995: 25). Senior managers must therefore make choices about which elements or aspects of events get 'noticed' or foregrounded, and subsequently woven into their theory of what happened and why. Selective interpretation is common in the wake of policy fiascos. As previously noted, various stakeholders may simply take from an official inquiry what suits their purpose: 'crisis inquiries and their outcomes are subject to different interpretations and are fought over by different interests for their own purposes' (Boin et al., 2005:11). This selective interpretation can reflect an unwillingness to face up to unpalatable facts, or simply be a device to avoid blame and ensure that the responsibility for follow-up action lies elsewhere. Selective interpretation is more likely in situations where the facts are disputed, the sequence of events is complex, and the trail of evidence difficult to follow. Gephardt (1984) provided a colourful example of claim and counter-claim in the aftermath of the blow-out at Union oil sites in Santa Barbara in 1968:

> The Corporation estimated the leak was 500 barrels per day; environmentalists claimed a figure 10 times this amount. Residents asserted that the oil was creating a dead sea that had killed hundreds of seals and sea lions. Union Oil responded that the sea lions were only sleeping (1984: 206).

But still other aspects of sensemaking are relevant to understanding how policy fiascos are interpreted

Social aspects of Sensemaking

The construction of a narrative of policy fiasco is strongly related to social aspects of sensemaking. Managers typically interact with each other in trying

to make sense of policy fiasco, and the results of this interaction is reflected in their theory of what happened and why, or what Argyris (1980: 12) described as the 'maps people have in their head'. The social aspect of sensemaking is particularly relevant to this study because we are interested in how senior managers interpret fiascos that have happened in other organizations within the same sector, and learn from them.

The extent to which there is a shared, collective interpretation at the top management level is a critical determinant of follow-up action at sectoral level: 'change is blocked unless all of the major decision makers learn together, come to share beliefs and goals, and are committed to take the action necessary for change' (Stata 1989: 64). While it is clear that a degree of consensus is critical to formulating a coherent and consistent sectoral response, Stern (1997: 80) also cautioned that 'excessive conformity and insufficient diversity of analytical perspectives can seriously undermine attempts at learning from, and acting upon, the experience of crisis'. In this study, establishing the extent to which there is a shared interpretation of events surrounding policy fiasco is important to understanding the process of learning in their aftermath.

The Relevance of Time

Time is another aspect of sensemaking that is relevant to this study. There are many 'moments' that make up a policy fiasco. There are the events themselves, the public inquiry, the evidence of witnesses and experts, the publication of a report, the pronouncements of politicians, and the reporting of events by the media. We noted earlier that in the immediate aftermath of policy fiasco there is huge pressure on those in charge to act and act quickly, and to be seen to stabilize the system and satisfy the public demand for accountability. We have also noted that this immediate aftermath provides a window of opportunity for action, but that as time passes the incentive and pressure to act reduces. The passage of time may lead to a more considered reflection on events, but may also constrain the potential for meaningful follow-up action. It is therefore relevant to consider how time impacts on the

process of interpreting policy fiasco and how 'people chop moments out of continuous flows' (Weick 1995: 43) to create a theory of what occurred.

Sensemaking, Identity, and Enactment

Sensemaking is also grounded in who we are, our past experience, our style, and how we wish to be seen by others. The experience, interests, talents, and style of managers may influence not only how they interpret fiascos, but also how that interpretation may influence their future approach. According to Boland and Yoo (2002: 2) environment 'continues to be changed by a managers own actions'. Weick (1998) provided compelling evidence that management enactment of their future environment contributed to creating the conditions that led to the Union Carbide disaster at Bhopal. The interpretation of longer-term consequences, while not as specific or action-oriented as 'lessons', can provide important clues to how senior managers interpret changes in their environment, and through this process contribute to the creation of that environment. Czarniawsaka (1998: 20) captured this well: 'every novel contains a potential script; every narrative waits to be enacted. Organizational narratives are both inscriptions of past performances and scripts, and staging instructions for future performances'.

Sensemaking theory provides us with a detailed set of concepts that we can use to analyse the processes of interpretation and learning in the wake of policy fiasco. These concepts provide the basis for developing an analytical framework to facilitate such an analysis. However sensemaking does not explicitly deal with the processes whereby managers learn from events that happen in other organizations. To date there has been little research into such analogic learning, and none specifically in the area of policy fiasco. However there are some relevant conclusions from research into learning from policy transfer. Because in this study we are particularly interested in understanding how senior civil servants learn from adverse events that happen in other organizations, we need therefore to complement the sensemaking concepts, and sharpen the analytical focus, by considering the theory of lesson-drawing

Lesson-Drawing

In the field of policy learning the concept of lesson-drawing has become well-established through the work of Rose (1993), Sabatier (1988), and Stone (1999). It describes how public policymakers draw on the experience of other organizations, and typically organizations in other countries, to draw lessons about what works and does not work in the field of policy, and then apply this learning in their own organizations. Very often it is the experience of failure that provides the trigger for lesson-drawing:

> When one's organization faces a problem common to many agencies, this is a stimulus to examine how others are responding. Generalization from experience is the essence of unselfconscious lesson drawing. (Rose 1993: 5)

The process of lesson drawing, while evidence- based, is not purely scientific and involves interpretation. For example, Stern (1997: 80) argued that there may be a tendency to 'dismiss the failure of others when in an optimistic frame of mind, by focusing on real or imagined differences between one's self and the other'.

Lessons may be drawn across space and time (Rose 1993). They are drawn across space when experience or practice in other organizations, possibly in other countries, is used to modify practice within ones own organization. Lessons may also be drawn across time by looking to events that have happened in the past as the basis for learning. However, whether this is the 'near' or the 'distant' past is relevant, particularly given the possibility that circumstances may well have changed in the meantime.

What is particularly useful is the way in which the theory of lesson drawing helps to formalize the connections between interpretation and learning. According to Rose (1993: 16) there are normally four stages involved in lesson-drawing: searching experience for programs of action that appear to have brought satisfaction elsewhere; abstract a cause and effect model from what is observed; create a new program of action based on what has been

observed; evaluate prospectively about what the consequences of adopting the program of action will be.

By combining the theories of sensemaking and lesson-drawing with our knowledge of the complex concept of policy fiasco developed in Chapter 2, I now propose a theoretical framework not only for understanding how senior managers interpret policy fiasco, but also for understanding how that interpretation determines both the immediate lessons that are drawn, and the longer-term learning outcomes.

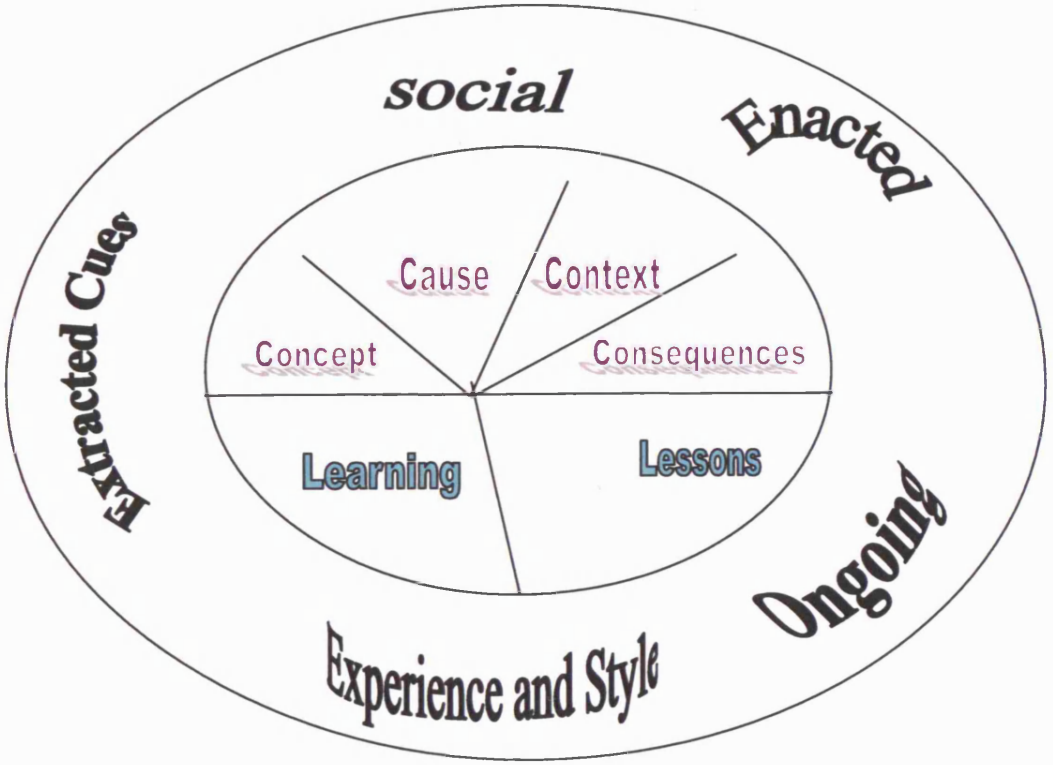
Theoretical Framework

The framework developed on the basis of the literature review provided a guide for interviews, a means of organizing data collection, of conceptualising the process of interpretation and learning, and guiding the development of a template for the coding and analysis of data. As noted earlier, understanding the process of interpretation and learning from policy fiasco involves understanding both the 'what' and the 'how', the process and content of learning. The inner segments of the framework presented at Figure 1.1 below describe a cognitive model of policy fiasco based on existing theory and research, and the key components are the concept itself; the causes of fiasco; the context; and the consequences or implications of fiasco. This part of the framework is based on the evidence presented in Chapter 2 that policy fiascos are commonly represented in terms of the nature of the fiasco, its causes, context, and consequences. Together these represent a basis for understanding the cognitive schema developed by individual managers. This is a model that describes how we organize our understanding of what happened and why, and represents the content of interpretation.

However, in this research 'what' questions are also closely related to 'how' questions because we need to understand not only the content of interpretation, but also the process. Blaikie (2000) has argued that within the qualitative research paradigm answering 'how' is built on previous answers to 'what' and 'why' questions (2000: 123). Therefore in the theoretical model I

have also developed an outer layer to represent the 'how', or the process of interpretation. This is based on the review of the literature presented earlier in this Chapter. The outer layer is based largely on the theory of sensemaking developed by Weick (1995). Why is this useful? Both Senge (1990) and Huff & Schwenk (1990) described how understanding the sensemaking process involves learning about the 'mental models' that the key actors have about events. In particular, Senge (1990) noted that the mental models that different actors have of the same events will frequently differ and that mental models are rarely explicit, but formed tacitly. The research process therefore involves bringing these mental models to the surface and making them explicit. Studies on sensemaking have helped us understand how people structure their worlds (see for example Ring & Rands, 1989). In creating narratives of policy fiasco, there is evidence to suggest that top managers attempt 'to make the unexpected expectable' (Robinnson, 1981: 60) and this allows them to enact a new reality.

Figure 1.1



While the inner circle of the model helps us to understand and make explicit the cognitive maps developed by these managers to interpret, and draw

lessons from, policy fiasco, the outer layer of the model describes the processes associated with interpretation and learning.

We noted earlier that the sensemaking model, through concepts such as 'extracting cues', 'identity' (in my framework modified to 'experience and style'), and the inner components that describe the content of learning, allow us to access the individual processes of learning. However a number of other components of the framework allow for the exploration of the links between the individual interpretation and organizational and societal level processes. Two in particular, 'enactment' and 'social', are worth discussing here in a little more detail

Weick (1995: 30) described enactment as 'preserving the fact that in organizational life people often produce part of the environment they face'. *Enactment* is related to learning insofar as learning is given expression through changed attitudes arising from the way in which the consequences of policy fiasco are interpreted. This is learning at a deeper level than what might simply be described as 'lessons'. Interviewees may, for example, indicate that their attitudes and beliefs have changed, perhaps even in a negative way, and these changes now impact on their approaches to other unrelated situations. In the framework therefore enactment is closely linked to learning through the concept of 'consequences'.

The notion that sensemaking is at least a partly *social* is generally recognized in the literature. In organizations CEOs will make sense of events at least partly in conjunction with others. They will interact with other people in their own organization and in other organizations. What is of particular interest in this study is the extent to which the group of Secretaries General make sense of the events by talking to each other. The group of Secretaries General could be described as a loosely knit professional community. The extent to which they perceive themselves as a group that collectively interprets and draws lessons from events is most interesting.

We have noted that time is an important factor in policy fiascos. Have the views of participants changed over time? *Cues* are extracted, according to Weick (2005), for their capacity to enable action, not because they are 'right' or 'true'. What then are the cues extracted by these civil servants in the aftermath of policy fiasco, and from where are they extracted? Through the development of this relatively simple model, I had a rich basis for exploring the content and process of interpretation and learning from policy fiasco.

Details of the use of this theoretical framework within the research methodology and in particular its links to other methods used in this study are presented in Chapter 4.

Conclusions

In this Chapter I have explored the research to date on learning from failure and policy fiasco, and in particular the critical role of managerial sensemaking and interpretation. We have seen that there are real barriers to learning from failure, not least because of the stigma attached to discussing it openly in organizations. Learning from policy fiasco in the public sector is even more problematical because of their contested and political nature, and the need to be seen to 'restore order' quickly in their aftermath. Senior public servants operate in an increasingly ambiguous and crowded space. The public expects the public service to manage risk on their behalf, but with the minimum of regulation. Despite the new emphasis on accountability it is still exceedingly difficult to define agreed measures of success and failure when it comes to issues of public policy. There are frequently widely diverging views on whether there was a failure in the first place, and if there was, what were its causes and consequences. This is related to the differing expectations and objectives of different stakeholders, attempts to avoid or shift blame, and attempts to score political points when increasingly political debate is about competency to deliver rather than policy positions.

In my review of the literature I found that the process of learning from policy fiascos is little understood, even though the consequences are frequently grave. Although public inquiries serve a purpose by appearing to re-assert

the legitimacy of government, the processes typically adopted by public inquiries are inadequate for learning because they adopt an overly simplistic and rational perspective. The interpretation of policy fiascos is not a purely rational process, and yet official inquiries bestow a sort of retrospective rationality on these events. My thesis is that in the aftermath of policy fiasco learning within organizations is constructed, and senior managers, particularly the Chief Executive, play a critical role in this. It is not nearly sufficient to rely on an organizational-level analysis that ignores informal learning and individual sensemaking. It is therefore to the informal processes of interpretation and sensemaking used by senior managers that we must look in order to add to our store of knowledge about how top management understands policy fiascos, and how organizations learn from them.

On this basis I presented a theoretical framework that provides an approach to understanding both the process and content of learning in the aftermath of policy fiasco. The inner segments of the model represent the elements of the cognitive schema of events developed by managers, and the outer segments represent the processes by which interpretation and learning occur. This framework is integrated within the overall research methodology in the next chapter.

It is in the interests of shedding light on this process, of which we are currently largely ignorant, that I now turn to our research methodology. Consistent with the thesis that meaning is constructed and reality interpreted differently by different stakeholders in the aftermath of policy fiascos, the research methodology will be based on a theoretical framework that facilitates the deepening, and refinement, of our understanding of the interpretative process by top managers, and the implications of this for understanding the process of learning from these events.

Chapter 4

Developing a methodology for understanding the interpretation of, and learning from, policy fiascos

Introduction

In this Chapter I set out in detail the research strategy and methods used, including the rationale for the approach adopted, and some of the ethical issues that arose.
To briefly recap the research question is

'How do top civil service managers interpret policy fiascos, and how does this contribute to our understanding of learning in the aftermath of such fiascos?'

There are two elements to this question. The first 'how' part relates both to the content and process of interpretation, and therefore an analysis of both process and content is necessary to achieving a deeper understanding of how managers interpret policy fiascos. I address the second part of the question by using the analysis of the data to identify the implications for our understanding of the process of learning. I seek to answer the question by addressing the following issues which are derived from the survey of existing literature and research in Chapters 2 and 3, including some of the gaps in knowledge identified.

With regard to the content of interpretation:
How do Secretaries General interpret the concept of policy fiasco? Do they equate policy fiasco with failure?
What do they interpret the causes of policy fiasco to have been? Are these the same or different to the causes identified by the official inquiry?

What do they interpret the relevance of context to be, and what aspects of context are deemed most important to policy fiascos?
What do they interpret the consequences and the lessons of policy fiasco to be?
What are the implications of the answers to the above questions for the process of learning from policy fiasco?

With regard to the process of interpretation:
Which are the sources that the Secretaries General look to when they seek to make sense of policy fiascos?
What aspects of policy fiasco particularly get noticed by them and why?
To what extent is the interpretation of policy fiascos a collective and/or social process and to what extent an individual process?
What role does time play in the process of learning from policy fiasco?
What role, if any, does the past experience, style, and interests of Secretaries General play in their interpretation of policy fiascos?
What are the implications of the answers to these questions for understanding the process of interpretation of policy fiascos by senior civil servants and the process of learning from these events?

I begin by setting out the overall research strategy, including the epistemological and ontological assumptions upon which the strategy is based. This is an interpretative study within the overall tradition of qualitative research. As such it is important that the researcher clarifies his position in relation to the research project, and this I do, and also describe how my interest in this particular area developed. A case study approach was used and some of the strengths and weaknesses of case studies in the context of the current study are discussed, as well as how I sought to overcome other potential weaknesses in the methodology. I describe how I developed a theoretical framework based on current theory in a number of different areas, and how this provided the basis for guiding the research effort, structuring the interviews, and developing a template for coding the data. Template analysis was used to support the theoretical framework. I also set out details of the interview strategy, and the basis for some of the decisions made in that

regard. Finally I also deal with some ethical issues that arose, particularly in relation to the sensitivities of interviewees about discussing the case, and the issue of confidentiality.

Developing the Research Strategy

As indicated in Chapters 2 and 3, a review of the literature revealed little by way of previous research into the process of interpretation and learning in the wake of policy fiasco. This was a little surprising given the ubiquity of such events in mature democracies, and the emphasis that governments typically put on learning lessons from these events. Much of the research that has been done has tended to focus on the 'before' and 'during' stages of fiasco, but with little focus on the aftermath. Commenting on the general lack of research into the process of learning from failure in organizations, March & Olsen (1975: 160) noted that 'this process requires some ideas about the imputation of meaning and structure to events. Such ideas have had little role in the organizational literature'. There has been some research into the process of lesson-drawing and how it works in practice, but as noted earlier, this research has almost exclusively related to policy learning in an international context, and has generally has been based on secondary sources. For example, Dekker and Hansen (2004) conducted a study into the effects of politicisation on the process of lesson-drawing from crisis using a two-case study approach. Their methodology was based entirely on document analysis. However some of their conclusions are of relevance to the current study. For example, they noted a difference in the nature of learning between the two cases 'which remains a matter of speculation', although they hypothesised that the relative weight attached to the public inquiry reports in each case was probably a significant factor (Dekker & Hansen 2004: 221). They also noted that the content of learning changed over time. These insights provided further motivation for the study, including some ideas for the development of a theoretical framework.

In developing the research strategy, I was influenced by the approaches adopted by a number of researchers working in the fields of sensemaking and learning, including Parry's (2003) phenomenological case study-based

research into sensemaking by senior executives in the NHS; Coopey et al's (1997) study of interpretation and sensemaking in the IT industry; and by Schwandt (2005), Weick (1995), and Milliken & Starbuck (1988) on the connections between learning and sensemaking. Schwandt (2005) developed the interesting argument that executive sensemaking, insofar as it operates through established cognitive frameworks, may even inhibit learning. I was particularly influenced by the qualitative approach adopted by Reynolds and Toft (1994) in their study of behaviour in crisis situations. They advised that in selecting a methodology 'there is no need to search for orthodoxy: the format chosen is likely to be one which fits both the investigator and the kind of problem under scrutiny' (Reynolds & Toft 1994: 200).

This body of work, together with the review of the literature on policy fiascos and learning from policy fiasco, convinced me of the value of exploring the process of interpretation in the aftermath of policy fiascos from a sensemaking perspective, and linking this to learning through the theory of lesson-drawing. In this way I could introduce an interpretative approach to a field of study that has been in the grasp of rational models.

Situating myself in the research project

A number of authors have emphasised the value and importance of the researcher clarifying his or her own position with regard to the research project (see Riesman 1993). Addressing the issue of reflexivity is particularly important when adopting an interpretative approach. Reflexivity recognises the impossibility of remaining totally outside the subject matter while conducting research. Reflexivity then urges us "to explore the ways in which a researcher's involvement with a particular study influences, acts upon and informs such research" (Cromby & Nightingale 1999:18). Therefore it is appropriate, before setting out the methodology in detail, to give some background on how my own thinking developed in relation to the chosen research topic, and how this subsequently guided the design of the methodology.

As mentioned in the introduction, I was initially attracted to this research topic by a series of high profile policy fiascos in Irish public administration over the past decade. For example, recent years have seen the introduction and subsequent withdrawal of e-Voting machines for local and national elections; the costly failure and subsequent deferral of a HR and payroll computer system in the Irish health sector; the fall of a government over the loss of a file in the Office of the Attorney General relating to prosecution proceedings against a paedophile priest; the voiding of a number of legal judgments due to the failure by the Department of Justice to de-list a serving judge at his mandatory retirement date; and, the guiding case study for this research, the illegal charging by the State for long-term institutional care in health board which resulted in a bill to the taxpayer of €2bn and the removal from office of a senior civil servant. There have been many more such cases, including a number that came to prominence during the course of this study. For me the study represented 'an expression of curiosity of the other, about people who construct their worlds differently from the way I construct mine' (Czarniawska 1998: 21).

In the course of my work with senior public servants, I was struck by the extent to which these policy fiascos caused upset, shock, and demotivation within the ranks of the public service. In many of these cases it seemed to be the case that familiar, 'tried and trusted' approaches had been found wanting. Senior public servants clearly struggled to make sense of these adverse events and the negative publicity that surrounded them. As previously noted, the response to such events was often characterised by defensiveness. The media played a major role in publicising the policy fiascos, and in many cases named and blamed individual public servants in news reports. Senior public servants privately indicated that in such cases they were conflicted between on the one hand their loyalty to government and Minister, and on the other hand their wish to defend the public service against what they regarded as a misrepresentation of the facts.

I was also intrigued by the ritualistic nature of the response to policy fiascos. There was typically extensive media coverage, public commentary by

various experts, heated debate in parliament, and the establishment of an official inquiry to investigate the circumstances that led to the fiasco. Yet once the inquiry had reported, and recorded the 'lessons to be learned', the fiasco was effectively over. On some of these occasions the resignation of key figures was also an outcome of the process. I noted that despite the public outcry and media attention, there was little formal discussion or dialogue within the public service about the events and the opportunities that they might present for learning. I was also struck by the many different and contested interpretations of the same set of events. I was intrigued by the frequency with which similar problems subsequently arose in other organizations, and this seemed to indicate that little or nothing was being learned within the system as a whole from past fiascos. This led to my initial interest in the process of learning from policy fiascos, but my observations of these events over many years and my subsequent review of the literature significantly influenced my ontological and epistemological perspective.

As previously noted, much of the research into policy fiasco and learning from failure has adopted a rationalist and realist perspective. While the overall tone and approach of this work rang familiar, it did not fit with my observation of contested and conflicting interpretations in a complex political and administrative environment. When I came across the work of Bovens and 'tHart (1996) on policy fiasco it helped to confirm and formalize my understanding of these negative events in the public sector. However even in this work little attention was paid to the process of learning from such events, even though the drawing of relevant lessons typically features prominently in the reports of Inquiries. I directly contacted both Mark Bovens and Paul 'tHart who confirmed a gap in the research in this area, referred me to other relevant research, and put me in contact with other researchers doing work in this area. This gave me greater confidence in some of my initial 'hunches'.

Perhaps because of my own role as a practitioner, I had for some time been influenced by the call from Argyris and Schon (1978) for research that links theory and practice. While achieving a better understanding of how top civil

servants interpret policy fiascos and the implications of this for learning both interested me intellectually and seemed to address an important theoretical gap, it also served a practical purpose. The evidence suggested that in Ireland and elsewhere mistakes were being repeated, and the lessons of previous policy fiascos were not being learnt. The cadre of top management in the civil service was critical to the process because of their pivotal role as interpreters of events. Weick (1988) used the analogy of cartography to explain how senior managers use a variety of mental maps to explain reality. Different managers have different maps, and the maps of others are compared with our own 'as we try to carve out a momentary stability in a continuous flow' (Weick 1998: 201). I was interested from a theoretical and practical point of view to understand how these senior public servants constructed mental maps in the post-policy fiasco phase, to what extent their maps overlapped or diverged, and how they contributed to the process of drawing lessons from fiasco. I identified the theory of lesson-drawing as being particularly useful for analysing the links between sensemaking and learning from policy fiasco.

Therefore my worldview had developed over some time through a combination of workplace interactions with key participants in policy fiascos, through my own sensemaking and reflection on specific cases, and through my interrogation of relevant literature and research. This led me to the conclusion that in the social world we interpret and enact our reality in an ongoing cycle of reflection and creation, and that as social researchers it is necessary for us to achieve a greater understanding of this process as it applies to particular phenomena.

Research Strategy

An abductive research strategy was employed whereby

> The starting point is the social world of the actors being investigated; their construction of reality; their way of conceptualising and giving meaning to their social world; their tacit knowledge (Blaikie 2000: 25).

This research strategy comes firmly within the qualitative research paradigm. Denzin and Lincoln (1994) defined qualitative research as 'involving an interpretative, naturalistic approach to its subject matter. Qualitative researchers study things in their natural setting, attempting to make sense of or interpret phenomena in terms of the meanings people bring to them' (1994: 15). Qualitative research places a greater emphasis than do quantitative approaches on the richness and diversity of individual human experience. In this research project my premise was that in order to better understand learning in the aftermath of policy fiasco, we must understand how key managers who interpret events on behalf of their organizations and the system as a whole make sense of the events. Achieving a greater understanding of this process requires an interpretative approach. Bovens and 'tHart (1996) noted that

> An interpretative approach is well suited to the research of policy fiasco. In performing such an analysis we may lose deductive rigour and parsimony but gain understanding of how the principal actors interpreted and re-interpreted the evolving situation, and the behavioural imperatives that flowed from such interpretation (1996: 151).

However by leaving all to interpretation we run the risk of being left with a mass of undifferentiated data that leaves us asking, 'so what?' It is the researcher's role to make sense of and interpret what he or she finds, always in the knowledge that this too is interpretation and not 'truth'. Reynolds and Toft (1994) argued that

> We are obliged to categorise to some degree the events and phenomena which we encounter in the world if we are to bring any order to our experience. To make it possible to learn from them and to avoid the madness of total unpredictability, we have to typify or construct general classifications (1994: 196).

This point is particularly pertinent to the study of policy fiascos, which of themselves are unpredictable. The research strategy adopted in this study

was consistent with a relativist ontology and a constructivist epistemology. There is no objective unitary reality out there to be observed and measured. Human actors based on their interpretation of the social world create meaning, and the researcher's role is to help make this process more explicit. For the purpose of guiding the research, and as described in the previous chapter, I developed a theoretical framework that combined existing theory of lesson drawing, policy fiasco, and sensemaking. A theoretical framework describes 'a set of ideas and principles taken from relevant fields of inquiry to structure a presentation' (Reichel & Ramey 1987). It is a tool to scaffold research (Smyth 2004). The model provided a theoretical perspective that guided the study. It provided a useful way of both linking back to relevant theory, and also to support analysis of the data and the presentation of findings. The link between theory and research is particularly important within an abductive research strategy. According to Blaikie (2000):

> The two are intimately intertwined: data and theoretical ideas are played off one against the other in a developmental and creative process. Research becomes a dialogue between data and theory mediated by the researcher (2000: 156).

This seemed useful particularly because I wished to combine theory from three separate areas so as to achieve a deeper understanding of the process of interpretation and learning from policy fiasco at senior levels. However while the theoretical framework seemed useful I was concerned that it should not blind me to other possibilities in the data.

In this regard, and in the face of the diversity and messiness of the social world, it is important that the researcher retains a tolerance for ambiguity (see Walsham 1993). One of the problems with combining elements of existing theory within a framework is that it can be a hindrance as well as a help, a way of 'not-seeing' as well as of 'seeing'. However, as argued by Walsham (1993: 71), 'a good framework should not be regarded as a rigid structure, but as a valuable guide to empirical research'. Parry (2003) described how in his research he sought to 'forget what he knew' in order to be true to the phenomenological approach. I regarded this as a somewhat

artificial stance and agreed with Blaikie (2000) when he stated that the social research process always involves some interplay between existing theory and the data. Indeed in hindsight Parry (2003) admitted the impossibility of maintaining such a stance in practice. I also wished, while adopting a rigorous and defensible research methodology, at the same time to engage in a fresh and vigorous way with the subject, and in such a way that 'the research method is not a slavish adherence to step by step instructions, but more an approach, an attitude, an investigative posture with a certain set of goals' (Keen 1975: 23).

A case study approach was used. While case study research may be conducted for a variety of purposes, one of the most common is to achieve a greater understanding of a phenomenon. Case studies have been used extensively in the research of policy fiascos and also in research into executive sensemaking. In this study the case study was used as revelatory, in order to illuminate the process of learning from policy fiasco. I sought through the use of a particularly strong and recent case to draw the interviewees into a wider discussion of policy fiascos, and to explore their interpretation of the particular case, but also invite more general observations on policy fiascos. The detailed approach is described below in the section on case study.

For the study I decided to interview the cohort of top civil servants in Ireland, the group of Secretaries General, and these interviews provided the primary source of data. Through using semi-structured interviews as the key data collection method I was interested in exploring sensemaking and lesson-drawing from policy fiasco at the most senior level. Not only the detail of the interviews, but the construction of the overall narrative of policy fiasco was important to developing my understanding of how these managers interpreted and drew lessons from the fiasco.

Finally, and for the purposes of data analysis, I used template analysis. While the theoretical framework provided guidance and a basis for linking data collection to previous research, I was not satisfied that such a

framework was sufficiently robust on its own to support disciplined analysis within the interpretative study. I therefore decided to use template analysis in support of the theoretical model to facilitate coding and analysis of the data. King (1998: 118) situated template analysis between content analysis with pre-determined codes, and grounded theory with no pre-determined code. This approach of using template analysis linked to a theoretical framework within a case study approach, constituted a coherent research strategy that was consistent with the ontological and epistemological position adopted. The strategy allowed sufficient flexibility to facilitate the desired interplay between existing theory and new data, and sought to avoid a theory-driven approach while still not forgetting the theory. There were, of course, weaknesses in the methodology that I sought to overcome, and these are dealt with in detail in the sections that follow.

Research Methods

Case Study Approach

As noted earlier, the literature on policy fiasco makes extensive use of case studies. Bovens and 'tHart (1996), Reynolds and Toft(1994), Gray and 'tHart (1996), Kaufman (1981), Etheredge (1985), Edmonson (1996) Boin and 'tHart (2003) have all used case studies to analyse different aspects of the phenomenon. There is also a tradition of using case studies in the research of sensemaking at managerial level, for example in the work of Brown (2000), Weick (1998), Parry (2003), and Coopey et al (1997). The case study approach is particularly well suited to the study of policy fiasco because according to Yin (1994 : 13), 'case studies involve empirical research that investigate a contemporary phenomenon within its real life context'. Policy fiascos represent contemporary phenomena where context is particularly important. Connaughton (2006) used a single case study based on the Long Stay Charges fiasco, which is also used as the case study in this research, as a basis for her research into the reform of politico-administrative relations in the Irish System. Yin (1994: 14) also noted that case studies are appropriate where 'the boundaries between phenomenon and context are not clearly evident'. Once again, a particularly distinctive aspect of the

phenomenon of policy fiasco is that it involves a dynamic and complex interplay between the events themselves and the context of those events.

Cresswell (1997) described a case study as a single, bounded entity, studied in detail, and using a variety of methods. The case study of policy fiasco is bounded by time. Policy fiasco commences with a set of events that are elevated by the public and the media to the status of 'crisis'. The circumstances that gave rise to the fiasco may have been in place for some time, but it is the sudden escalation of the events, typically triggered by a particular combination of circumstances, that marks the start of the policy fiasco. It is not so clear when the fiasco finishes. In a sense they never finish, and in certain cases the aftershocks are felt for many years afterwards. Evidence of this was provided by the architect Jorn Utzon (see Murray 2003), fired for his work on the Sydney Opera House, which at the time of its construction was widely regarded as a policy fiasco, only later to be celebrated as a triumph of creative design. He observed that the greatest damage done by the labelling of the project as a 'fiasco' was the number of innovative and creative design projects that were foregone for many years afterwards for fear of being similarly labelled (Murray 2003). However the media attention that is characteristic of policy fiascos usually only lasts until the publication of the report of the public inquiry, after which point the events tend to lose their political and human interest. So while it is more difficult to say when a policy fiasco ends, it is generally recognized in the literature that the detail of events only stays with the key stakeholders for a limited period of time, and that after this point the opportunity for learning will be limited.

Because I wished to use a case study that would still resonate in the minds of the senior managers to be interviewed, for this research I took a 12 -month period after the emergence of the fiasco as a key criterion for selection of the case. This decision had implications for the choice of case, and also raised certain ethical issues. However this choice was also made in the knowledge that an 'iconic' fiasco had happened just over 12 months before, one that reverberated through the whole of the Irish public service, and seemed to

have all the classic hallmarks of policy fiasco referred to in the literature. The case of illegal charging for nursing home care for the elderly under the policy of the Department of Health and Children, that emerged as a fiasco in early 2005, was clearly the major fiasco to have hit the Irish public service in recent years.

The very nature of policy fiascos is such that there are no identical cases. By definition they arise from some unique set of circumstances that were not foreseen. Therefore in choosing a case study it is not appropriate to try to identify a 'typical case', although it is necessary to identify a case that clearly comes within the definition of a 'policy fiasco'. The selected case represented a particularly strong example of policy fiasco, since it combined major media attention, very significant financial consequences, public outrage at the perceived mistreatment of a vulnerable group, heated political debate, and led to a public inquiry. In addition, it resulted in the removal from office of the Secretary General of the Department. The ethical issues raised by the choice of case are dealt with in more detail below. This leads us to the issue of generalisation of findings

Single case studies have drawbacks, particularly with regard to the difficulty of generalizing from a single case. However because I had adopted an interpretative, sensemaking approach I decided that the use of multiple cases would lead to a less-focused and in-depth approach because of the variety of circumstances, organizations, and time periods involved, and in practical terms would only allow for limited analysis because of the relatively short timeframe available for the study. However, while in the interviews I used the single selected case to structure and guide the discussion, I also invited more general observations on the phenomenon of policy fiasco within the Irish public service, including an invitation to specifically reference other policy fiascos at the discretion of the interviewee. This interview strategy was partly pragmatic because of the ethical issues arising, but proved useful in helping to tie the discussion of the specific case to more general points about policy fiascos. To some extent this strategy addressed the issue of generalisation from a single case, because in many instances the case in

question was used to illustrate more general points about policy fiasco, and in other cases the interviews dealt more generally with policy fiascos than with the specific case.

Yin (1994) has also argued that with single case study research the goal is to expand and generalize theories, 'analytical generalization', rather than 'statistical generalization'. Single case studies do not represent a problem with regard to generalization because 'a well-constructed single case is no longer singular' (Bourdieu, 1990: 57). The key to achieving analytical generalization is to develop a rich description supported by a reasonably sophisticated analysis, rather than simply to create something that can be replicated. If such an approach is adopted then, according to Denzin (1978), the possibilities for generalizing from even a single case are reasonably good. If the case, and its context, are well described, then the reader can decide how closely connected this case is to other similar situations.

Most importantly for this research, the primary purpose of the case study was to shed light on an area that has been neglected to date in the research, and in this respect the generation of data through a single case study for the purposes of illumination is valid. Flybjerg (2006: 219) argued that the criticism of single case studies because of the difficulty with generalisation represents a misunderstanding: "formal generalisation is over-valued as a source of scientific development whereas the "force of example" is underestimated'. The key group of interest in this project was the group of 17 top civil service managers, or Secretaries General, who are in charge of government ministries in Ireland. This is a group that individually and collectively deals with policy fiascos on an ongoing basis. The research objective was to further develop our understanding of the individual and collective interpretations by these key people so as to better understand the process of learning from such events. Therefore in this case the issue was not so much whether the findings could be generalized to other groups of senior managers, but rather how the research helps us understand how this critical group thinks and acts in relation to policy fiascos. In other words, access to this key senior group of civil servants in itself added significant value and

richness to the study. It is also of course important that the conclusions from the research can be tested in the case of other policy fiascos, and through this ongoing process further develops our understanding of learning from such events both in Ireland and elsewhere. This is in line with Stake's argument (1995) that as individuals come vicariously into contact with new cases, they have the opportunity to strengthen, modify, or reject generalizations from single case studies based on similar events.

The case study approach typically relies on the use of a variety of methods. Within the overall research question, I was interested in exploring the content of interpretation, the 'what?' However I was also interested in the 'how', the process of interpretation and learning from policy fiasco. I relied primarily on semi-structured interviews with the Secretaries General to answer both aspects of the question. While the interviews were the main pillar of the research strategy, the official reports of the inquiries, media reports, and witness statements to the Oireachtas Committee were also used. According to Yin (1994) documentary evidence is first and foremost a way of corroborating and augmenting evidence garnered from other sources. This was the spirit in which I analysed other relevant documentary evidence in the case. This supporting documentary analysis was primarily for the purpose of identifying the extent to which the interpretation of the fiasco was shared by the various groups including key individual witnesses, and more specifically to what extent the various groups and individuals agreed on the lessons to be drawn. Transcripts of witness evidence to the Oireachtas Inquiry were obtained, as was a copy of the report of the official Inquiry, and archived media reports were also retrieved. However, Hartley (1994: 152) observed with regard to the case study approach that without a theoretical framework the researcher is in danger of providing 'description without wider meaning''. Therefore a theoretical framework was developed to guide the research effort.

Interviews

Yin (2003: 89) regarded interviews as one of the most important sources of case study information. Of particular interest for this study, Rubin and Rubin (1995) argued that interviews allow for the modification of theories to fit

new situations, thus making the theory more generalizable. Devine and Heath (1999) argued that interviews are appropriate when the aim of the research is to explore people's experiences, and where context is important, because they allow the interviewee to place their attitudes and behaviours within a context (1999: 138). Given my argument that reality is cyclically interpreted and constructed by the social actors involved, interviews took on a singular importance as the primary means of accessing the interpretative and learning processes used by senior managers in the civil service to interpret policy fiasco. According to Becker (1970: 64) 'to understand the persons behavior we must understand how he perceives the situation.'

In keeping with the overall research strategy of attempting to strike a balance between utilising existing theories while staying open to finding something new, I used a semi-structured approach in the interviews. A short document was circulated to the interviewees about a week in advance of the interviews. This set out the background to, and purpose of, the research, some assurances about confidentiality, and the types of questions that I was interested in pursuing. The use of such an interview guide was important given the complex nature of the topic, the fact that the events of the case happened 12 months previously, and the fact that I was dealing with very busy people. I hoped that the guide would prompt some thinking about the issues prior to the interview. The interview guide generally followed the logic of the theoretical framework. Although the questions raised in the guide mainly related to the 'what' or content of interpretation, I also sought to prompt reflection on the more difficult question of how the interviewees went about interpreting the events, and how they drew the lessons that they did. This was in the knowledge that while such questions about process might elicit some useful information, that it was only by listening to the narratives and how they were constructed that I would discover most about this process. I piloted the guide and the interview process with two senior civil servants, and made some minor modifications as a result.

The interviews were scheduled to last between 60 and 90 minutes. I commenced the interviews with a reference to the background document,

and thereafter used the interview guide as an aide memoir. Given the fact that I was interviewing the top civil servants in the state, it was inappropriate to guide or prompt too much, so I allowed the narrative to develop and used the guide to summarise, or simply to remind me of areas that had not yet been covered. I had previously met all of the interviewees through my work. This not only helped with access, which otherwise I believe would have been much more difficult, but also allowed for a more relaxed atmosphere. However there were some important and sensitive issues that arose.

Ethical Issues

I was conscious when selecting the research topic that policy fiascos by definition are controversial, and bring into play complex issues about the operation of the public service, including the sensitive relationship between the political system and the public service. As we have already noted, the issues surrounding the events are frequently contested at political level. I was further conscious that in selecting the particular case study relating to Nursing Home charges, which led to the removal from office of one of their colleagues, I was potentially 'hitting a raw nerve' with the interviewees. However I had to balance this with selecting another case that may have had much less resonance, and much less potential for addressing the research question.

I sought to alleviate any concerns of interviewees by making clear that the research was confidential, that no subsequent paper would be published without their permission, and that individual contributions would be kept confidential by coding responses. Despite these assurances some interviewees rang me before the interview to seek some clarifications on the line of questioning that was to be adopted. In a small number of cases the interviewee indicated that they would not deal in detail with the LSC case, sometimes because they had played a central and confidential role in dealing with the issue. In such cases I gave an assurance that I would not ask specific questions about that case, but would invite them to refer to that case, or perhaps other cases, by way of illustrating certain points. While this level of sensitivity constituted something of an obstacle to more detailed questioning

about the particular case in a small number of interviews, there was a benefit insofar as in those cases it led to a wider discussion of policy fiascos, which could be compared and contrasted with the main case. I was also heartened by the fact that despite the sensitivity involved thirteen out of the seventeen Secretaries General agreed to be interviewed, four were unavailable for various reasons, nobody pulled out of the interviews, and those that had any difficulty with the topic were anxious to find a way of resolving it. This gave me re-assurance on the choice of research topic, which was regarded by all of the participants as being a worthwhile area of study that would be of practical benefit to the system.

While I was aware of the value of tape recording interviews (see for example Bryman, 2001), I knew that because of the sensitivity of the subject matter and the seniority of the people involved that this would not be possible in all cases. At the start of every interview I outlined the benefits of tape recording from a research perspective, and assured the interviewees that the recording would be destroyed following transcription. A small number refused, in which case detailed notes of the interview were taken.

An important point emerged from this reaction to the subject matter. This related to the level of sensitivity that still surrounded the policy fiasco even 12 months after it had happened, and the extent to which certain matters are regarded as 'undiscussable'. This is dealt with later, but has implications for the process of learning from such events, and is also a factor of which future researchers in this area need to be aware.

I was also conscious of my own role as an interviewee, and as somebody who was already known to most of the interviewers from my role within my organization. In one sense, as indicated above, this facilitated access and I believe was a factor in the high positive response rate to the request for interview. On the other hand I believe it may also have initially somewhat inhibited some interviewees, who would be aware of my organizations role as a commentator on public affairs. This is one of the main reasons that I put a strong emphasis on the fact that the interviews were confidential to the

researcher and the research process within a doctoral programme, and would not lead to any published work without prior clearance having been sought. Thirteen out of the seventeen Secretaries General contacted agreed to the request for interview. Two others indicated a willingness to be interviewed, but subsequently arrangements could not be made because of their absence on business. There were no replies from two others, one of whom would have been centrally involved in the affair and I interpreted this as an unwillingness to participate for confidentiality reasons.

Use of a Theoretical Framework

The theoretical framework I developed, and presented at the end of Chapter 3, described a model for understanding the process of interpreting and learning lessons from policy fiasco. The framework was based on the model of sensemaking developed by Weick and others, and of lesson-drawing developed by Rose (1993). In using this framework I was seeking not only to test elements of existing theory, but also to better understand the process of interpretation and learning from policy fiascos. The framework was sufficiently flexible to allow for the nuances of meaning to emerge from the data. The use of such a framework is in the tradition of a 'sensitising scheme', described by Reynolds and Toft (2004: 10) as 'loosely assembled congeries of concepts intended to sensitise and orient researchers to certain critical processes'. It is also in the tradition of developing a theoretical model as part of the research strategy that

> contains a rationale and a mechanism. The rationale is a point of view about the phenomenon, a way of looking at the social world, an organizing idea that comes from the mind of the researcher. The structure of the relationships between the concepts forms the mechanism of the model (Blaikie 2000: 169).

However there are a number of potential drawbacks to using a theoretical framework. Chief among these are the risk of limiting the investigation, of being sensitive to certain data and not others, and of limiting the conclusions of the research (Mason, 1996). However by being aware of these drawbacks, and by resisting the urge to develop too detailed a framework or using overly

strong rules when classifying, it was possible to retain some of the 'freshness' of the data, and to stay open to new ways of viewing the data. Therefore developing a framework not only guided and 'scaffolded' the research process, but also provided a flexible structure for data collection and analysis. Another important aspect of this study was to identify the extent to which an analysis of events and an approach to lesson drawing was shared by the various actors, and the extent to which their analysis aligned with official reports and media analysis. Such a comparative analysis also requires a framework.

While the framework was valuable for operationalizing the research, and using existing knowledge of policy fiasco and learning as a basis for answering the research question, it was not sufficient for the detailed coding and analysis of data. For this reason I supplemented and complemented the framework by using template analysis.

Template Analysis

I wished to find an approach to collating, coding, and analysing the data in a way that complemented the research methods described above and was consistent with the overall research strategy. In keeping with an abductive research strategy, and to maintain consistency with the theoretical framework, I chose template analysis. Template analysis allows the researcher to reflect the interplay between existing theory and data at the data analysis stage, and retains the flexibility and sensitivity to allow for unexpected findings. It allowed for the template to be aligned with the conceptual framework. To maintain flexibility and openness, high-level codes were assigned to most of the key themes included in the framework with a view to assigning lower-level codes during detailed data analysis. Coopey et al (1997) conducted a study of executive sensemaking related to innovation in the IT industry, and used predefined themes as the basis for interviews with senior executives in a number of firms. They then coded the interview data using template analysis to extend or modify the pre-defined themes.

Template analysis also allows for parallel coding, which was particularly useful in this piece of research. Parallel coding allows for 'the same segment of data to be classified within two or more different codes' (King 1994: 120). In particular this allowed for data to be classified as appropriate to the inner 'content' elements of the framework, but also to the outer 'process' elements. King (1994) suggested that a good place to start constructing the initial template is by reference to the interview topic guide. Since in this case the interview guide effectively mirrored the theoretical framework, it was used as the basis for developing the initial template. I did not have access to another researcher familiar with the data so was not able to get a second opinion on the template as recommended by King (1994). This was a weakness. However, I was able to test the template by analysing documentary evidence such as the report of the public inquiry and the evidence provided to the parliamentary committee, and to test the coding structure against this data. This helped me to confirm the high level codes I had selected but also to begin to identify some potential second-level codes. Template analysis also helps to address reflexivity in research by forcing the researcher to make explicit his/her decisions and choices about codes and the approach to analysis of the data.

There are disadvantages to the use of template analysis that are similar to the disadvantages of using a theoretical framework. There is a dearth of guidance on the application of this approach, with King (1994) being the main contributor. King (1994) has also pointed to the risk of developing overly simplistic or overly complex templates, and of the possibility that the voices of participants will be 'lost' in dense structure. However I was also conscious that template analysis was relatively straightforward, and was consistent with my use of a theoretical framework.

I sought to minimise the potential drawbacks by being conscious of them.

Development of the coding system, including identification of themes and sub-themes

Preliminary Work

As described in Chapter 4, template analysis involves the development of themes and a related coding system, where each code represents a theme or sub-theme. The identification of themes, and the coding of themes, facilitates the organization and subsequent analysis of data. However, as also noted earlier, there are drawbacks to the use of a theoretical framework, in particular the tendency for the researcher to limit the analysis by being sensitive towards certain aspects of the data and not towards others. With these potential drawbacks in mind, I adopted an approach to reviewing the data similar to that used by Reynolds and Toft (1994) in his research of the public inquiry into the Summerland disaster. I worked my way in detail, and in several iterations, through the transcripts of the interviews, and then through the official report into the inquiry, through media reports, and through the testimony of the key witnesses to the Oireachtas Committee. As I worked through the transcript data paragraph by paragraph, I labelled each idea on 'post-it' adhesive papers, together with their source paragraph. I ended up with over 300 separate 'post-its', all of which I posted on the walls of my study. I then began to group the 'post-its' under the themes of the theoretical framework.

This approach had several advantages. Firstly it provided me with a highly visual and flexible way of organizing and re-organizing the data. It facilitated the grouping of ideas under different themes and sub-themes, and subsequently re-arranging these as necessary. It made it easier to explore relationships between themes and sub-themes. It allowed me to develop a variety of 'maps', or ways of looking at the data, thus reducing the risk of being overly attached to one particular reading or interpretation. It helped me to familiarize myself with the data and 'get a feel' for the key issues. It allowed me to get a sense of how well the data fitted the framework, and the types of sub-themes that were emerging

Detailed work on coding structure

Through the process just described I developed a 'first cut' set of themes and sub-themes for the template, and a related coding structure, and applied this to the data from each interview. A simple embedded coding system was used, whereby each of the themes within the theoretical framework were assigned a code, and then sub-themes were assigned sub-codes within the overall code for that theme. The coding of data was 'parallel' to the extent that the data was reviewed against both the inner 'content' elements of the framework, and also the outer 'process' elements. While it has already been noted that the 'what' and 'how' elements are closely inter-related, where a particular theme or sub-theme seemed particularly pertinent to both then they were coded twice.

Since the semi-structured interviews were conducted using the broad headings in the framework, the interview data generally lent itself easily to the coding structure. I returned to this coding structure a number of times and revised it. One of the judgements I had to make was to identify sufficient sub-themes to reflect the granularity of the data, and yet not over-analyse and lose sight of the bigger picture. For example under the 'Cause' theme I initially identified a separate 'Legal' sub-theme, but on reflection I merged this with the sub-theme 'Administrative' because it allowed for a more sensible reading of the data. In some cases there were fewer ideas linked to a theme, for example 'Ongoing', and in those cases I did not seek to further separate the data into sub-themes. There were also judgements to be made about under which themes particular ideas should be coded, since there were a number of cases where they could be reasonably coded against more than one. While I had the option of coding ideas to more than one theme, and as earlier mentioned did some parallel coding against both the 'what' and 'how' sections of the framework, I judged that to do so extensively would lead to over-analysis and a confused presentation. Generally I was able to overcome this problem by simply replicating the labelled idea, and in that way ensuring that nothing important was lost to any code. This process of identifying and revising themes, sub-themes, and coding the ideas in the interview transcripts happened over several weeks. I found it useful to leave this part

of the work aside to concentrate on other aspects at certain times, and this allowed me to return to the data with a fresher perspective.

Some changes to the original template

It should be noted that while in general the overall themes were based on the theoretical framework presented above, the sub-themes were developed based on what emerged from the data. There were two significant changes made to the final template compared to the original theoretical framework. It was anticipated that a difference would be identified between 'Lessons' and 'Learning' with the former representing lessons drawn but perhaps not yet applied, and the latter representing lessons applied. In fact the data revealed that that the only lessons referred to by interviewees were ones already applied. The consequences of this are discussed in Chapter 6, but for the purposes of coding the two elements were collapsed under one code. Finally, a new theme emerged that had not been anticipated in the theoretical framework. This was 'Prevention' and related to the preventative strategies being employed by Departments on an ongoing basis and frequently cited as a reason why fiascos were avoided. 'Prevention' was therefore coded as a new theme.

The detailed coding structure that was devised, incorporating the headings from the theoretical framework, and associated codes, sub-themes and related sub-codes, is presented at Appendix 2.

I now turn to the presentation of the general organizational context, and specific details of the case study, that were used as the focus for this research study.

The Long Say Charges Case Study

In order to understand the case study it is necessary to start with a brief contextual description of the Irish system of administration

Irish Administrative System

The Irish system of administration has its origins in the British Westminster system (see Mac Carthaigh 2005). Ministers are responsible for government departments. There are currently sixteen government departments (including the Revenue Commissioners), and there is a Secretary General in charge of each Department, with two Secretaries General in the Department of Finance. The 1924 Ministers and Secretaries Act established the civil service accountability to Parliament, and established the principle that every decision of a Department was effectively the decision of the Minister. According to Connaughton (2006), in practice Departments operate for the most part on the basis of implicit delegation from the Minister to the Secretary General. However, as pointed by MacCarthaigh (2005:19), the doctrine of ministerial responsibility for all actions of his/her Department has led in practice to some confusion about the respective roles and responsibilities of Ministers and their Secretary General, and particularly as the machinery of state has grown more complex.

As part of the public sector reform process the Public Service Management Act 1997 was introduced to help clarify the respective roles, and sets out in some detail the managerial responsibilities of the Secretary General, and also the role of special political advisers. However as pointed out by MacCarthaigh (2005: 16) the Act 'concentrated on managerial and legal aspects of the relationship between the Secretary General and the Minister, as opposed to the political element'. While there may be greater legal clarity, there is still ambiguity and complexity in the practical operation of that relationship, and this has been seen perhaps most starkly in the case of policy fiascos. Some of these came to the fore in the Long Stay Charges Policy Fiasco. There follows a description of that main case study, the policy fiasco referred to as the Long Stay Charges (LSC) case.

Detailed Case Study Description

The policy fiasco that came to be known as the 'Long Stay Charges' or 'Travers' case, the latter after the name of the former public servant who was appointed to investigate the affair, came to a head in December 2004. This is a brief description of the case that sets out the chronology of events and elucidates the key issues of relevance in what was a very complex case.

Background

For over 50 years charges had been levied by the State, through the regional health boards, on people who were being provided with long-term care in institutions owned or operated by the State. Typically these were elderly people who required long-term residential care. The practice of levying such charges was based at least partly on a perceived principle of fairness that everybody receiving care should make some contribution towards the cost of that care based on their ability to pay. This principle was re-affirmed in the national health strategy of 2001: 'It is fair that all those in receipt of publicly provided residential long-term care should make some contribution towards accommodation and daily living costs, if they can afford to do so' (Department of Health 2001: 25). In the Irish health services the demand for resources outstrips the exchequer's ability to meet them, so an independent source of funding available through charging certain categories of people for long-stay care was closely guarded. This was particularly true of the period from 1970 to 1990, when the Irish economy was weak. The worst of this period was characterised by massive unemployment of over 20%, emigration, low growth rates, and high levels of government debt. By 2001 the income from long-stay charges represented 21% of the total cost of providing long-stay care in the State, and was therefore substantial.

The principle of charging for care was first enshrined in the Health Act 1970 and was applied to all, except those with full or limited eligibility to avail of long-term care free of charge. Full eligibility generally applied to all those over 70, while limited eligibility applied to those under 70 with medical cards. The conditions under which charges were made was further complicated by the distinction made between long-term residential care that was interpreted as 'non-medical', effectively shelter and maintenance in a

state institution for the elderly, and long-term care interpreted as requiring ongoing medical care. In the case of the former, everybody had to pay regardless of eligibility status, whereas in the case of the latter only those with limited eligibility had to pay.

The question of what constituted 'medical care', and therefore who should pay or not pay, was tested through the courts in respect of an individual case in 1975. The judgment of the High Court and Supreme Court in that case effectively interpreted the Act in such a way as to extend free services to the vast majority of those in long-term care, and was greeted with some alarm in the Department of Health and the health boards, who through this judgment saw the independent source of funding drying up at a time of severe budgetary difficulties. The Department therefore moved to 'rectify' the situation, and to restore the original charging mechanism by introducing an amending regulation. They did so with the approval of the Department of Finance, and with the stated aim of seeking to reduce budgetary pressure, but also based on that key underlying principle that 'it seems reasonable that where a patient who has not full eligibility and has no dependants, that he should contribute towards the cost' (Travers 2005: 12).

The fundamental lack of clarity over the meaning of 'medical care' and 'eligibility', was now compounded by disagreement over whether it was lawful to re-define these terms by means of amending regulation or whether new legislation was required, and this was the subject of varying interpretations over the next 20 years. The independent legal advice consistently indicated that the charges were not legally defensible in the courts and needed to be clarified through primary legislation. This view was supported over the years by reports from the Ombudsman, and the Commission on Human Rights, and indeed on the evidence of memoranda released to the Inquiry, this was also recognised within the Department of Health. The issue was also frequently referred to in government policy documents as an area that needed attention.

The fact that no clarifying legislation was brought forward by the Department of Health over a period of over 30 years, despite the legal advice, became a critical issue. One of the reasons identified for this was that there was unwillingness at political level to grasp what was regarded as a 'hot potato', and at civil service level a reluctance to force this 'hot potato' onto the political agenda. In addition the principle of charging based on ability to pay seemed logically, and morally, defensible, and certainly so within the Department of Health. The Inquiry found that the belief in this principle appeared to override any legal concerns. Also, the adverse economic circumstances up to the mid-'90s had significantly influenced policy thinking within government departments and had made the protection of sources of revenue a priority. The fact that there was no direct legal challenge from any individual directly affected by the charges was perhaps surprising, but the Human Rights Commission suggested that this may have been due to the elderly, or otherwise vulnerable, nature of the people affected (Human Rights Commission, 2003).

To many this appeared to be no more than an arcane administrative matter that involved complex technical and legal issues, and that 'trundled on' for over 30 years as 'background noise' while matters of greater importance and higher priority received attention.

By 2003 the circumstances of the country had changed substantially from those that had obtained up to the early-90s. The economy was growing strongly, there was almost full employment with net immigration, and budget surpluses. Where once there was deficit, now there was plenty. While all of the economic indicators were strong, Ireland still suffered from an infrastructure deficit and public services were finding it difficult to keep pace with public expectations. All of this changed with the events at end-2005, which elevated this background issue to the status of policy fiasco.

The events leading up to the Fiasco

A regular meeting of the Management Advisory Committee (MAC) of the Department of Health with Chief Executives of Health Boards took place in the Gresham Hotel, Dublin in December 2003. The Minister and his political

advisers were due to attend (Ministers usually attend some meetings of their MAC although practice varies across Departments). As a result of another legal advice recently received from a Health Board, the long-stay charges issue was listed for discussion. The health sector at this time was in the middle of a major reform process, part of which involved the abolition of the health boards, and with them the jobs of the eight Chief Executives. The Department of Health, and in particular the Secretary General, was charged with leading this reform process. The issues related to the reform process dominated the agenda at that Gresham meeting. The Minister was late for the meeting, and therefore missed the discussion on long-stay charges, but his political advisers were present. According to the Secretary General, he briefed the Minister on the key issues that had already been discussed, including the long-stay charges issue, as he accompanied him down the corridor to the meeting. After the meeting the Department established, as agreed, a working group on the LSC issue that reported in early 2004 and recommended that the advice of the Attorney General be sought on the matter. The file was sent to the Secretary General, who recollects sending it to the Ministers office.

However the advice of the Attorney General was never sought, and according to the Secretary General this was because the file had not been returned by the Minister's office. He indicated that he did not follow up on the matter because of the severe pressure of other business, particularly relating to the health reform process, and that it would have been the return of the file that would have triggered his next action. The file could not subsequently be found and the Minister stated that he had never received it. Within the Department, according to the evidence given to the Inquiry, the relevant officials assumed the matter was being dealt with someplace else, and that the advice of the Attorney General had indeed been sought.

In September 2004 the deputy leader of the Government was appointed Minister for Health as part of a normal cabinet re-shuffle. The Secretary General prepared briefing papers on key issues in the Department, as would be normal, but the long-stay charges issue was not mentioned. The

Opposition raised the long-stay charges issue during Question Time, and in developing a response the new Minister established that the advice of the Attorney General had not been sought, and asked for that advice to be requested immediately. When received, the advice of the AG indicated that the system of charging for long stay residential care had been illegally based for 30 years. The charges, which had been deducted at source from state pension payments, amounting to over €2bn, would have to be repaid to the 300,000 people affected.

This represented a significant and unplanned 'hit' on the exchequer. The Secretary General, under fierce public and political pressure resigned, and was subsequently assigned the role of Chairman of another public agency. There was extensive and critical media coverage of the issue in the following weeks. This generally took the form of criticism of the ineptitude of the Department for over 30 years, the possible implication of Ministers in the affair, the financial consequences, and the apparently uncaring attitude of faceless bureaucrats towards a weak and vulnerable group in society. A respected ex-public servant was appointed to investigate the affair and he reported in March 2005. He based his investigation, completed within a number of weeks, on a trawl through official files and documents within the Department over 30 years, and also interviews with some of the key administrative and political figures involved. In his conclusions, he identified ' long-term systemic corporate responsibility and failure within the Department of Health and Children at the highest levels over more than 28 years'; a failure of public administration 'that rests primarily with the management of the Department'; poor judgment; adherence to a principle of what was believed to be right in the face of legal advice to the contrary; the weight attached to financial concerns over all others; an unwillingness to raise politically sensitive matters; weak analysis; lack of prioritisation of work; non-existent file tracking and follow-up; poor risk assessment; a weak and dysfunctional management team; and poor briefing of Ministers (Travers, 2005: 80).

The 'lessons to be learned' all related to making improvements in each of these areas. Although most of the recommendations were directed specifically at the Department, some wider lessons were drawn for the civil service as a whole, including the need to assure the legal base for all charges by the State, proper recording of decisions based on discussions between the Secretary General and his/her Minister, addressing competency gaps in the Civil Service, and protecting whistleblowers. Although the Report also identified deficiencies at political level, the blame was laid squarely at the door of the Department of Health and the Civil Service. A subsequent Oireachtas All-Party Committee was asked to further investigate the affair, but descended into a political squabble between the opposition parties who were seeking to implicate the Minister, and the government parties who were seeking to resist such an analysis. Their Report essentially reached the same general conclusions as Travers, although the opposition parties refused to sign-up to the final report.

Conclusion

In this Chapter I have set out in detail the methodology that was used in the research study. I have described an abductive strategy that supports the interplay between theory and data within an overall theoretical framework. The framework was also designed to guard against the danger of simply having a descriptive case study but without wider meaning. The fact that the full group of top civil servants in Ireland constituted the interview population added a richness and weight to the study. I used a recent and iconic example of policy fiasco as my case study, and this was described in detail. While a single case study was used, this group of top civil servants was also engaged in a more general discussion of policy fiascos, so it was reasonable to anticipate some valid generalization about policy fiascos in the central government sector in Ireland. Further generalization to other sectors or to policy fiascos in other countries must await further case-based research. I paid particular attention to issues of confidentiality and sensitivity, and worked on the principle that safeguarding the integrity and confidentiality of the interview process was of paramount importance. I believe that my efforts

in this regard developed greater confidence among the interviewees and resulted in more open and honest interviews.

Overall I believe that the strategy developed is robust and based on sound research principles, consistent with the research philosophy, and designed to support data collection and subsequent analysis.

Chapter 5

How senior civil servants interpreted the concept, causes, context and consequences of policy fiasco Data Description

Introduction

In this chapter the data collected from interviews related to concept, cause, context, and consequences of policy fiasco are presented. This essentially forms the content of interpretation. The readers' attention is drawn to the raw data presented in an uncoded format at Appendix 4, which provides an understanding of how the process of organizing and re-organizing the data progressed. I summarise the key messages from the data in this chapter. In order not to lose the overall sense of each individual interview, and because the emphasis and approach of individual interviewees is also relevant to understanding the various interpretations, a short narrative of each of the interviews is presented at Appendix 3. Finally the data gathered from other sources and subsequently coded is presented at Appendix 6.

The interviews with thirteen Secretaries General of Departments that formed the main basis for this research were conducted in May, June and July 2006, almost exactly a year after the affair came to general public attention. Throughout the interviews references were made to technical and/ or specifically Irish terms, and commonly used acronyms. These are explained at Appendix 1.

Data Description

The data relating to the inner segments of the theoretical model that was shown at Figure 1.1 in Chapter 3 is now presented. These relate to the content of interpretation. In the next chapter I present the data relating to the outer segments of the model, or the processes of interpretation. As described in Chapter 4, each idea or 'chunk' from the interviews was identified, and then coded and allocated to the 'Theme' table. The coded

theme tables are presented at Appendix 5. These coded theme tables were used as the basis for the description of the data and the subsequent analysis of the key issues. The description of the key data that follows includes excerpts from the interviews, so that the reader can hear the 'voice' of the interviewees, and hence getter a better sense of how the issues emerged, and how certain conclusions are subsequently drawn. In the following sections I set out the key messages that emerged from the interviews relating to the concept, cause, context, consequences, lessons, and prevention of policy fiasco.

The Concept of Policy Fiasco

Data relating to the interpretation of the concept of policy fiasco was organised under two coded headings: whether it was regarded as a failure, and the criteria used to categorise a set of events as a policy fiasco.

Was it regarded as a failure? (coded as COCON)

In general there was a fair degree of disagreement on this point. Some interviewees expressed concern about the use of the term 'policy fiasco', on the basis that it de facto appeared to imply failure:

> "Are these really mistakes? Revisionism is a problem here "
>
> (Interviewee E: 04/06/2006)

On the other hand, most interviewees seemed to recognize the phenomenon, and they referred to other events that could be classified as 'fiascos':

> "There have been many recent fiascos: Mini CTC, Lourdes Hospital, PPARS"
>
> (Interviewee F: 19/05/2006)

A number of interviewees were unwilling to categorize the events surrounding LSC as failure or otherwise, on the basis that they were 'too distant' from the events, and were therefore not qualified to make a judgment. Passing judgment on what happened in another Department was regarded as 'interference'.

"Whether it was as described by the media or the inquiry I'm not so sure. I'm not close enough to the system to say for sure"

(Interviewee G: 23/06/2006)

Without referring to the LSC affair specifically, a number of interviewees questioned why certain matters come to public attention at certain times. There was a view that the media had a significant influence, and that if the media did not get hold of the story there would be no 'fiasco'. This was reinforced by the view that although fiascos had happened in the past, because there was not the same level of scrutiny or media attention they did not come to public attention:

"There were lots of fiascos in the past but now there is more media interest, they are more hyped-up"

(Interviewee J: 16/06/2006)

There was a view that there was almost always a political dimension to policy fiascos, and this made it more difficult to say whether there really was a failure or not. It was argued that purely political, or purely administrative, problems do not usually turn into fiascos, but only affairs that combine both elements. It is frequently the political dimension that gives the fiasco the 'oxygen' needed to propel it to become a fiasco:

"There are political reasons for fiascos, but this cannot be taken as a measure of failure"

(Interviewee H: 02/07/2006)

The complex nature of the work of the public sector, and the fact that different groups look for different outcomes, was noted as another reason why the concept of 'success' and 'failure' had to be treated with caution:

"Fiascos are to some degree inevitable in a large, complex, multimillion euro business like ours"

(Interviewee G: 23/06/2006)

"The issues about success and failure are often contested because lobby groups have different interests"

(Interviewee L: 18/06/2006)

However a number of interviewees were quite categorical that the events surrounding the LSC case did indeed represent a failure of public administration:

> "We were shocked: it looked like a disaster from the outside"
>
> (Interviewee A: 23/05/2007)

So while there was some agreement that there was a failure in the LSC case, there was a significant degree of circumspection about the reasons why the failure had come to prominence, the difficulty of interpreting from a distance, and the complex political and other issues involved.

The Criteria for defining a Policy Fiasco as a failure (coded as COCRI)

The criteria by which events might be categorised as a failure were suggested, but again differed widely. Many cited negative financial consequences as the most important criterion, and this was particularly so in the LSC case:

> "The financial consequences are critical-money lost is certainly a barometer of failure"
>
> (Interviewee H: 02/07/2007)

Others regarded the lack of a legal basis for policies and programmes to be the critical reason why the LSC case should be adjudged a failure. Some others identified the perception of damage to public confidence and trust in the public administration, or a perception that the Department is not well managed, as the defining criteria. Another view was that the length of time that the issues had remained unaddressed was the key criterion:

> "If a system continues on a faulty basis for so long, clearly there was a failure".
>
> (Interviewee G: 23/06/2006)

However, there was little agreement on the criteria that could be used to definitively categorise a policy fiasco as a failure, even in the specific case of LSC.

The Causes of Policy Fiasco

The data relating to the interpretation of the causes of policy fiasco was organised under four headings: causes regarded as internal to the Department of Health; administrative causes; causes related to judgement; and political causes.

What were the causes that were identified as being unique to Department of Health? (Coded as CAHLT)

There was reference to the particularly difficult environment of that Department, the fact that it is frequently dealing with life and death issues, and also dealing with the most vulnerable groups in society:

> "Health is always more prone to crisis because of the nature of the business"
>
> (Interviewee C: 13/05/2006)

In that Department there are many matters vying for attention at the same time. The fact that the Department of Health was dealing with a major reform process at the time of LSC was identified as a factor, and they simply took their 'eye off the ball':

> "The Department of Health always have 1000 things to do-they are under incredible pressure"
>
> (Interviewee D: 17/05/2006)

It was also noted that since most other Departments deal exclusively with policy or exclusively with delivery, it is easier for them to ensure that the legislative basis for their activity is sound:

> "It's easier if you just dealing with policy or with delivery: but if you are dealing with both, as was Department of Health, there is increased scope for confusion"
>
> (Interviewee A: 23/05/2006)

What were the administrative causes identified? (Coded as CAADM)

There were references both to administrative causes considered relevant in the LSC case, and to some wider administrative causes of policy fiascos.

Specific administrative weaknesses were identified, including the view that one part of the Department of Health did not know what the other part was doing, the apparent weakness in the system for briefing Ministers, and the lack of a file recording and tracking system:

> "Some fiascos are down to sloppy work- sloppy MAC meetings, or sloppy briefings of Ministers"
>
> (Interviewee C: 13/05/2006)

Technology was identified as a source of problems because of the perceived lack of rigour in technology-based filing systems compared to paper-based systems:

> "Technology is an issue and an issue in LSC was how things were stored, filed, and followed up".
>
> (Interviewee F: 19/05/2006)

Some referred to the 'mindset' issue whereby civil servants relied on tradition where this was no longer appropriate:

> "Sometimes people don't lift their heads and continue to administer systems for years without change".
>
> (Interviewee M: 15/06/2006)

Lack of competency was a general problem identified. While the Civil Service in general is increasingly required to deliver new types of service and projects, the internal competencies have not necessarily been developed to match these demands. For example, a lack of legal expertise and project management competency was identified as specific causes of fiascos in the recent past:

> "There is now a mismatch between the competency of the Civil Service to deliver and the needs of the citizen".
>
> (Interviewee L: 18/06/2006)

The preference for 'grand plan' projects was also leading to problems, where sub-optimal, incremental approaches may have been more appropriate:

> "Big bang solutions don't work. Attempts at grand plans often lead to problems".
>
> (Interviewee E: 04/06/2006)

What causes were identified relating to errors of judgement? (Coded as CAJDG)

While none specifically suggested that lack of judgment was a direct cause in the LSC case, nonetheless 'judgment', particularly at Secretary General level, emerged as a significant theme in their interpretation of the causes of fiascos. The Secretary General has to make judgments all the time about where the 'line is drawn', and whether that line can be crossed:

> "Maintaining the balance between observing the letter of the law and showing due discretion is always difficult".
>
> (Interviewee B: 18/06/2006)

Many compared the reality of managing a Department with the theorised or idealised view. In the real situation there are significant political pressures for certain kinds of actions, and also sometimes the necessity to pursue a particular course of action at the edge of the rules:

> "The Secretary General's job is about relationship management- we are always making decisions 'on the edge' –you have to get the job done".
>
> (Interviewee D: 17/05/2006)

There are so many potential areas that could cause problems, the critical issue for the person at the top is deciding which ones should be given priority. If you make 'the wrong call' then you can end up with a fiasco on your hands.

What political causes were identified? (coded as CAPOL)

Political aspects were by far the most frequently cited cause of fiascos, and were regarded as having particular relevance to the LSC case. The relationship between the Secretary General and the Minister was frequently cited as a key factor in the LSC case:

> "That relationship is unlike any other and when it breaks down it may lead to the removal of the Secretary General"
>
> (Interviewee B: 18/06/2006)

However, with the appointment of political special advisers the situation has become more confusing, particularly with regard to briefings. For example, special advisers deal directly with the civil servants but

> "The LSC case emphasised that the communication must be from senior civil servants to Minister-not through advisers".
>
> (Interviewee K: 07/07/2006)

There was a general sense that there is a subtle but significant shift occurring in the relationship between the civil service and the political system. The LSC case served to highlight, and perhaps accelerate, these changes. There was a concern that over the years the civil service may have developed too cosy a relationship with the political system and had been overly accommodating of political manoeuvre.

There was a view that this had come back to haunt them in the LSC case. This overly deferential attitude to the political system was in evidence in the apparent unwillingness in the LSC case to raise a politically sensitive matter with successive Ministers. Now the Civil Service was being blamed for that:

> "Probably there was an unwillingness to disturb the status quo. It (LSC) raised the issue of the Civil Service being unwilling to raise unpalatable issues"
>
> (Interviewee I: 29/05/2006)

The extent to which a Minister needs to be briefed, and on what matters, is now perceived to be quite a critical issue, since lack of briefing was identified as a factor that led to the removal of the Secretary General in the LSC case. Related to this was the question of what MAC meetings the Minister attended, and some believed that the Minister should have a more active role in overseeing administrative matters in the Department.

Therefore in terms of what were considered to be the causes of the policy fiasco there were a variety of views, and different interviewees emphasised different aspects. Some stressed the unique pressures on the Department of

Health that made it prone to fiasco. Others identified the competency deficit in the public service arising from the changing expectations and needs of citizens. Secretaries General must achieve the delicate balance between being pragmatic in the face of considerable pressure, and adopting a very strict interpretation of the rules. But most emphasis was on the complexity of the political relationship and how increasingly the changing nature of that relationship was creating the conditions for fiasco.

Context

The interpretation of the context of policy fiascos was organised under five headings: internal administrative context; political context; changing workload; public service context; and wider social and economic context.

What elements of internal administrative context were deemed relevant? (coded as CXADM)

Many noted the gains from the public sector reform process, but this also had led to a much greater level of scrutiny:

> "The business of government is more clearly articulated now through strategy statements and business plans. But there is more scrutiny now from PAC, and C&AG"
>
> (Interviewee B: 18/06/2006)

But ironically, with greater transparency and scrutiny, there is greater potential for fiascos:

> 'There is a rise in the number of fiascos because of more transparency".
>
> (Interviewee H: 02/07/2006)

What elements of political context were deemed relevant? (coded as CXPOL)

The changing political context was regarded as one of the most influential factors in creating the conditions for policy fiasco. The nature of democratic politics, and specifically the electoral cycle, led the political system to put pressure on the civil service at certain times:

"Opposition politics leads to mistakes being highlighted. The public service becomes the 'meat in the sandwich".

(Interviewee B: 18/06/2006)

There was concern that the pressure for action, which was often a response to media reports, led to actions that were not always fully considered and analysed, and that this could lead to problems in the future:

"There is a demand for a faster response now from the political system. Then on to the next issue"

(Interviewee A: 23/05/2006)

With some reference to the political debate that surrounded the LSC case, there was a view that with the general shift in Irish politics to the centre, the traditional areas of political debate had receded:

"Politics is increasingly in the centre, and the performance of the public service is increasingly a political issue"

(Interviewee J: 16/06/2006)

The changing nature of the relationship between politicians and civil service was emphasised, and the perception that the LSC and some other recent cases, had damaged a trust relationship:

"The political-administrative relationship is a fragile one based on a long history".

(Interviewee K: 07/07/2006)

Workload pressure relevant to fiasco (CXPRE)

One of the major contextual factors referred to was 'the press of time'. The perception was that this is significantly greater now than in the past:

"I get 150 emails every day. If something went wrong, an Inquiry could show that I looked at a certain email at a certain time-but I might have no recollection of this".

(Interviewee K: 07/07/2006)

The problem is compounded by the fact there is also a greater volume of work, particularly at senior levels, but with the same level of resources. The pressures at the top are immense, with many issues competing for attention. The result, it was argued, is that there is a greater potential now for things to go wrong:

> "There is so much complexity in the system now I am always thinking how many unexploded bombs are around me, and how can I recognize them in time."
>
> (Interviewee G: 23/06/2006)

However it was also a general view that inquiries into fiascos do not take sufficient account of the pressures on senior people and the multiple issues vying for their attention:

> "In 20: 20 hindsight you can isolate a sequence of events. But this does not reflect the real world dynamic"
>
> (Interviewee D: 17/05/2006)

What aspects of the wider public sector context were deemed relevant? (coded as CXPSC)

Interviewees referred to the differences between the public and private sectors. In particular they expressed the view that the private sector can, and do, make many costly mistakes in the interests of innovation, but that the public service must always get it right:

> "If 5000 airplanes land successfully at Dublin airport that does not make the news. But if one crashes? That is the problem for the public service."
>
> (Interviewee B: 18/06/2006)

The risk and accountability environment has changed and the demands on the Secretary General have increased:

> "There is more emphasis on accountability, and more rules from 'the centre'. The Secretary General has to sign off on everything."
>
> (Interviewee K: 07/07/2007)

The fact that there are more agencies and more relationships to manage has rendered the governance environment more complex. If more autonomy is given to agencies one must accept the risk that things may go wrong.

What aspects of the wider social and economic context were deemed relevant? (coded as CXSOC)

There was considerable emphasis given to recent rapid economic development in Ireland. The problems of unemployment, deficit, and emigration of the '80s had been transformed into their opposites by the late '90s. The interpretation of policy in the LSC case was made at a time when economic circumstances were much more difficult:

> "We were in deficit, now we are in plenty. This changed the frame of reference".
>
> (Interviewee F: 19/05/2006)

Also emphasised was the relatively short timescale during which this economic transformation has been achieved and this in itself helped to create the conditions for policy fiascos:

> "Everything turned around and with prosperity came the demand for schools, roads, better health services etc."
>
> (Interviewee B: 18/06/2006)

Instead of the competency of the public service being measured in terms of how good it is at conserving scarce financial resources, as used to be the case, now it is about how good it is at spending those resources. This requires a different set of competencies.

Allied to economic transformation were the wider changes in society. Many mentioned a greater willingness to challenge the authority of the Department:

> "The authority of Departments has increasingly been deconstructed and undermined".
>
> (Interviewee J: 16/06/2006)

Now lobby groups and a well-informed public were ever willing to challenge every decision that is made. This is also interpreted as creating the conditions for fiascos, because while attitudes towards authority have changed, when looking for the reasons for policy fiasco one must take account of the attitudes that prevailed when the policy was made:

> "There is often a historical context. Looking at legacy issues through the lens of the present day is problematic".
>
> (Interviewee L: 18/06/2006)

While the public service is expected always to get it right, the data shows that Secretaries General identified that the context in which the public service operates is changing in ways that make policy fiasco more likely. There is greater scrutiny and accountability. The changing political landscape is resulting in a greater focus on the performance of the public service. There is more pressure, particularly on senior people, and less time to consider the quality of responses. There have also been massive changes in Irish society in a relatively short time, and this is leading to greater pressure on public services, and higher expectations. When taken together, these create the conditions for policy fiasco.

Consequences

The data relating to the interpretation of consequences was organised under three headings: consequences for the administrative environment; political consequences; and consequences for the risk and accountability environment.

Consequences for the Administrative environment (coded as CQADM)

In terms of consequences for internal management and administration, there was a general sense that there has been some adjustment of attitudes and approach following LSC. There is a heightened awareness now of what can go wrong and of the serious consequences of failure, even at Secretary General level, and hence a greater degree of caution:

> 'People are more careful about what they write and say'.

(Interviewee B: 18/06/2006)

This caution is allied to a determination that fiascos such as LSC will not be allowed to fester, but will be 'outed'.

There was a sense of frustration, and a view that civil servants had been demotivated, because of the emphasis on what were perceived to be isolated mistakes:

> "These reports only highlight what goes wrong, not the majority of things that go right".
>
> (Interviewee I: 29/05/2006)

There was also a view that the response to policy fiascos may sometimes pull the system in the opposite direction to the reform process:

> "One of the responses is a tendency to suck power back to the centre- but this is the antithesis of what we are preaching through the reform process"
>
> (Interviewee G: 23/06/2006)

Consequences for relationships with the political system (coded as CQPOL)

As noted previously there was a view that LSC, as well as other recent fiascos, had seriously damaged the relationship of trust with the political system:

> "The LSC case sent a shockwave through the senior civil service. When the chips are down we cannot take that relationship of loyalty for granted any more."
>
> (Interviewee G: 23/06/2006)

However there was also an emphasis on the loyalty of the civil service to the political system and that this had to be safeguarded:

> "LSC did not cause convulsions here. It did not change relationships with the political system- we decided that it is good to retain some flexibility in that area."

(Interviewee J: 16/06/2006)

Some believed that an inevitable consequence of the trend was a move to a European style of politically appointed civil servants:

> "We are inevitably moving towards the European style of cabinet"
>
> (Interviewee C: 13/05/2006)

Yet the overall sense of betrayal of the civil service in the LSC case was balanced by the recognition that a working relationship with the political system had to be maintained.

Consequences for the Risk and Accountability Environment (coded as CQRSK)

One of the major concerns expressed related to the consequences of LSC for the balance between innovation and accountability. A number expressed the view that while public sector reform was promoting more innovation and 'smart risk-taking' by the public service, the impact of LSC and other fiascos was to make civil servants ever more cautious:

> "You can't punish people for making mistakes but now the emphasis is on finding scapegoats."
>
> (Interviewee D: 17/05/2006)

A key role for the Secretary General is to ensure that a proper balance is maintained:

> "Sometimes people say 'play it safe and do nothing' but you have to encourage risk-taking. But maybe risk avoidance is emphasised more now."
>
> (Interviewee A: 23/05/2006)

It was also acknowledged that in the aftermath of LSC the ongoing need for innovation was a difficult message to sell to staff:

> "Selling the need for both accountability and innovation to staff now requires a highly nuanced message"
>
> (Interviewee G: 23/06/2006)

There was concern expressed as to how this tension between risk management and innovation would be resolved. But there was also a view that the consequences of LSC for risk management are consistent with a more general trend towards greater caution

> "There is somewhat more risk aversion now as a result of LSC case. But maybe this is an appropriate and well-judged adaptation to a changed environment."
>
> (Interviewee J: 16/06/2006)

There was also a concern that in a complex network of agencies responsible for delivering government policy, safeguards were not necessarily being applied uniformly across all of the public service, particularly as one moved further out from the centre:

> "It is sometimes difficult to get the accountability message over to the agencies. The screw of accountability has tightened in the civil service not so much elsewhere."
>
> (Interviewee J: 16/06/2006)

While there was a general sense that the ground rules for the relationship with the political system were changing, loyalty to the political system is regarded an absolute and non-negotiable core value in the Irish civil service, and although the LSC affair had damaged the relationship, this loyalty could not, and would not, be compromised.

Lessons and Learning

The data relating to the lessons of, and learning from, policy fiasco was organised under two headings: the administrative and other lessons from the affair, and their evaluation of the nature and quality of the learning.

What are the administrative and other lessons from the affair? (Coded as LEADM)

> There were a significant number of examples of what might be termed 'single loop learning' in the form of direct responses to the LSC case to

modify systems or procedures. These were in most cases directly linked to the recommendations from the Inquiry:

"LSC prompted us to review the legislative base for everything we do."

(Interviewee G: 23/06/2006)

"Record management process has been improved as a result of LSC."

(Interviewee L: 18/06/2006)

In a number of cases, the response to LSC led to the uncovering of potential problems:

"As a result of LSC we identified an area of legislation where something had been omitted."

(Interviewee G: 23/06/2006)

"We recognised vulnerabilities in the system."

(Interviewee A: 23/05/2006)

The view was that the public service is reactive, and not very adept at preparing for, or handling, the media feeding frenzy that inevitably follows such affairs:

"We are poor at managing the media fallout-we do not anticipate the coverage and try to deal with it"

(Interviewee E: 04/06/2006)

The public service should try to portray a more positive image of itself and then, it was believed, when things do go wrong they would not be portrayed so negatively

These 'single loop lessons' reflected what were generally referred to as the 'learning' from the affair. It was clear that 'learning' was generally equated with the specific systems and procedural responses to the affair, and the actions taken as a direct result. However as noted in the in the earlier section on 'Consequences' and elsewhere in the data, it is clear that there was also

learning in terms of changed attitudes, and sometimes behaviours, and this represents learning at the deeper level of attitudes and behaviours.

Clearly deeper messages had been internalised as a result of the affair. Some noted that relationships with politicians, including Ministers, and with their management colleagues, had been formalised as a result of LSC, and that there was less reliance on trust:

> "I was conscious that informality can creep in where you've worked with colleagues for years, including recording of decisions. I'm more conscious of that and have tightened up this area".
>
> (Interviewee A: 23/05/2006)

In general there was a greater alertness to danger, a greater awareness of the possible significant negative consequences that can flow from apparently small matters:

> "LSC created alertness to danger: does this have a Travers smell?"
>
> (Interviewee G: 23/06/2006)

There was a greater awareness of the potential political consequences of administrative failures. Related to this sensitivity to risk was the belief that an important role for the Secretary General was to protect those who bring these problems to attention, in a way that they had not been protected before.

> "Top management must protect those who raise these issues-in the past people have been ostracised for doing so."
>
> (Interviewee I: 29/05/2006)

Evaluation of the lessons and learning from fiasco (coded as LEEVAL)

While there were relatively few comments relating to the evaluation of the learning to date, possibly because of the relatively short time since whatever lessons have been applied, there were three key points made. The first related to the process of learning, and emphasised the importance of taking a measured and reflective approach:

> "A year on we have learnt but not in a knee jerk way".

(Interviewee G: 23/06/2006)

Secondly it was emphasised by many that the central departments (namely Department of Finance and Department of the Taoiseach) have an important role in drawing lessons from these affairs on behalf of the system, but that this process is not consistent, and not necessarily clear and coherent:

> "There needs to be more direction from the centre. I don't remember anything coming after LSC."
>
> (Interviewee G: 23/06/2006)

However, this can be contrasted with the point made earlier that some saw the guidelines from the centre as only creating more potential for problems.

Prevention (Coded as Pre)

This theme emerged as significant during interviews, and was the dominant theme in two of the interviews. It is described under a single heading. It relates to the actions that were, and are, being taken on an ongoing basis by Secretaries General and their teams to prevent fiascos. These are not necessarily specific responses to LSC or other cases, but ongoing processes. The perception was that fiascos were much less likely to happen in these Departments because of the precautions taken.

> "You always get the unexpected, but if you plan accordingly we can counter a lot."
>
> (Interviewee M: 15/06/2006)

The LSC and other recent fiascos appeared to reinforce certain interviewees in their belief in the value of the precautionary measures they were taking, and that LSC had arisen at least partly from the absence of such measures in the Department of Health:

> "I hold a co-ordination meeting of senior management twice a week-this acts as an early warning system."
>
> (Interviewee M: 15/06/2006)
>
> "I communicate with my Minister up to three times a day."

(Interviewee M: 15/06/2006)

Getting input from people from outside the Department was identified as an important way of preventing 'groupthink', and this was considered by some to be an important aspect of the Secretary General's role:

> "My job is anticipating flashpoints, disrupting thinking and conventional logic, and challenging people to look at issues in a different way".
>
> (Interviewee L: 18/06/2006)

Another preventative process identified as important was to identify trends in the environment, and to interpret their consequences:

> "We identify trends and patterns and put appropriate changes in place."
>
> (Interviewee M: 15/06/2006)

It was also considered by some that the style of the Secretary General, particularly being seen to be 'hands-on' and on top of things, gave an important signal to the rest of the staff.

Conclusion

In this chapter I have set out the key messages and patterns that emerged from the data under the various themes and sub-themes relating to the understanding of the causes, context, and consequences of policy fiasco by the group of top civil servants, and some of the lesson and learning that resulted. There was considerable disagreement over what constitutes a policy fiasco, and to what extent the LSC affair in particular could be described as a failure of the civil service. There was little agreement on the criteria that can be used to categorize a policy fiasco as a failure. A variety of possible causes were identified ranging from causes that are unique to the Department of Health, to the weaknesses in administrative systems or lack of competence, to causes related to the complex relationship with the political system. While there was a general sense that the ground rules for the relationship with the political system were changing, loyalty to the political system was regarded as absolute and a non-negotiable core value in the Irish civil service.

Context was regarded as critical to interpreting policy fiasco. Policy fiascos were seen as products of a particular time, place, and set of circumstances. The accountability and risk environment had changed and led to more scrutiny. The political context had changed with now a greater ambiguity in the relationship between the senior civil service and the political system. The demands and expectations placed on the public service by citizens had increased with economic prosperity. These contextual factors were deemed specifically relevant to the LSC case, but more generally these changing conditions were creating the conditions for more, rather than less, policy fiascos.

Many different consequences were identified ranging from demotivation of civil servants and a greater level of formality in relationships, to a more risk averse system that was concentrating more on doing things right, than necessarily doing the right things. In a number of respects the longer-term consequences of policy fiasco were interpreted as negative, and leading to approaches and behaviours that run counter to the objectives of public sector reform. The consequences were described as changes that had taken place, not perhaps in a very obvious way, but that nonetheless could be regarded as significant indicators of future behaviours and approaches. In many respects these consequences can be contrasted with the lessons of policy fiasco, which were typically described as technical, short-term responses to policy fiasco, such as changes to administrative recording systems. Prevention emerged as a significant theme, and an aspect of the role that the Secretaries General considered to be most important in seeking to avoid policy fiascos in the first place.

At this point it is time to describe the issues that arose in the data relating to the interpretation and sensemaking processes applied by Secretaries General in the aftermath of policy fiascos.

Chapter 6

The Processes of Interpretation:

Data Description

In this chapter I present the data relating to the processes of interpretation, organised on the basis of the theoretical framework presented in Chapter 3. As in the previous chapter these were coded by interviewee, and then by theme and sub-theme according to the template presented at Appendices 4 and 5. Although the interviews with these thirteen top civil servants again provided the main source of data, other sources were also generally used to support the case study, particularly with a view to establishing the extent to which they provided similar or different accounts of events to those provided by the Secretaries General. The first of these supplementary sources was the Inquiry Report written in the aftermath of the LSC fiasco, known as the 'Travers Report' (2005). The second supplementary source was the evidence of some of the key witnesses to appear before the Oireachtas Committee Inquiry, including the evidence of the current Minister for Health, and the former Secretary General of the Department. The third supplementary source was newspaper articles that appeared in the Irish Times in the three months after the affair, and these provide an insight into the media coverage by the 'quality' press. The data from these sources are described later in the Chapter and presented in detail at Appendix 6.

Firstly the data collected from interviews relating to the major processes and sub-processes of interpretation are described. The data is described under the themes and sub-themes identified. These relate to how cues were extracted; what social processes of interpretation were used; what role did time play in the interpretation process; and what influence does the personal

style and experience of the Secretary General have on the interpretation process.

Extracting Cues to interpret policy fiasco

In this Section I describe how cues were extracted to make sense of fiasco. Specifically what grabbed their attention; what were the external sources of cues; what were the internal departmental sources; and how were cues drawn from the Inquiry?

How do policy fiascos grab the attention? (Coded as CUEATT)

It was clear that the LSC case grabbed the attention of the Secretaries General because it shocked them. It was an event that disrupted normal patterns and routines. What seemed to be particularly shocking to them was that one of their Secretary General colleagues had to resign, and this made them feel particularly vulnerable:

> "Something like that goes straight to the gut! It was a frightening experience because it made us feel our own personal vulnerability. Could this be me?"
>
> (Interviewee G: 23/06/2006)

In the midst of so much activity this event seemed to give them cause for reflection, and for re-prioritising:

> "LSC was a 'wake-up call, go back and look at the knitting'. There is no point in changing the world if you get something basic wrong back at home."
>
> (Interviewee G: 23/06/2006)

The survival instinct acted as a prompt for learning:

> "We learn partly out of self-preservation"
>
> (Interviewee G: 23/06/2006)

What are the sources external to the Department, apart from the Inquiry, that are used to extract cues? (coded as CUEEX)

There was, as noted earlier, a somewhat mixed view of the role of the centre in these affairs. It was clear that the Secretaries General do look to the central Departments for guidance on making sense of policy fiascos, but there was some dissatisfaction that this is not consistently provided. There was also a view that rather than help, that new guidelines simply create more opportunity for mistakes to be made:

> "Circulars from the centre only create more procedures to trip us up."
> (Interviewee D: 217/05/2006)

It was also believed that the messages disseminated in circulars from central Departments did not achieve the same level of ownership as internal communications:

> "There is less ownership if lessons come from circulars than if it is an issue within the Department."
> (Interviewee L: 18/06/2006)

But on the other hand it was believed that the centre could play an important role in facilitating learning from policy fiascos:

> "The centre has an important role in monitoring and managing the civil service" (Interviewee E: 04/06/2006)

> "Circulars from the centre provide the institutional veins to facilitate learning"
> (Interviewee L: 18/06/2006)

How is the Inquiry used to draw cues? (coded as CUEINQ)

In the case of the LSC fiasco, there were two investigations, the first carried out by a former senior public servant appointed by the Minister, and the second by an All-Party Oireachtas Committee. Given the resources that go into such Inquiries, and since their reports effectively become the 'official version' of events, the views of the Secretaries General on Inquiries was particularly relevant.

On the main official inquiry there were generally quite negative views. Most interviewees believed that the Inquiry did not tell the full story:

> "The Inquiry Report put an inordinate emphasis on what was written, but that does not tell the full story"
> (Interviewee G: 23/06/2006)

The main criticism was that the methods employed by the Inquiry failed to take due account of context or of the subtleties of the relationship between senior civil servants and Ministers:

> 'Inquiries do not contextualise. They are too speedy to do proper justice to the issues."
> (Interviewee K: 07/07/2006)

Inquiries have extensive resources available to focus on one thing, whereas Departments have to deal with multiple issues with limited resources:

> "In 20:20 hindsight you can isolate a sequence of events but this does not portray the real world dynamic of many things competing for attention."
> (Interviewee D: 17/05/2006)

However despite these misgivings many considered that Inquiries were valuable for a variety of reasons:

> "An independent report is valuable. We can argue about the quality, but it is a good way of highlighting issues."
> (Interviewee A: 23/05/2006)

> "We took the Inquiry Report at face value and considered what the different scenarios might mean for us." (Interviewee H: 02/07/2006)

It was clear that the perceived quality of an Inquiry and its findings was also at least partly based on who was conducting it, and the perceived equity of the process. There was a suggestion that Inquiries be conducted by a new

centralised standards agency as a way of professionalizing and standardising the process, and of creating a central repository of lessons and learning.

The Oireachtas Committee Inquiry was viewed in a much more negative light than the Inquiry by the independent official. It was perceived to be a purely political exercise, without any real effort to get at the truth of what happened:

> "Oireachtas Committees are hugely political-officials are an easy target" (Interviewee K: 07/07/2006)

However, in general there was dissatisfaction with the inquiry process, and concern that the reports of Inquiries are subsequently regarded as the official version of 'the truth':

> "Findings of Inquiries take on a life of their own and can't be questioned." (Interviewee K: 07/07/2006)

What are the internal sources in the Department that are used? (coded as CUEINT)

The interpretation process that happened inside the Department was clearly the most important way of making sense of the fiasco. Secretaries General seemed able at the same time to take a distance from the events, and even disagree with the findings of the Inquiry, and yet extract lessons that were seen as relevant to their own Department:

> "We had to separate out what are the issues that were unique to this Department from the issues more generally relevant. We had to develop an appropriate response for us". (Interviewee G: 23/06/2006)

It was clear that each Department took its own view of events and that this was regarded as the way things should be:

"There will be different learning in each Department because of the differing nature of their work, different cultures, and different emphases by the Secretary General." (Interviewee L: 18/06/2006)

Some Departments saw themselves as 'similar' in terms of function to the Department of Health, and others saw themselves as different, and this sense of similarity or difference was significant for interpretation and lesson-drawing:

"We are a very technically dependent organization and therefore we are particularly interested in fiascos related to technology."
(Interviewee I: 29/05/2006)

"If the fiasco has been internal the learning will be more vital and ongoing. When it is external it is more difficult to see the relevance and keep it alive"
(Interviewee L: 18/06/2006)

It was widely believed that the interpretation of a policy fiasco that happens in another organization is critically dependent both on the Secretary General, and on the relationship between the Secretary General and the Minister:

" The Secretary General has a very important role as interpreter of these events." (Interviewee L: 18/06/2006)

In summary, the events surrounding LSC had a particularly deep impact on the Secretaries General and caused them to reflect on both the personal and organisational implications of such affairs. This was particularly relevant to creating urgency about extracting cues. The role of the centre in consolidating and disseminating learning in the aftermath of fiascos is regarded with some ambivalence. In theory there is a potentially significant role for the central departments in drawing lessons for the system, but in

practice this process is regarded as somewhat haphazard, and does not achieve ownership of learning.

There were particularly interesting views about the role of Inquiries. They were viewed with a great deal of caution, and they were faulted for failing to contextualise and for making the dynamic and complex appear simple and linear in hindsight. There was some resentment at the extent to which Inquiry Reports are regarded as the only authoritative version of events. On the other hand the messages from Inquiries were taken on board in a pragmatic way, if not with any great enthusiasm. Finally, the internal processes of interpretation and drawing cues were regarded as by far the most important, and it was a general view that it is up to each Department to draw their own lessons from fiascos, but with the Secretary General as the lead interpreter.

Social processes of Interpretation

What follows in this section is a description of the social processes that were used to interpret policy fiasco.

What were the social processes used that are external to the Department (Coded as SOCCO)

The Secretaries General meet weekly after Cabinet meetings, primarily to discuss issues arising at Cabinet. They also meet once per year for a more reflective discussion.

While most agreed that Secretaries General made some collective sense of fiascos, there were a number of different views on the level of formality or extent of this process:

> "There is some unease at using the weekly Secretary General meeting for discussions of this nature."
> (Interviewee G: 23/06/2006)

The nervousness around having such discussions, seemed to be related to the perception that for historical reasons collective discussions by Secretaries General on what might be considered policy matters, may be frowned upon:

> "There has been for many years a concern in some areas at political level about formal meetings of the Secretary General group. The culture is that each Department runs its own show"
> (Interviewee A: 23/05/2006)

This emerged as an important inhibitor to any formal review or discussion of policy fiascos by the group of Secretaries General, and it appeared to be particularly true of the LSC case:

> "Some issues have been almost undiscussable over the years".
> (Interviewee K: 07/07/2006)

There also appeared to be a reluctance to discuss the LSC case because to do so might mean acknowledging that collectively they disagreed with some of the conclusions of the Inquiry:

> "There was a reluctance to discuss the LSC case at senior level because it might mean acknowledging certain things."
> (Interviewee G: 23/06/2006)

Some believed that it would be useful if the group reviewed policy fiascos more formally in order to learn from them:

> "If Secretaries General could reach a more collective view on these issues it might be useful"
> (Interviewee I: 29/05/2006)

Yet others believed that it was best left up to each individual Secretary General:

> "We all know our own business best."
> (Interviewee A: 23/05/2006)

What are the social processes used that are internal to the Department (coded as SOCINT)

The important role of the Management Advisory Committee (MAC) in interpreting policy fiasco, and in deciding on follow-up action emerged as a strong theme:

> "The MAC has a very important role –it is there to advise the Secretary General" (Interviewee E: 04/06/2006)

It was clear that discussion at MAC is one of the key ways in which each Department uniquely interprets policy fiasco and in which the lessons perceived as relevant to the Department are extracted:

> "In each Department the Secretary General discusses the issues with his MAC and they deduce for themselves what are the appropriate lessons."
> (Interviewee G: 23/06/2006)

It is the Secretary General who initiates such discussions and the MAC is used to 'proof' the interpretation of the Secretary General:

> "It is my job to interpret. My MAC would not be aware of views at Secretary General level generally, so I pass on insights."
> (Interviewee J: 16/06/2006)

In some Departments there is a large MAC with close to 20 members and it was reported that this, together with other factors, can make detailed discussion about policy fiasco quite difficult.

> "We have a large MAC, which makes it more difficult."
> (Interviewee I: 29/05/2006)

"Only some older members of the MAC may be unwilling to share and contribute outside their own portfolio."
(Interviewee I: 29/05/2006)

Some Departments set up special groups to review the issues arising from fiascos, and in at least one case a group of senior staff volunteered because of their interest in the topic. A number referred to 'away days' for the senior management team when they took time to reflect on important issues from the previous 12 months, including LSC, and the nature and quality of their response to them:

"We took the whole team away for reflection-you cannot sort all the problems by working faster and harder."
(Interviewee G: 23/06/2006)

The hierarchical nature of government departments was reflected in some of the social processes described:

'Each Assistant Secretary discussed the issues arising with his/her Principal Officers'. (Interviewee G: 23/06/2006)

In summary, most of the social processes described were internal to the Department. This reflected a general view that each Department should make up its own mind on these matters. There was a reluctance for historical reasons to have formal discussions on this type of issue at Secretary General level, although there was clearly considerable informal discussion and sensemaking going on. Some believed more formal discussions might facilitate leaning, but others considered that these were matters best left to each Department. The current culture is clearly strongly biased towards interpretation and drawing of lessons within individual Departments, with the Secretary General playing a lead role. The MAC has a particularly important role, although there can be barriers to effective discussions at MAC, and in some cases special groups have been established to consider the implications of policy fiascos. The current processes of interpretation

reflected the hierarchical and Departmental nature of the system, with relatively weak processes at collective civil service level.

Ongoing

What role does time play in the process of interpreting, and learning from, policy fiasco?

How was the process of interpretation and learning from policy fiasco ongoing? What role does time play in interpretation? (coded as ON)

Many of the Secretaries Generals noted that there was an intensity of activity immediately after the policy fiasco, mainly focused around the official inquiry, but while this may serve a 'cathartic purpose' it was not a good idea to rush to judgment in the heat and emotion of the immediate aftermath:

> "There is lots of hype immediately after the events but often little structured follow-through."
> (Interviewee I: 29/05/2006)

It was considered important to learn the right lessons and to do so reflection was necessary:

> "You have to let it settle to get at the real lessons."
> (Interviewee G: 23/06/2006)

However there was also a view that there was a 'window of opportunity' and that after a certain point the issue went off the agenda:

> "There is a period of time and you have to take advantage of it. We're very busy so you have to get back to normal business." (Interviewee A: 23/05/2006)

An example of how quickly the events can 'go cold' was supplied by one interviewee who noted that the LSC affair was a topic for questions at promotion interviews for senior civil servants:

"At TLAC for six months afterwards learning from LSC was a standard question. But not anymore!"
(Interviewee G: 23/06/2006)

Some reported that formal departmental mechanisms they had put in place to assess follow-up:

"Now we have a follow-up group-to see if lessons are being applied or there are more lessons to learn."
(Interviewee H: 02/07/2006)

However it was generally considered that the process of follow-up needed to be strengthened:

"There should be an onus on Departments to demonstrate what has changed as a result."
(Interviewee F: 19/05/2006)

So while on the one hand there is a limited period when issues related to the fiasco are 'live' and vital, there was also the view that there should be no 'knee jerk' reaction and that there needs to be time for reflection. Once again follow-up mechanisms seemed to be mainly decided on by individual Departments and there was a view that more formal processes of follow –up to establish the learning outcomes are desirable and necessary.

Experience and Style

Do the experience, background, and style of the Secretary General impact on interpretation?

How do the experience, interests, talents, and/or work style of the Secretary General influence how policy fiascos are interpreted? (coded as EXSTY)

There was a very high degree of consensus that not only does the Secretary General have a critical role as an interpreter of policy fiasco, but that they interpret these fiascos differently:

"It's like a rugby match. We all watch the same match but pick out different things and interpret it differently."
(Interviewee K: 07/07/2006)

It was acknowledged by virtually all interviewees that different styles, interests, and personality are relevant to how events are interpreted:

" The personality and style of Secretaries General differ and this will influence the lessons that are drawn."
(Interviewee I: 29/05/2006)

It was noted that the tendency to 'default' to a preferred style or area of interest may be a weakness, and indeed can even be a contributory factor to policy fiascos:

" The style of Secretary General is important. The visionaries may not be so good at process and vice-versa."
(Interviewee L: 18/06/2006)

But some identified their own weaknesses and had set about managing the risk:

"Procurement is a difficult issue. Maybe I stood back too much in the past. Now I have to work at it."
(Interviewee M: 15/06/2006)

The interests of the Secretary General influence the lessons that are drawn. The suggestion was that the Secretary General would be predisposed to draw lessons that reflect his/her own interests:

"How the Department responds may come down to the Secretaries General' priorities and interests e.g. is he a 'techie'. ''
(Interviewee E: 04/06/2006)

Although policy fiascos heightened awareness of potential problems, there was also a risk of being blind to potential problems that did not share the same characteristics:

"By their nature they are not easily recognisable-we must be careful not just to look out for ones like before."
(Interviewee G: 23/06/2006)

Previous experience also comes into play in interpreting fiascos. One interviewee referred to his personal experience of a previous policy fiasco, and how it changed his approach:

"In my previous role the PAC threw the book at me and I had to plead guilty. That experience seared me. Staff will tell you I do not tolerate mistakes."
(Interviewee C: 13/05/2006)

Experience in previous positions and roles also informed current approaches to dealing with situations:

"Because of my experience as a press officer, I am more sanguine about the political system."
(Interviewee D: 17/05/2006)

It was also clear from the overall narratives of interviews (see Appendix 3) that different Secretaries General showed an affinity for, and an interest in, different areas. Where some emphasised process, control, or prevention, others emphasised managing the relationship with the political system, or the importance of good judgment. Some indicated they were more comfortable dealing with the media, whereas others avoided such contacts believing that courting the media could 'backfire'. So clearly Secretaries General interpret policy fiascos differently, and these different interpretations are at least in part due to their different work experiences, different interests, and their perceptions of their own strengths and weaknesses. There was some indication that the individual 'default' interpretation can become a weakness, blinding one to other possibilities. But clearly the individual Secretary General strongly influences the interpretation of policy fiascos within the Department.

Description of data from other sources

As mentioned earlier data was also collected from three other sources, the Report of the Inquiry into the LSC affair, the testimony of key witnesses to the Oireachtas Committee, and media reports in the immediate aftermath of the LSC fiasco. These were also coded according to the coding scheme and these tables are presented at Appendix 6. The data from these sources was primarily useful for comparison with the interpretations provided by interviewees. They provided a basis for the analysis of difference and similarity in the interpretation of policy fiascos as between different stakeholders, the implications of which will be explored further in Chapter 7.

There follows a brief description of the data from these other sources presented under the same content or 'what' headings as for the interviews. Generally speaking these sources did not refer to interpretation processes, but only to content. In order to preserve the overall sense of the data, the data is not presented by reference to the sub-codes, but these can be viewed in the tables at Appendix 6.

Concept

The press coverage in the immediate aftermath of the of the Travers affair showed that media commentators were in no doubt that this represented a major failure, and almost exclusively they laid the blame at the door of the Civil Service and the Department of Health:

> "Why should Ministers pay for the mistakes of civil servants? Senior public servants are paid phenomenal salaries, they have phenomenal job security. We are entitled to hold them responsible in the departments. We have never had leadership in public sector reform"(Coulter 2005).

Much of the media coverage also focused on the length of time that the matter had been 'ignored', and this, together with the fallout from the fiasco

and the financial and administrative consequences, seemed to be the main criteria used to categorize the episode as a failure:

> "The Minister said that everybody accepted the situation was a total mess. The consequences are considerable, involving 315,000 people and going back to 1976. Some institutions are closed and no records exist. Besides the huge amount of money involved, this issue represents a mammoth task from an administrative and logistical point of view" (Houston 2005).

The official inquiry also clearly labelled the episode as a failure:

> 'A long term systemic corporate failure' (Travers 2005: 101)

Although it was acknowledged in the report of the Inquiry that politicians should have probed more into this issue, the blame was laid squarely at the door of the Department. The events represented a "failure of administration" (Travers 2005: 93).

In her testimony to the Oireachtas Committee, the Minister for Health backed up the Inquiry findings and laid the blame squarely at the door of the Department:

> "Why it was not acted upon was just amazing, incredible"(Harney 2005).

On the other hand the former Secretary General of the Department took a somewhat different view and he criticised the inadequacy of the approach used by the Inquiry:

> "You can't just look at the mechanics of a,b,c. Context is critical." (Kelly 2005)

> "Judgments on past events must be by reference to context and circumstances prevailing at the time" (Kelly 2005)

The former Secretary General also rejected the negative presentation of the Department and questioned the balance of the report:

> "It is possible to take either a benign or malign interpretation and in this case the interpretation taken has not been benign" (Kelly 2005)

Political and media sources, with few exceptions, categorised this as a clear and serious failure on the part of the civil service and in particular the Department of Health, although opposition parties were keen to implicate government ministers and advisers. On other hand the officials, particularly the former Secretary General, were much more circumspect, and while conceding that mistakes had been made drew attention to the importance of context, including the press of other business, as important mitigating factors.

The Context of Policy Fiasco

The Travers Report did make some minimal reference to context both in the recent and more distant past. It stated that the approach to charging for care "must be placed in the context of its times" (Travers, 2005: 62) and that the resistance of the Catholic Church and the medical profession during the '60s and '70s to the public provision of free health services, and consequently the decision to charge for long-stay care, 'was in keeping with the ethos of the time' (Travers 2005: 62). As mentioned previously, the weak state of public finances was also noted in the Report as a factor that influenced decision-making (Travers 2005: 60). Also noted were the 'wide scope and complexity' of the business of the Department of Health, the constant media and political attention, and the 'life and death' nature of issues with which the Department deals (Travers 2005: 76). Travers (2005: 76) also acknowledged the significant additional work pressures on all officials, including on the Secretary General of the Department, that arose during the period 2003-2004 from the health reform strategy and the EU presidency. However, the conclusion was that regardless of these contextual factors, the problem was one of 'long-term systemic corporate failure' within the Department (Travers 2005: 115).

As noted previously, while media reports did also refer to mitigating contextual factors such as the lack of clarity about the respective roles of civil servants, advisers, and Ministers, the difficulties that surrounded legal interpretations, and the pressures on the Department, they mainly focused on

perceived weaknesses within the Department. On the other hand, the former Secretary General in his evidence to the Committee stressed the importance of context to understanding why the problem had not been identified and dealt with on a number of occasions:

> "This is not an attempt to excuse the practice of raising charges without a sound legal basis but rather an attempt to explain why it could have continued on this basis for so long without being fundamentally questioned and changed. It is necessary to think about the context and the exact circumstances in which these events occurred over that period." (Kelly 2005).

He also referred to pressure of work, the difficult economic circumstances, and

> "An ingrained desire to do the best for people in care coupled with an inherited belief that this was settled policy" (Kelly 2005).

In summary, whereas the Inquiry Report, the politicians, and the media focused almost exclusively on causes internal to the Civil Service and the Department of Health, it was only the civil servants, and particularly the former Secretary General, who focused on contextual factors as being of critical importance.

Cause

In the Report of the Travers Inquiry (2005) a number of causes for the failure were identified. These included embedded practices over time; adherence to a belief in a principle, a belief that strengthened with 'the effluxion of time'; a dysfunctional management team; poor document tracking and file management systems; inadequate legal competency within the Department; an unwillingness by senior civil servants to raise politically sensitive matters; an over-riding interest in protecting a source of revenue; poor judgment, mainly at official, but also at political, level; and inadequate recording of decisions (Travers 2005: 86 et seq).

Media reports also focused mainly on the same causes identified by the Inquiry. However several negative comments about the Department of Health were attributed to 'other sources': 'the Department 'hunkers down', circles the wagons when there is trouble, and is undealable with' and 'the culture of the Department is sect-like and dysfunctional' (Houston 2005). The legal position, particularly with regard to the respective roles of Secretary General, political advisers, and the Minister, required clarification. There was perceived negligence by successive Ministers in not pursuing the issue more vigorously.

The former Secretary General in his evidence to the Oireachtas Committee (Kelly 2005) referred on several occasions to the 'white heat' pressure under which both he, and the Department, were operating in 2003 and 2004. In particular the pressure of implementing the health reform process and managing the Departments involvement in the EU Presidency took attention away from 'minding the shop'. The long-stay charges issue 'fell off the radar'. He referred to the dynamic nature of the work of the Department and the high-risk environment in which it operated, where priorities changed from day to day. The practice of charging for long-stay care 'reflected the state of mind in the Department and the health boards at the time' (Kelly 2005). He criticised the 'simplistic view' put forward in the Travers Report, which suggests that everything of importance is written down. He referred to the complex legal issues involved, and that the Department had made a 'bona fide interpretation' of the law. He suggested that the Department had leaned too far over the years in facilitating political manoeuvre, and that this flexibility was now being used to blame the Department. He also noted that Department officials had been focused on dealing with the problem' prospectively', rather than looking at the issue 'retrospectively' (Kelly 2005).

Consequences

The consequences identified in the Travers report are necessarily tied to the identified causes, and to the lessons that flow from that. The Report summarised the situation as follows: ' The problems that have accrued

...arose from the failure to resolve in a satisfactory way the good aims and objectives of administrative process with those of due legal process' (Travers 2005: 78). Thus, according to this analysis, the remedy lay in addressing these weaknesses and in protecting officials who bring problems to the attention of their supervisors.

In his evidence the former Secretary General implied that the analysis of the affair required a 'greater depth of understanding of context and circumstances' (Kelly 2005). He also implied that in order to avoid such a situation in the future the Department and its officials had to be less will willing to facilitate 'ease of manoeuvre at political level' (Kelly 2005). The former Secretary General also referred to the evidence of politicians to the Inquiry and their apparently changed expectations about clarity and transparency of decision –making. This would 'bring relief to civil servants who feel torn between public service obligations and the professional need to maintain a constructive working relationship with the political level'(Kelly 2005). He disagreed with the Inquiry's' conclusions about the effectiveness of the MAC, and hoped that 'no Secretary General would ever go through this experience again' (Kelly 2005).

The media reports referred to some general consequences that could or should flow from this 'debacle'. One political commentator referred to the need to reverse the trend of not writing things down which had been a consequence of Freedom of Information legislation and predicted that as a result of the LSC case: 'Ministers will be now be swamped by files so that civil servants can say they were told' (Mansergh 2005). Another article referred to a new awareness among politicians that administrative problems in Departments can cause political difficulties: 'Why should Ministers pay for the mistakes of the civil service?' (Doorley 2005). A number of reports referred to the need for a review of the legislative basis for administrative charges generally. A general sentiment expressed in media reports was that: 'The Travers Report is likely to have a major impact not just on the Department of Health, but on the way the civil service operates' (Hunter 2005).

Lessons and Learning

The lessons drawn by the Inquiry Report have been referred to elsewhere but are briefly summarised here. These are contained in that section of the Report titled 'The lessons to be learned' (Travers 2005: 79 et seq). They were: Get the legal basis for decisions right; ensure proper analytical input to important policy issues; ensure that briefings for Ministers are comprehensive and fully inclusive of the facts; ensure de minimus recording of decisions; put a proper risk assessment process in place; ensure that decisions are made and recorded in a timely fashion; isolate 'issues of singular importance' and deal with them; do not allow political sensitivity to compromise the integrity of the analysis of policy options; rebuild the MAC; put a file tracking system in place; and Ministers should seek assurances that their Department has all of the above in place (Travers 2005: 79 et seq) . As can be seen most of these are based on the analysis of the issues that led to the problem and therefore are directed at the Department of Health, although equally could be applied to other Departments.

In her evidence to the Oireachtas Committee the Minister for Health indicated that she accepted all of the lessons that were drawn in the Travers Report and was determined to implement them. She indicated that these lessons 'could be applied right across the public service' (Harney 2005). She highlighted a couple of lessons for special mention:

> "If there is any lesson that we must all learn from it is that notwithstanding the urgent things that must be done daily, the important things must be dealt with too. The reality is that mistakes were made and we will pay a heavy price for them. We must make sure that we learn a lesson from these mistakes" (Harney 2005).

The former Secretary General indicated that while he accepted many of the recommendations in the report he disagreed with a number. In his evidence he indicated that the criticism of the quality and performance of the MAC and the Department generally were unfounded: 'I do not accept the

generalised criticisms of the Department'(Kelly 2005) . He also rejected the lesson that the Department must be better able to identify and deal with 'issues of singular importance', because in his view the Department identified such issues all the time. The difficulty in addressing these issues lay with the lack of resources. He particularly welcomed the suggestion in the Report that there was a need to clarify the role of special advisers and Ministers for State, and the implication in the Report that if a Minister rejected the policy advice of civil servants, that this would also be recorded together with the reasons (Kelly 2005).

Conclusion

In this, and the previous chapter, we have set out in detail, using the coding structure in the template, the data that emerged from interviews relating to the interpretation of the policy fiasco by the interviewees, to the processes of interpretation that were being used, and the data from the other key sources in relation to how the LSC fiasco was interpreted by politicians, the media, and other officials. It is not the purpose here to summarise all of the key themes that emerged. These will be presented again in the next chapter, and tied to the analysis that leads to the key findings from this study.

In relation to the interpretation of the fiasco, the Secretaries General emphasised context as being central to understanding these affairs, particularly the changing economic, political, and social context. It was not possible to separate any perceived failure in the Department of Health from other failures in the wider system of governance. Some specific causes could be identified within the Department of Health, but generally these too arose to some extent from changing circumstances. There were consequences that they identified as flowing from this affair, including more formality in relationships with the political system, damage to trust, more risk aversion, an alertness to the damage that can be caused by policy fiascos, but also a sense of demotivation within the civil service. These can be contrasted with the more pragmatic lessons that were drawn, which were generally short-term and technical, relating to reviews of legality, new file tracking systems, or more written records.

This analysis by the Secretaries General was in many respects in quite stark contrast with the analysis provided by the media, by the official Inquiry, and by the politicians that gave evidence to the Oireachtas Inquiry. Their analysis rather focused on causes within the Department of Health and the civil service. For them, LSC was unquestionably a massive failure and there were few mitigating circumstances. The lessons drawn were generally short term and technical relating to revised procedures and systems, and the need for a greater awareness and alertness to risk in the civil service.

With regard to the processes of interpretation, the LSC case certainly grabbed the attention of Secretaries General because it, inter alia, made the Secretaries General feel vulnerable. It was a 'wake-up call'. There was criticism of the role of the centre in disseminating lessons, and most relied heavily on their own experience and style to interpret the events on behalf of their Department, supported by their management team. Almost all of the interpretation and discussion relating to LSC was individually based or internal to Departments. There was little or no evidence of collective discussion, in fact this was considered to be inappropriate. While there was pressure on the official inquiry to report in a short timeframe, the view was that for real learning that interpretation needed to be more reflective and long-term. In general the role of inquiries, including the process they used, was viewed with scepticism. The Secretaries General were the significant interpreters of learning for the system, and they relied not only on informal networking with colleagues and their own Departmental management team, but also on their own experience and background. What then are the implications of this data for addressing our research question?

Chapter 7

How Secretaries General interpret policy fiascos and the implications for learning: Analysis, Findings, and Conclusions from this Research

Introduction

I set out with the research question:

How do top civil service managers interpret policy fiascos, and how does this contribute to our understanding of learning in the aftermath of such fiascos?

In Chapter 2, I surveyed the existing literature and research on organizational failure and policy fiasco in the public sector. I discovered that while policy fiascos share some similarities with corporate failures in the private sector, they have a number of characteristics that set them apart. Different stakeholders have frequently interpreted the concept, the causes, and the context of policy fiasco quite differently. Yet both theory and practice has to date largely ignored differences in interpretation in favour of an organizational level analysis of failure and policy fiasco that is dominated by rational, objective approaches based on a sequential, retrospective analysis of the 'facts'. My starting position was, therefore, that given the complex and contested nature of policy fiasco, such approaches were insufficient for fully understanding and learning from these events.

In Chapter 3 we saw from a review of the literature that although the consequences of fiascos are frequently grave, and their occurrence apparently ever more frequent, we know relatively little about the process of learning from them. In a review of the theory of organizational learning I noted the divergence between those theorists who emphasize a collective and

process-based view of organizational learning, and those who emphasize the individual as the primary agent of learning within the organization. I progressed on the basis that understanding the interpretation of the individual manager, and uncovering the dynamic processes by which he or she learns, is critical to answering the research question. By examining how individual learning is related to both organizational and societal-level processes we can seek to overcome the dualism imposed by these competing theoretical perspectives. Learning may not always result in positive outcomes as assumed in normative theories associated with the 'learning organization'. Organizational-level theories such as these tend to concentrate on canonical and explicit learning processes within the organization, whereas I have argued that to fully understand learning from policy fiasco we must also consider non-canonical, unconscious, and 'hidden' learning processes. Nowhere is the emphasis on the rational and explicit more pronounced than in the work of official inquiries set up to investigate policy fiascos. Official inquiries are the favoured method of getting at the 'truth' of what happened, and they typically proceed on the basis of a rational analysis of organizational reality. However my position is that analysis by Inquiry typically provides just one interpretation of events, and one that is often symbolic in its intent. There are other interpretations, and I identified the interpretation by the Chief Executive of the organization as being particularly relevant to understanding the learning process.

From the literature review it is clear that the Chief Executive, or in the case of the Irish Civil Service, the Secretary General, makes sense of policy fiasco on behalf of his or her organization, and this interpretation of events is relevant to how the organization learns. Their sensemaking results in the construction of a theory or 'map' of events, and a theory of consequences. This theory provides the platform for future actions and behaviours. In order to understand how this theory is developed I explored the concepts of sensemaking and lesson-drawing. These provided the basis for developing a theoretical framework based on a constructivist epistemology and a relativist ontology. This framework focused primarily on interpretation at the level of the individual, but also encompassed the processes by which individual

learning influences and connects to organizational learning. I used this framework to develop the structure for interviews with thirteen Secretaries General in the Irish Civil Service, and also as the basis for coding the data from the interviews, and from a number of supplementary sources. In Chapters 5 and 6, this data was presented under the coded themes.

In this chapter I present the key findings from this research, and the analysis upon which the findings are based. In reaching these conclusions I have tried not to 'overstretch' the data by drawing on relatively minor evidence, although at certain points the data suggested some intriguing possibilities, some of which are referred to later in regard to opportunities for further research. Rather, I confined myself to those issues and themes that were well developed in the data, and that made sense in the context of the overall interview narratives. There were differences, and particularly differences in emphasis, in each of the thirteen interviews. These differences are relevant to better understanding the learning process. But the research question is ultimately answered by uncovering the content of the cognitive maps developed by Secretaries General in the aftermath of policy fiasco, by understanding how they developed these maps, and the ways in which these maps subsequently connected to wider organizational and system-wide learning processes.

I conclude the chapter by summarising the overall conclusions from this research, identify some of the limitations, and some of the implications for future research and practice.

Findings

In this section I present ten key findings from the research, and the analysis upon which each finding is based. The findings relate both to the content of the learning by Secretaries General, but also the processes by which this learning occurred. The findings deepen our understanding of learning in the aftermath of policy fiascos, not least by identifying some of the barriers to effective learning, and the reasons why mistakes are repeated.

Finding 1: ***Adopting an interpretative approach, based on the individual perspective of senior managers, is critical to understanding the process of learning from fiascos.***

This finding links all of the other findings that follow. Fundamental to my thesis was the assumption that an individual, interpretative approach was critical to understanding the process of learning from policy fiasco. I noted that the emphasis in the research literature to date has been almost exclusively on a rational, objective, and organizational-level of analysis. These approaches have failed to take adequate account of tacit learning, informal processes of interpretation and learning, and the potentially significant role of top civil servants in interpreting the causes, context, and consequences of policy fiascos,

The data shows that there is a richness in the individual interpretations of top civil servants that is almost completely ignored by the official processes of learning. The content of their learning, which is dealt with in more detail in a number of the findings below, is at odds with the official version of what happened. The research has also developed our understanding of the processes of interpretation and learning that senior managers use in these circumstances. These processes have also been shown to be quite different to the processes used by the official inquiry.

The study has helped me to understand more clearly, not only the individual processes of interpretation and learning, but how these link to organizational and wider societal-level processes. As discussed in more detail below, individual interpretations are partly based on personal experience, but also shaped through contact with processes and phenomena both inside and outside the organization. The individual engages with and enacts his or her environment, but in turn is influenced by that environment. There is an ongoing cycle of enactment and reflection that contrasts with other rational models of learning, By working from the individual level of analysis I have been able to uncover some of the complexity of interaction with organizational and societal levels, thus clarifying the process by which individual senior managers influence organizational learning.

The theoretical framework, based on sensemaking, has also proved particularly valuable as a basis for understanding both the content and processes of learning and this could be modified for use in further research in this area.

Finding 2: ***The interpretation of the concept of policy fiasco is contested, and this has implications for learning***

The data confirmed the contested nature of the concept of policy fiasco based on the interpretations of Secretaries General, but also clearly shows that rival interpretations are largely ignored in the official process of learning, particularly by official inquiries. The literature review suggested that while the concept of organizational failure is relatively straightforward and easily measurable in the private sector, this is not the case in the public sector. Despite public sector reform there are still few clear measures of success or failure available in the public sector, and particularly measures that can be agreed upon by the various stakeholders.

The data confirmed the highly contested nature of policy fiasco. There were differences in how the Secretaries General interpreted policy fiasco, and in particular their assessment of whether the LSC case really represented a failure at all. Despite the fact that LSC was a problem that had continued for over 30 years, led to a charge on the exchequer of over €2bn, and was almost universally portrayed by the official inquiry, by the media, and by politicians as a major failure on the part of the administration, at best this view was only partially shared by the Secretaries General. Even where there was willingness to admit some failure on the part of the civil service, their view was that at most civil servants were only partially responsible. The fact that this view was not shared by the Official Inquiry added to their scepticism of that process, and led to their distancing themselves from the official version of events.

This reluctance to unequivocally label this affair as a 'failure' could be interpreted as a demonstration of collegiality and loyalty, or simply defensiveness. On the other hand, it could equally be regarded as an

interpretation that is based on a nuanced and well-informed understanding of how the public sector really works. In my view the responses of the Secretaries General reflected a combination of these factors. The very fact that they did not share the view that this policy fiasco represented a failure on the part of the civil service is important for understanding the process of learning in the aftermath of policy fiasco. When even supposedly clear-cut cases of failure, such as LSC, are not acknowledged as such by the top civil servants, and when there are so many misgivings about the nature of the official inquiry process, then the opportunity for drawing relevant lessons is seriously diminished. This difference in interpretation about the fundamental issue of what constitutes failure makes the transfer of learning to the organization highly problematic and uncertain.

Finding 3: ***Realist/pessimistic interpretations of the causes of policy fiasco by Secretaries General contrast with positive/optimistic interpretations by the official inquiry, with consequences for learning***

In the review of the literature a number of different perspectives on the causes of organizational failure emerged. These ranged from the deterministic, organization life cycle perspectives that have been applied extensively in the private sector, to human cognition theories that regard people as the primary source of failure. Much of the research has focused on managers and their role in failure, and for example how defensiveness and the filtering out of unpalatable information can lead managers to ignore vital warning signs. We noted earlier that in practice official investigations frequently identify cognitive shortcomings, such as poor decision-making at senior management level, as the primary cause of failure. This represents an 'optimistic' interpretation insofar as attributing failure to human shortcomings implies that failure need not have happened in the first place, was an aberration, and can be avoided in the future. This reflects the point made by Dekker & Hansen (2004) that in the aftermath of fiasco public officials seek to identify individual shortcomings "in order to depoliticize the problem ...but such a bias diverts attention from structural problems, thus

undermining the learning potential for the organization as a whole". (2004: 34)

The Inquiry Report indeed focused almost exclusively on human and technical failings. It blamed a 'dysfunctional management' for failing to address the problem, and blamed 'groupthink' for allowing the Department to persist with an erroneous policy. The media reports tended to repeat these causes, and focused on the weaknesses in the Department and their dysfunctional 'sect like' approach to dealing with problems. The former Secretary General in his evidence blamed work pressure, competing priorities, and the fact that politicians were unwilling to deal with an unpalatable issue.

By contrast a largely different set of issues related to 'cause' emerged from the interview data. The area that received most emphasis was the complexity of the political/administrative relationship and the potential this had for giving rise to policy fiascos. Closely related to this was the theme of 'judgment' and the view that. Secretaries General, operating in a highly complex and pressurised environment, rely on judgment all the time to make difficult decisions. Their view was that in order to get the job done you sometimes have to cut corners, and faced with limited resources and a heavy workload, exercising good judgment is becoming more difficult. Administrative causes were also identified, ranging from the weakness of file tracking systems, poor recording, lack of competency to meet changed circumstances, and the new reality of dealing with interest groups who are always willing to challenge authority. Overall a general view emerged from the interviews that while more could be done to avoid fiascos, they could never be fully eliminated.

There was a clear difference therefore between the Secretaries General, who drew on a wide range of sectoral, political, social, media and economic factors in constructing their theory of cause, and the official inquiry, which focused almost exclusively on human, and specific technical causes. They

each looked to different sources when developing a theory of cause, and these divergent interpretations have implications for learning. Because official inquiries tend towards an optimistic interpretation of the causes of policy fiasco, the lessons that are drawn are, in turn, procedural and technical, and represent examples of 'single loop learning'. The interpretation of Secretaries General is based on a realist/pessimist perspective that views the occurrence of policy fiasco as unsurprising, if not inevitable. Such an interpretation is more sceptical about the value, and even the possibility, of learning from these events. From this perspective for policy fiascos to be rendered less likely, if not completely avoided, the conditions that give rise to them in the first place must be addressed. Interestingly there was no evidence from the data to suggest that the Secretaries General themselves, despite their senior position, regarded themselves as having any role to play in addressing these deeper issues. I would argue that even a conservative reading of the data suggests that the Secretaries General have less confidence in the potential for learning lessons from the fiasco, than was the case with either the Inquiry, politicians, or the media.

In summary, an optimistic analysis of policy fiasco that is based on an organizational-level analysis leads to the conclusion that learning is both possible and valuable. The lessons derived from such an analysis purport to provide the basis for overcoming the identified weaknesses, and the means to avoiding similar problems in the future. However from a realist or pessimistic perspective learning from fiasco is perceived to be a much more problematical process, and the benefits of learning much less clear. For example there is no guarantee that even where lessons are learned that similar fiascos can be avoided in the future, because cause is perceived to be deeply embedded in the system. If problems are perceived to be embedded in the system then it is only a matter of time before circumstances conspire to create another fiasco. No two fiascos are ever the same, and so learning from one does not mean avoiding another. Therefore while Inquiries adopt a positive and optimistic view, the primary agents of learning within the system, the Secretaries General, dismiss this interpretation as naïve and

superficial, and are much more inclined to the view that the causes of policy fiascos are deeply embedded in a complex system. This difference in the interpretation of cause represents another barrier to learning.

Finding 4: ***Context as critical to interpreting policy fiasco and the 'official' process of learning through Inquiries is challenged by top civil servants precisely because it fails, in their view, to take sufficient account of context and the conditions that give rise to policy fiascos.***

The literature review revealed some important aspects of the changing social, economic, technological, and public service environment that are relevant to the interpretation of fiascos. The 'Risk Society' thesis (Beck 1986) is that as society becomes more complex, so we increase risk. However with increasing wealth and increasing access to information there is at the same time less public acceptance that things can, or should, go wrong. A number of commentators have also argued that public service reform, and in particular the process of creating more and more agencies, has simply created more problems that it has solved, and actually increased risk.

Indeed the data confirmed that the Secretaries Generals regarded context as extremely important to the understanding and interpretation of fiascos. For example, the interview data revealed that much emphasis was placed on the transformation in Irish society over the past decade. Because in Ireland circumstances have changed so quickly and so radically, and problems of deficit have been replaced by problems of surplus. Public expectations of the public service have been revised significantly upwards, and the public service is finding it difficult to meet these. The data also supported the view that there are now more challenges to the traditional authority of the civil service. There is growing distrust between politicians wary of being blamed for civil service mistakes, and civil servants who feel 'squeezed out' of their traditional sphere of influence by political advisers and assorted lobby groups and pseudo-experts. There was a view that the relationship of trust between Secretary General and Minister has been jeopardised by recent fiascos. But the growing ambiguity and complexity in the relationship was also perceived to have

contributed to the causes of policy fiasco. The sense given in these interviews was that senior civil servants find themselves under increasing pressure from all sides, and increasingly unsure of their place in a complex and changing set of relationships.

This emphasis on context can be interpreted in a number of ways. A 'negative' interpretation might be that this is a way of obfuscating the real issue and deflecting attention away from the failures of the civil service. This is an interpretation supported by those theorists who argue that blame avoidance strategies are pursued by public servants in the wake of fiascos. However a more benign interpretation would be that the Secretaries General are in a better position than others to understand the 'realpolitik' of policy making and implementation, and have less need than politicians or the public to find 'easy' answers. It could be argued that they have the most to gain from avoiding a repeat of the fiasco, so it is in their interests to try to really understand what happened. Therefore their more nuanced interpretation involves drawing on a different and wider range of sources than did the official inquiry. Their analysis may be more complex, but also more balanced and complete, than that of the Inquiry or other commentators.

It is impossible to be definitive about which interpretation is more correct. However regardless of which is more correct, from a learning perspective the study clearly shows that the Secretaries General construct their understanding by embracing a much wider range of social, economic, and political phenomena than the Inquiry, which analysed the problem with a much more narrow-focused organizational lens and deconstructed a set of very complex events by translating them into a series of apparently simple, sequential steps. The individual managers engaged with the wider organizational and societal levels in reaching their conclusions, whereas the Inquiry almost exclusively relied on a rational, objective organizational analysis. This divergence in the approach to analysis and the relevance of context raises important issues about the process of learning from policy fiasco. For example, to what extent should the learning process focus on critical contextual changes which, according to the Secretaries General, are

actually creating the conditions for more and more policy fiascos, and to what extent should the process of learning take a more technical, Taylorist approach which assumes a positive relationship between procedural and behavioural changes and organizational outcomes? The conclusion from this study is that much more attention needs to be paid to context, if only to enhance the legitimacy of the official learning process.

However this is not to suggest that there is no learning in the aftermath of policy fiascos. On the contrary, the evidence of this research suggests that there is, and it is the nature of this learning that forms the basis of our next key finding.

Finding 5: ***Following policy fiasco, there is technical learning that arises in the form of 'lessons drawn', but also deeper 'unofficial' learning arising from the interpretation by top civil servants***

'Lessons drawn' relate to those specific procedural or technical changes proposed immediately in the wake of fiascos, and as we have seen, are typically the type of changes proposed by official inquiries charged with restoring order and confidence in the public administration. The data showed that Secretaries General were willing to transfer these lessons to their organizations, but not necessarily because they thought they were particularly useful. The types of lesson explicitly transferred in this way related to initiating reviews of the legal basis for policies, implementing new procedures and formalising systems, and were all examples of 'single loop learning'. The sense given in the interviews was that these were necessary responses to the LSC affair, but not nearly sufficient to address the deeper underlying issues that gave rise to the fiasco in the first place.

This research however also revealed deeper, and potentially much more important 'unofficial' or 'hidden' learning in the post-fiasco phase in the form of changed attitudes, perceptions, and behaviours. These were not necessarily directed towards what could be considered as positive organizational outcomes. For example Secretaries General indicated that

they were now more cautious, less trusting, and more formal in their dealings with the political system than before. There was evidence that as a result of policy fiasco there was less willingness generally to innovate or take risks, and a tendency for control and authority to be sucked back to the centre.

These are learning outcomes of policy fiasco that run counter to the objectives of the public sector reform process. This learning could be regarded as the unintended, 'hidden', and negative consequence of policy fiasco. It is 'hidden' to the extent that the lack of open or collective discussion means that the implications are not being discussed, but are still having impacts on the system. It is having potentially significant effects on the way the system operates, but is being completely ignored at an official level.

Finding 6: ***Cues are extracted from some sources and not from others, and depending on certain criteria***

One of the objectives of this research project was to try to achieve a greater understanding of the processes by which senior managers, in this case Secretaries General, interpret and learn from policy fiascos. Because it was noted early on that the theories of organizational learning are based on relatively high level assertions that remain largely untested, part of my research purpose was to understand better, based on empirical data, how some of the micro-processes associated with individual and organizational learning actually worked in practice. This study provides insights into what managers paid attention to when interpreting policy fiasco, and why.

Firstly it is clear that the LSC affair did have the effect of grabbing the attention of the Secretaries General, of 'getting noticed'. This was primarily because it made them feel personally vulnerable. The fact that another Secretary General had been adversely affected by the LSC affair meant that this fiasco had a particular resonance for this group, and even had a shock effect. The relevance of the sense of personal vulnerability created by a policy fiasco as a stimulus to learning has not been raised in the literature, and yet seems to be particularly relevant to understanding the process of learning.

The issue of 'distance' is also of particular interest here. Their sense of 'closeness' or 'distance' from the events was clearly relevant to the nature and extent of the lessons they drew. For example, whether or not the events occurred in what was regarded as a 'similar type' of Department was considered relevant, the implication being that fiascos that occur in Departments that are dissimilar have less potential for lesson-drawing. This tends to confirm the assertion by Turner that "scant attention is given to crisis events that happen in other organizations because it is assumed that the events are unique and unlikely to be repeated" (1994: 198).

With regard to the relationship between individual learning and organizational learning we noted that structuration theory suggests that process and structure can enable organizational learning, or create barriers to such learning. This study reveals more clearly how this works in practice. There were mixed views about the role of central departments, particularly the Department of Finance, in drawing lessons on behalf of the system as a whole in the aftermath of policy fiasco. There was a general view that they do have a role but that the dissemination of messages from the centre is inconsistent. There is less ownership of messages disseminated through the formal mechanisms such as circulars, and speeches, the means typically employed by central departments. The role of central Departments was considered much less important than the internal Departmental processes used to extract the lessons of policy fiasco. If not actually creating barriers to learning, these formalized central processes were at least perceived not to be enabling.

On the other hand internal processes, such as discussions at the MAC, were used extensively for extracting relevant cues. This was the key mechanism for 'separating the wheat from the chaff', for taking from the fiasco what was regarded as relevant to the Department. The process of interpreting the LSC affair was regarded as something that each Department had to deal with in its own way, and this appeared to reflect not just pragmatism, but also a core value of not meddling in the affairs of other Departments. There was an

acceptance that interpretations would vary between Departments, and indeed that this was as it should be.

The fact that the internal processes represented the most important collective approach to making sense of the policy fiasco is significant for understanding the process of learning. For example, it is less likely that learning will be consistent across the system. This is at odds with the clear assumption in the Inquiry Report that there should, and would, be uniform learning across the system, and that the lessons of the Inquiry would be taken as presented rather than re-interpreted. The overall picture created was of strong individual and Departmental processes of interpretation and relatively weak central processes, with strong evidence of variation in the nature and extent of learning. Based on the evidence of this study the personal, the informal, and the internal processes stimulated learning while the formal, the 'distant', and the centralized processes created barriers to learning.

We noted earlier the theoretical divergence between those who propose that learning is primarily the outcome of social, participative processes in organizations, and those who argue that it is based primarily on individual learning. The next two findings shed further light on these issues.

Finding 7: ***Following policy fiasco, learning is fragmented and 'silo-based', and formal, collective discussion is discouraged***

While there was little evidence from this study of formal, collective learning within the civil service system as a whole, as noted in the last section there was substantial evidence that each Secretary General and each Department drew their own lessons. The data suggested that the formal processes for collectively interpreting policy fiascos across the civil service system are weak, but deliberately so. In the Irish system at least, there is reluctance, for historical reasons, to have formal discussions at Secretary General level about policy issues of this nature. This is related to the separation of the role of government as policy maker, and the civil service as the executor of policy. Despite the fact that many stressed the value of informal networking with colleagues at Secretary General level on these matters, the lack of

formal collective discussion represents a barrier to the development of a community of critical inquiry that could systematically and collectively interpret critical incidents, and that could develop systematic and consistent follow-up. Whether this inhibition on collective discussion at sectoral level is just true of the Irish system, or reflective of a wider phenomenon in public administration, is an issue for further research.

The internal collective Departmental processes primarily involved discussions by the MAC. This was the key forum for internal collective sensemaking, and the data suggests that across all Departments serious attention was given to the 'fallout' from the LSC case. While all Secretaries General indicated that the issue was discussed at MAC, the level of formality in the process varied. In some cases specific groups were established to investigate the issues that arose, and to follow them up. In other cases they simply formed an agenda item on the MAC. This seemed to be due to the different approaches adopted by Secretaries General, the sense of how 'distant' or 'close' the events were experienced by the Secretary General, and the culture of the Department. Indeed the fact that there is such a heavy emphasis on the internal Departmental processes means that the individual interpretation of the Secretary General is more influential in determining learning outcomes in his or her Department. Again this reinforces an in-built bias towards variability in approaches to learning across Departments.

Weak system-wide collective processes, together with strong individual and collective internal processes, means that the nature and quality of interpretation and learning is highly specific to individual Departments, and therefore is likely to be inconsistent across the system as a whole. One of the conclusions that can be drawn from the study is that the potential for fiascos to be repeated is likely to be higher in such a system, than in one where there is a more consistent and collective approach.

If the collective processes are weak, what did the data reveal about the differences or similarities in the way in which individual Secretaries General interpreted policy fiasco? This leads to the next finding.

Finding 8: ***The Secretaries General, although reaching many common conclusions, did so as the result of highly individualised processes of interpretation.***

In a number of the earlier findings relating to concept, cause, and consequences we noted a high degree of similarity in the conclusions reached by the various Secretaries General. For example, they generally demurred from the official view that LSC categorically represented a failure by the system, they were sceptical of the value of the procedural and technical solutions proposed, and they regarded changing context as the critical factor in explaining why policy fiascos occur. However while there was a fair degree of commonality in the content of the mental maps they developed, the data also shows that they arrived at approximately the same destination by a variety of different routes.

The concept of 'identity' introduced by Weick (1995) was modified in my framework to include the style, experience, and individual interests of Secretaries General. These were all factors that influenced how they went about interpreting the fiasco. For example, in the summary of interview narratives (see Appendix 3) there were clear differences in emphasis that emerged in the way that the Secretaries General framed the issues and went about interpreting the events. Certain interviewees emphasised the critical role of judgment in a complex and changing administrative-political space. Others emphasised rational, preventive, and process-based approaches. It was clear from the data that for some, the events surrounding LSC were experienced as personally threatening, and reminded them of their vulnerability in a way that they had not been so conscious of before. They also referred to their previous experience in particular roles, their interests, their areas of skill and strength that in different ways influenced how they interpreted events. Their attitude in most cases was that while it was impossible to be certain that such events could never occur in their own Department, that their approach, their attention to process, their understanding of the political system, their experience, or their good judgment would render it much less likely.

This could reasonably be interpreted as a means of maintaining confidence in the wake of policy fiasco, of creating distance between themselves and the events that happened, and of providing reassurance both to themselves and their staff. The way in which they created a narrative of events was plausible in terms of how they viewed their own individual strengths. The narratives were framed in such a way that the way of preventing such fiascos was by reference to the talents and/or experience that they themselves possessed as individuals. This 'defaulting' to familiar frames of reference, while confirming some previous research, suggests that the focus on individual strengths rather than possible weaknesses constitutes a barrier to learning from fiascos. Interestingly, in the case of the LSC fiasco there were a number of Secretaries General who took the view that it was the style, and the dominant interests of the Secretary General that led to an over-emphasis on the strategic and 'visionary' aspects of the job, and caused him to give less attention to the operational role, and that this was one of the causes of the fiasco.

The evidence from this study is that even within a public bureaucracy where senior managers have spent most of their formative career, that previous experience, interests, and style of individual Secretaries General are significant factors in how he/she interprets events. Given the weak collective processes of learning, this renders the individual interpretation at the top level of management particularly influential with regard to organizational learning, and potentially contributes further to unevenness and inconsistency in learning across different Departments. Additionally, the tendency for Secretaries General to frame their interpretation in a way that reflects their own biases, interests, personality, and strengths creates a potential weakness because it can result in 'blind spots' in their analysis. These same individual interpretations could become a real strength within the system if they were openly discussed and shared, and thereby contribute to a richer set of perspectives on policy fiasco.

Finding 9: ***Time represents both an opportunity for, and a barrier to, learning***

In our review of the literature the relevance of time to the understanding and interpretation of policy fiascos was highlighted. Weick drew attention to the importance of understanding the 'moments' in a train of events that are isolated by the 'sense makers' (Weick 1995). The Secretaries General were critical and wary of what they interpreted to be 'knee jerk reactions' in the immediate aftermath of policy fiasco, and that such reactions, while perhaps necessary for restoring public confidence, were not useful for getting at the important lessons. Rather, they emphasised the need to reflect and take time 'to get at the real lessons'. The data suggests that over time, and informally, the Secretaries General had drawn certain conclusions about the consequences of the affair. These were different to the conclusions drawn by the official inquiry in the immediate aftermath of the affair, and reflected learning at a different level.

The data also confirmed that policy fiasco creates a 'window of opportunity', and this was perhaps most vividly illustrated by the observation that the LSC fiasco had formed the basis of questions at senior civil service interviews for six months afterwards, and that the events therefore provided a limited window of opportunity for change. However it is also interesting to note that the sensitivity about openly discussing the fiasco appeared to last much longer than did this 'window of opportunity'. The reluctance to openly discuss the issues twelve months after the affair is relevant to the process of learning because paradoxically, by the time the key actors feel more comfortable with discussing the events it is also likely that the context will have changed, and the opportunity for learning may well have passed.

This research therefore confirms the view that there is a limited 'window of opportunity' for learning in the aftermath of policy fiasco. However this period is perceived as often being dominated by 'knee jerk' responses that may be necessary to restore confidence, but not sufficient to address the real issues. The need to be seen to take corrective action in the aftermath of policy fiasco is seen to conflict with the need for more reflective learning. At

the same time the reluctance to openly discuss these issues until after the 'window of opportunity' has passed militates against reflective learning. There is therefore a strong bias in favour of single –loop learning over double-loop learning in post-crisis situations. This leads to the last main finding from the research project.

Finding 10*: The value of prevention is reinforced by the occurrence of policy fiascos, but the application of preventative strategies is haphazard*

One of the unexpected outcomes of the research, and one that has not been dealt with to any great extent in the literature on organizational failure or policy fiasco, was the emphasis that many Secretaries General placed on the importance of prevention of fiascos. The role of the Secretary General in disrupting 'normal logic', the precautionary reading of all relevant material, the regular and extensive briefing of management and staff, the emphasis on robust process, context auditing of policies, and monitoring of trends in the environment, were all cited as examples of the precautionary measures adopted by different Secretaries General. The suggestion was that because of these measures they were less likely to fall victim to policy fiascos. Particularly in the aftermath of a fiasco in another organization, they set great store by the processes they had individually put in place to avoid similar problems, and saw this as a significant part of their job. Numerous examples were given of how potential fiascos had been avoided in this way.

These preventative processes represent examples of ongoing organizational learning, where the Secretary General is a key agent and instigator of learning. By challenging, interpreting, looking outwards, and looking forward, the Secretary General seeks to ensure that systems, including people, are constantly adapting to new circumstances and managing new risks. However the study also shows that these preventative strategies vary from one Department to another, and are significantly influenced by the style and approach of the individual Secretary General. However these preventative measures are not shared, and therefore remain haphazard and highly dependent on the individual manager. A more collective and shared

approach to prevention would lead to deeper, wider, and more consistent ongoing learning across the system.

Summary of Findings from this Research

In this study I was particularly interested, by addressing the research question, to understand the specific processes of interpretation and learning used by top managers in the aftermath of policy fiasco, and how these in turn link to collective and organizational levels of learning. It is only by developing such an understanding that we can further refine the grand theories of organizational learning that have tended to dominate the literature to date, and at a practical level understand some of the real barriers to learning from policy fiascos, and how they might be overcome. Overall the individual interpretative framework used in this study has been particularly useful in deepening our understanding of the learning processes following policy fiasco.

In terms of the content of learning we noted the significant divergence between the explicit, objective learning proposed by the official Inquiry compared to the interpretation of individual Secretaries General. The latter disagreed on the very notion of equating policy fiasco with failure. They differed with the Inquiry's optimistic analysis of cause and remedy, instead favouring a more pessimistic analysis that regarded policy fiascos as an endemic part of the system. When making sense of what happened the Secretaries General relied very heavily on changing context and environment, whereas the Inquiry focused almost exclusively on internal organizational issues. These significant divergences between the official and the unofficial learning processes in themselves create significant barriers to learning from adverse events.

But these findings also help us understand at a more detailed level the processes of sensemaking and learning that are at work. The Secretaries

General pay heed to policy fiascos more or less depending on how 'distant' or 'close' they feel to the events, including the degree to which they feel personally vulnerable. They generally avoid collective and formal discussions of such events at the sectoral level, but favour informal discussions with colleagues or, more importantly, internal discussions with their own departmental management team. This means that the nature of the learning and the lessons drawn are highly specific to individual departments and highly dependent on the individual Secretary General. Secretaries General generally reached the same conclusions but by a variety of interpretative routes that were influenced by their own individual experience, style, and interests. All of the evidence relating to the processes of learning suggested great potential for inconsistency in the nature and application of learning.

There are also longer-term lessons drawn from fiascos but frequently these are not openly disclosed or discussed. This is the 'hidden' learning reflected as subtle changes in relationships, behaviours, and approaches. Because this learning is not disclosed or discussed, neither is it managed, but it still represents one of the important ways in which things change as a result of policy fiascos. For example in this study we saw evidence of less risk-taking, more formality in relationships, less trust in the political system, more caution about the potential personal implications of certain actions, as examples of such deeper learning in the aftermath of policy fiasco. So while policy fiascos prompt a response, this response is either the typically superficial and symbolic lessons drawn by Inquiries or the sometimes defensive reactions and 'hidden' learning by senior managers manifested in changed attitudes and behaviours.

Some Implications for Theory

As described in some detail in Chapter 3, major contributions to the theory of organizational learning can be broadly classified by reference to those that take a primarily collective or a primarily individual perspective on learning in organizations, and those that take a primarily normative or a primarily explanatory perspective. One of the problems consistently identified in the

literature was the lack of empirical data to support these various perspectives. I have also argued that these classifications also potentially disguise some of the real complexity of the learning process in organizations. This is particularly so in the case of learning in the aftermath of policy fiascos. Policy fiascos are politically, as well as socially and administratively constucted events that attract a lot of media attention. The process of learning from these events is therefore particularly complex. We noted indeed that there is significant evidence to suggest that policy fiascos tend to be repeated.

This study came within the individual, explanatory tradition of organizational learning. In this study I sought to explore some of the processes of learning by starting with the interpretation of individual senior managers, but also encompassing the transactions that occur between these managers and the wider organizational system in the process of interpretation. I contrasted these individual and participatory processes of interpretation with the objective organizational level analysis that typifies the official learning process. We saw that the content and process of learning from each was quite different, and this difference in itself represents a significant barrier to consistent and shared learning across the system.

The results shed new light on the processes of individual and organizational learning in the aftermath of fiasco and suggest why lessons may not be effectively learned, and mistakes repeated. The findings show how a reliance on rational analysis that produces explicit, objectified knowledge, as happened with the official inquiry, leads to short-term learning that is often superficial and symbolic. This is in contrast to the 'hidden' or tacit learning that results from the interpretation of Secretaries General and that leads to longer-term changes, but not necessarily changes that are always positive.

We also saw that organizational structure, process, and practice can enable or hinder learning. For example, formal centralized processes were often ignored by the top managers in favour of informal and distributed processes of learning. There were serious inhibitions among Secretaries General about

their formal learning as a group, and this clearly constituted a barrier to learning at the systems level. While there was little evidence of collective learning at the systems level, there was evidence of collective learning at the organizational level, although this was heavily influenced by the individual interpretation of the top manager. It was clear that the top managers attended to issues that they felt as 'close', that made them feel personally vulnerable, and that their response to the crisis was highly individualized and based on their own past experiences and areas of interest. These managers constructed their understanding from a wide range of ambient circumstances, political, social, administrative and economic. The study therefore showed that the dynamic ongoing interaction between the individual manager and his or her environment was particularly relevant to the learning process.

Ultimately the study demonstrated that by adopting an interpretative approach that focused on the individual senior manager we can not only develop a better understanding of learning at the individual level, but also understand how individual managers influence and affect the process of organizational learning. This is a field, as noted at the outset, that has been in the grip of rational models that have failed to fully comprehend and address the complex process of learning following traumatic organizational events, and in particular how the process of interpretation informs learning. At this point it is worth repeating the quotation from :

> Organizational realities are not external to human consciousness, out there waiting to be recorded. Instead, the world as humans know it is constituted intersubjectively. The facts of this world are things made. They are neither subjective nor objective in the usual sense (Brown 2000:48).

This study not only confirms the validity of this statement, but also brings us to a deeper understanding of the difficulties of learning from policy fiascos. It confirms the critical role of top managers in interpreting the lessons from adverse events on behalf of their organizations, and provides us with some unique insights into the process of interpretation in the senior civil service in Ireland. In these various ways I would hope that this study might encourage

further interpretative research into learning from policy fiascos, since there is still much to learn.

Some implications for practice

From a practical perspective there are a number of implications arising from this study. Given the often serious consequences of policy fiascos it is critical that everything that can be done to avoid or prevent them should be done. In this study a number of Secretary Generals discussed preventative strategies they had put in place. It would be practically very useful if a process could be established for disseminating and sharing information more generally on these strategies and whether, and how, they work.

It seems very clear from this study that a way has to be found of incorporating the views of senior civil servants, and indeed other stakeholders, into the official learning process. This would involve a more inclusive process that embraces a wider variety of interpretations of what happened and why. This should allow for greater emphasis to be given to contextual issues, and therefore more attention to be paid to identifying and addressing some of the deeper adaptive changes that are occurring and that may be creating the conditions for policy fiasco. While this might not serve the need for early closure and ready-made answers that is often demanded in the immediate aftermath of policy fiasco, current approaches often appear to lead to superficial learning. In the long run a more comprehensive and inclusive approach to learning would better serve the needs of all of civil society.

There was much criticism of the official inquiry process, and the fact that it is not necessarily perceived as impartial, and that the approach differs from one case to another. There may be an argument therefore for looking in more detail at the possibility of establishing some type of agency that would carry out such inquiries on an ongoing basis. This would have the advantage of

adopting a best practice approach that could be consistently applied, and that may generate greater confidence in the findings of inquiries. It could also act a repository of learning from fiascos, and provide a formal mechanism for follow-up. Based on the data, the approach to be adopted should be inclusive of a variety of interpretations of key stakeholders, and including senior civil servants.

The data shows that the Irish Civil Service is very much silo-based, with little evidence of shared collective learning across Departments. There is a tension between the line Departments who mostly act independently of each other, and the central Departments who frequently seek to centralize control in the wake of policy fiascos. At a practical level therefore there is a need to try to resolve this tension, and develop a more mature and shared learning process that aims at support, development and learning rather than simply allocating blame, drawing superficial lessons, all in the interest of seeking early closure.

Finally it also seems clear that the interests of learning would be better served if there were more open discussion of policy fiascos, including at Secretary General level. The current reluctance to discuss these matters at the highest level gives out a strong signal to the rest of the system. It is perhaps timely, given the remarkable changes in Irish society that have been referred to throughout this study, to revisit the reasons why such discussion was not deemed appropriate and to consider whether these reasons are still valid in current circumstances.

Limitations and areas for further study

While I have emphasised the value of working with individual interpretative frameworks as the primary basis for analysis, a drawback of this approach is that analysis too involves interpretation. My theoretical framework sought to support a robust analysis, and proved effective in the light of the data collected and the richness of the analysis that it facilitated. The analysis of the 'how' and 'what' components of interpretation proved to be particularly useful. However a potential drawback with any such framework is that the

research can be theory driven. This is of particular relevance to a study that is based on a relativist ontology that assumes that social reality is constructed. While I discussed at some length how I sought to minimise these drawbacks in the study, the fact remains that the theoretical framework guided my data collection and analysis. It would be useful therefore to test other frameworks for understanding the process of interpretation and learning from policy fiascos, not only to further test the conclusions from this research, but to provide further insight and understanding into these learning processes.

I acknowledged in the discussion of research methodology my own role in this study and, in particular, my role as interpreter. To be consistent with the philosophical position I have adopted in this study I must also acknowledge that as researcher I am just another interpreter of social reality, and that my interpretation has been influenced by my own background and life experience. Of course it is necessary, as already noted, that in order to avoid absolute relativism the social researcher must attempt to interpret social reality, but it would also be valuable for other researchers to undertake secondary analysis of the same data.

While, as noted earlier, we can have confidence that the conclusions from this research holds good for policy fiascos that occur within central government in Ireland, the extent to which interpretations of policy fiasco may differ in other parts of the Irish public sector, or by other stakeholders e.g. politicians, needs to be further explored and would add further to our understanding of the process of learning in these situations. We have also noted that a number of the barriers to learning identified in the findings relate to specific aspects of the Irish system, such as the historically-based inhibition on collective dialogue at Secretary General level. It would be useful for similar research to be carried out with senior civil servants in other countries to establish the extent to which country-specific factors may influence interpretation and learning.

While I have emphasized the value of working with the individual as the primary unit of analysis, I also recognize the value of research at an organizational level. In particular I believe that in order to complement the individual interpretative approach adopted in this study, it would be very useful to research the longer-term impacts of policy fiasco on organizations. Such an analysis would help us understand whether the technical 'single loop' learning from Inquiries identified in this study has any long-lasting impact, and more importantly how the 'hidden' learning by Secretaries General impacts on the organization in the longer term.

Overall I believe that the study has contributed to developing a greater understanding of the processes of learning in the aftermath of policy fiasco, but this is still a relatively new field of inquiry and would benefit from other research perspectives that would supplement and refine the findings.

Conclusion

We commenced this study with the research question

'How do top civil service managers interpret policy fiascos, and how does this contribute to our understanding of learning in the aftermath of such fiascos?'

My thesis was that by adopting an interpretative approach to understanding how the top civil servants interpret policy fiascos, and draw lessons from them, that I could discover some of the reasons why there is such difficulty in learning lessons from these events. The case study approach adopted allowed for the detailed analysis of an iconic case of policy fiasco, and its interpretation by the group of Secretaries General in Ireland. What the study revealed is that by understanding how senior civil servants interpret these events, we can understand much more about the complexity of the learning process involved. While official inquiries serve certain important purposes, they do not provide a sufficient basis for comprehensive learning from adverse events in the public sector. Because of the primarily rational,

retrospective, and mostly context-free approach that they generally adopt, their findings are viewed with some skepticism. This in turn impacts on the perceived legitimacy of the lessons drawn by such Inquiries, and their translation into effective action by civil servants. Senior civil servants on the other hand pay much more attention to context in their interpretation, and the issues that are identified as giving rise to policy fiascos are perceived to be multifaceted and multi-layered.

It has been acknowledged widely that when things are perceived to go wrong, often with serious consequences for certain vulnerable groups and individuals, that it is imperative that we learn from these events and prevent their recurrence. What this study reveals is that learning from policy fiasco is complex and that current official processes do little to address the barriers to learning, and in many respects serves to create further barriers. The study has also shown that organizational learning processes in the wake of policy fiascos do not submit to easy classification, but involve complex individual and collective interpretation processes that embrace organizational and societal-level concepts to shape understanding and meaning. Policy fiascos are themselves complex events, and reflect changes in society and the changing relationship between politicians, public servants, and citizens. To prevent the increased incidence of such fiascos in the future will require that learning processes embrace the variety of interpretations by different stakeholders, and on that basis draw implications and apply lessons. What this study has revealed are the complex processes of interpretation and learning that are at work, the critical role of the interpretation of senior managers, and has furthered our understanding of why learning from policy fiascos has proven just so difficult in the past.

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Appendix 1

Definitions, Acronyms, and Technical Terms

Assistant Secretary: Second tier of management in a Government Department

Department: Ministry

LSC: Long Stay Charges- the case of policy fiasco used in this study

MAC: Management Advisory Committee, the Management Committee established in each Department under the Public Service Management Act 1997, and chaired by the Secretary General

***Mini*-CTC**: Previous fiasco relating to a rail project

Oireachtas: the Irish Parliament

PAC: Public Accounts Committee, an all-party Oireachtas Committee responsible for scrutinising public expenditure and value for money, and which requires presentations by Secretaries General

Public Service Management Act 1997: Legislation introduced as part of a general public sector reform process and which, inter alia, defines role of Secretary General, and details the requirement on each Department to produce strategy statements and business plans.

Secretary General: The Permanent Secretary, or head of the Ministry

Special Adviser: Politically appointed advisers to the Minister

TLAC: Top Level Appointments Commission, responsible for filling senior civil service positions

Appendix 2

Description of Codes and Sub-Codes

Codes and Sub Codes	Theme	Related element of Theoretical Framework	Sub Theme	Brief Description
CO	Concept	Concept of Policy Fiasco		
cocon			*Concept of Fiasco*	*Was it regarded as a failure?*
cocri			*Criteria*	*Criteria used to categorise a fiasco as failure*
CA	**Cause**	**Causes of Policy Fiasco**		
caadm			*Administrative Causes*	*Administrative causes identified*
cahlt			*Dept of Health*	*Causes identified as unique to the Dept of Health*
cajdg			*Judgment*	*Causes relating to errors of judgement*
capol			*Political*	*Political causes identified*
CX	**Context**	**Context of Policy Fiasco**		
cxadm			*Administrative Context*	*Elements of internal administrative context deemed relevant*
cxpol			*Political Context*	*Elements of political context deemed relevant?*
cxpre			*Pressure of work*	*Workload pressure relevant to fiasco*

cxpsc			*Public sector context*	*Aspects of wider public sector context deemed relevant*
cxsoc			*Social and economic*	*Aspects of wider economic and social context deemed relevant*
CQ	**Consequence**	**Consequences of Policy Fiasco**		
cqrsk			*Risk*	*Consequences for the 'Risk Environment'*
cqadm			*Administrative*	*Consequences for the Administrative environment*
cqpol			*Political*	*Consequences for Political environment*
LE	**Lessons and Learning**	**Lessons and Learning from Policy Fiasco**		
leadm			*Administrative*	*Administrative and political lessons drawn*
leeval			*Evaluation*	*Evaluation of the lessons and learning from fiasco*
Prev	**Prevention**	**Strategies for preventing policy fiasco**		New code based on the data

Cue	**Extracting Cues**	**Extracting Cues to interpret policy fiasco**		Sources for extracting cues when interpreting policy fiascos
Cueatt			*Attention*	*How do policy fiascos grab the attention?*
Cueex			*External Sources*	*What are the external sources, apart from the Inquiry, that are used to extract cues?*
Cueint			*Internal Sources*	*What are the internal sources that are used?*
Cueinq			*Inquiry*	*How is the Inquiry used to extract cues?*
Social	**Social processes**	**Social Processes used to interpret Policy Fiasco**		
Socin			*Internal*	*What are the social processes that are internal to the Department*
Socco			*Collective*	*What are the collective social processes used?*

Ongoing	**Ongoing process of interpretation and learning**	**Ongoing**		
On			*Ongoing*	*How is the process of interpretation and learning from policy fiasco ongoing? What role does time play?*
Exsty	**Experience and Style**	**Experience**		How do experience/style influence interpretation

Appendix 3

Summary Narrative of Interviews

Narrative of Interviews:

In order to provide an overall sense of the interviews, including differences and similarities, I present below a short synopsis of each interview. The intention is not to provide detail, for this can be further gleaned from the codedtables below . Rather the intention is to provide the reader with an overall sense of the areas that were emphasised, and the tone and approach adopted by the various interviewees.

Interviewee A: Interviewed on 23/05/2006

Interviewee 1 took a pragmatic approach. He was 'too distant' to make a judgement on the complex events that happened in the Department of Health but examined the report to see what general lessons could be drawn and applied. Every Department 'does its own thing' and will draw its own lessons. The public service has become increasingly complex and this is no doubt contributing to these fiascos. The Secretary General needs to maintain a balance between risk avoidance and innovation in the aftermath. The follow-up action has now been completed, and some existing projects accelerated. There have been some adjustments to the way of working in the Department, but normal business must go on.

Interviewee B: Interviewed on 18/06/2006

This interviewee was more general in his responses, and by focusing on the changes in the context of public service work over the past two decades argued that policy fiascos were now more likely. The key message was that one must look to the changing economic, social, technological, and political landscape in which the public service operates to find the causes of these fiascos. The country has been transformed in a relatively short period of time and this has raised expectations and put huge pressure on the public sector. There was concern that problems that are 'slow burning' over a long period do not get the same attention as the high profile 'fiascos', even though their

consequences may be more serious. He identified the mistakes that were made in the wake of Irelands' accession to the EU that led to massive unemployment and debt for almost two decades as an example of this. The LSC case represented just another example of a system failing to adapt sufficiently quickly to radically changed circumstances and heightened expectations.

Interviewee C: Interviewed on 13/05/2006

The major emphasis in this interview was on the nature of the administrative-political relationship, and particularly the nature of the relationship between a Secretary General, his/her Minister, special advisers and Ministers for State. The dynamics of this relationship have been changing and continue to change, and this was critical to understanding the LSC affair. There is increasing confusion and tension in the relationship, less trust on both sides, and the ground rules are changing. This is where the biggest potential for policy fiascos lies, and managing these relationships effectively is critical to avoiding such problems. There was an emphasis on the interviewees' own experience of a fiasco, and how that had resulted in a greater awareness of the potential for small matters to grow into major problems.

Interviewee D: Interviewed on 17/05/2006

This interviewee focused on the 'realpolitik' of the work at Secretary General level –it is not the idealised role described in the LSC Inquiry report, but a job that requires judgment and the ability to get things done despite all of the constraints and pressures. Politicians have their job to do and civil servants have theirs. The pressure of time and workload is making this juggling act ever more difficult-but you can't have rules to cover every situation. Therefore it comes down to judgment. A number of cases were cited where the interviewee had made judgements that helped to avoid potential problems. However there is increasing pressure, not least because of media attention, to respond quickly to events and to cut corners, and this could be storing up more problems for the future.

Interviewee E: Interviewed on 4/06/2006

There was significant focus in this interview on the constraints that are on the public service on the one hand, and the increased expectations of politicians and public on the other. The public service operates to completely different rules than the private sector. For example the public sector cannot write off mistakes in the same way that the private sector can. The public sector causes problems for itself by pursuing perfect solutions, when incremental change is often more appropriate and practical. The public service needs to be better at managing its public image. There was a pragmatic view of the relationship between politicians and civil servants- each must play their respective roles. The Secretaries General network informally and in the past this has helped them to make sense of policy fiascos.

Interviewee F: Interviewed on 19/05/2006

This interviewee emphasised the need to learn from LSC case and similar fiascos, even where we might not agree with the detailed analysis and conclusions of an Inquiry. There was a failure of administration in the LSC case, but 'we did not get the full story'. The context of public service work is changing, and Inquiries do not pay sufficient attention to context. The growth in the number of agencies is leading to more problems of accountability and communications. There are significant pressures in the system. There are lessons from LSC but limited resources make them difficult to implement. There needs to be more follow-up to see what has changed, and the Secretaries General could develop their process for collective learning.

Interviewee G: Interviewed on 23/06/2006

This was the longest interview, highly reflective, and brought together points raised in many other interviews. There was clearly an administrative failure in the LSC case, but there were also political and other dimensions that did not get proper attention in the Inquiry and media reports. The relationship with Ministers and their advisers has to be handled with great care. This relationship was clearly an important aspect of the LSC case. The interviewee focused on the sheer complexity and pressure of work on the senior civil service. Small matters arise all the time and unless dealt with properly can 'blow up'. Judgment is critical here. The legislative base of many Departments is highly complex, and every day potential problems come to notice. While you does the best you can, and put all of the preventive mechanisms in place, it is impossible to guarantee that fiascos will never happen-the business is simply too complex for that. It is important to learn, but not in a 'knee jerk' way. The most significant process of interpretation of LSC had taken place with the management team in the Department. The Secretary General group is often reluctant to discuss certain issues because of the sensitivity about how that might be perceived by government. But the central Departments needs to be more proactive in disseminating lessons. In the aftermath of LSC many staff would probably prefer to avoid risk, and selling the continued need for innovation has become more difficult.

Interviewee H: Interviewed on 2/07/2006

This interview focused on rational, formal and structured responses to the LSC affair. Strategy statements, business plans, risk assessment and the formal procedures put in place to address any identified shortcomings were emphasised as the key methods for avoiding such problems in the future. There was an emphasis on competency gaps in the Civil Service. The demands on the Civil Service have changed and sometimes it just does not have the competency to deliver. This is leading to problems. He described probably the most formal and structured approach to the follow-up to LSC of

any Department. A group was established to review LSC and its implications, formal papers developed, changes introduced, and these are now being formally reviewed by a special group. Learning is an ongoing process and happens all the time, not just post-fiascos.

Interviewee I: Interviewed on 29/05/2006

While government departments and Secretaries General have to use discretion, a key message from LSC is that you must have the legal basis for action. There is no room for discretion here. The interviewee emphasised the role of prevention, and also emphasised the important role of the Secretary General and senior management in making sure that all staff are aware of the need to bring potential problems to attention, and to protect and encourage such behaviour. The Inquiry process can be flawed, and he would like to see this improved, perhaps through the establishment of a dedicated standards agency. In his own Department there had been one previous serious fiasco and many lessons had been learnt. Because the Departments has a technical remit and is decentralised, he generally looks to specific types of fiascos for lessons. There has also been negative learning from LSC because civil servants are now more cautious, and morale has been damaged.

Interviewee J: Interviewed on 16/06/2006

Emphasised that changes in society, including greater access to information, had diminished the expert/authority role of the civil service, and this was still not fully appreciated by civil servants. This was leading to fiascos because almost every decision of the Civil Service was being challenged by well-organized and well-informed groups. The civil service has had to adapt its approaches. But LSC was an example where this had not happened quickly enough. It was also an example of where decisions and actions were being analysed through the 'lens' of present-day attitudes and norms. The political system has less confidence now in the public service and is not willing to be blamed for what politicians regard as civil service mistakes. Departments will react differently to these fiasco situations and it is important to assess what are the relevant lessons for this Department. The internal management team is critical to the process of interpretation. The inquiry process can be

useful, and an example of a good Inquiry was mentioned, but this is not always the case.

Interviewee K: Interviewed on 7/07/2006

This interviewee put significant emphasis on context, particularly the relationship with the political system. Civil servants have huge loyalty to the political system, but this is being eroded by LSC and other recent events. There is ferocious pressure now and demands for immediate responses. Yet the Civil Service is always expected to get it right. The problem now is that if everything has to be 'signed off' then it will slow down the response. He was quite critical of what he perceived as the unfairness of the inquiry process, and the fact that 20: 20 hindsight cannot give due account to the dynamic context and nature of the work of a senior civil servant. Civil servants are easy targets. There is huge loyalty to the political system, but civil servants are constrained in the responses they can give when questioned on these matters. Anybody can be caught on a point of detail-it all looks very clear when one looks back, but not when one is dealing with so much every day.

Interviewee L: Interviewed on 18/06/2006

Put the major emphasis on the need to have proper process in place, often in spite of the pressure to get things done very quickly. Politicians may not always appreciate the need for process, but they can be convinced. Emphasised the leadership role of the Secretary General in disrupting 'normal logic' and avoiding groupthink to help the system look at issues in a fresh way. Staff have to be empowered to identify and solve problems before they grow into something bigger. The Secretary General has a very important role in interpreting these events of behalf of the organisation, but inevitably the different styles and interests of Secretaries General will mean that they will focus on different issues. Also referred to the reluctance collectively at Secretary General level to formally discuss such issues. While the centre has a role in disseminating lessons from fiascos, circulars do not generate 'ownership '.

Interviewee M: Interviewed on 15/06/2006

This interview was quite different from the rest insofar as it was dominated by the theme of preventing fiascos. The interviewee obviously expended considerable effort in avoiding problems, and cited many instances where they had been avoided as a result of the processes he had put in place. Maybe policy fiascos cannot be avoided completely but a lot can be done to minimise the risk. Emphasised the Secretary General role in identifying and interpreting trends and the risk inherent in such trends. Also emphasised the importance of the Secretary General being on top of everything that is happening, having regular communications with senior management and the Minister, and chairing relevant committees. There is a need not just to identify problems but also to make sure that appropriate mitigating action is taken. He also emphasised style, where in this case his style was to make sure that every member of staff knew that he had 'my finger on the pulse' , and then they will get the message. He suggested that if similar approaches had been adopted in the LSC case then maybe it could have been avoided.

Appendix 4

Data Coded by Interviewee

Interviewee A

1.		**cueint**	I did not look at detailed circumstances; not competent to do so; it was very complex
2.		**cueatt**	We used it as a reminder to look at our own procedures
3.		**cueinq**	An independent report is valuable. We can argue about the quality, but it is a good way of highlighting issues. I can't remember much about the Oireachtas Committee- that was more focused on political issues and not that useful.
4.		**exsty**	The Secretary General has a very important role because ultimately he is accountable. In the LSC issue the Secretary General was in the firing line. When you become a Secretary General you become aware of these issues.
5.		**on**	We discussed issues arising at the time and put changes in place but we did not go back to discuss it. There is a period of time and you have to take advantage of it. Had we found serious deficiencies, well that would be a different matter. We're very busy so you have to get back to normal business.
6.		**socco**	I would say each Department responded in its own way. I don't recall a collective discussion on the matter; the fact that some people were directly involved made this difficult. There has been for many years a concern in some areas at political level about formal meetings of the Secretary General Group. The culture is that each Department 'runs its own show'
7.		**socin**	We all know our own business best;
8.		**socin**	We got a group of people to analyse the report. Also discussion at MAC; internal discussion was very important
9.	**cahlt**		Its easier if you are just dealing with policy or just with delivery; but if you are dealing with both, as was DOHC, increased scope for confusion and mis-interpretation
10.	**cocri**		The scale of it was different; and the financial consequences so great
11.	**capol**		The interface between political/admin system is dynamic; they had to cut corners;

			we all do
12.	**cocri**	**cueatt**	We were shocked: It looked like a disaster from the outside; surprising it went on for so long
13.	**leadm**		We have a lot of systems to make sure risk is managed. Also a lot of stuff emanates from central departments that is taken on board
14.	**cqrsk**		In the conclusions from the Travers Report there was a lot of emphasis on control and accountability. This is consistent with the trend. But you have to keep a balance between that and the creative, innovating part of our work. Sometimes people say 'play it safe and do nothing' But you have to encourage risk-taking.
15.	**lersk**		But maybe risk avoidance is emphasised more now.
16.	**cxpol**		Demand for faster response now from the political system, then on to the next issue
17.	**cxpsc**		Its much more complex now, much more engagement with agencies e.g. Department of Health and Health Boards; web of interaction more complex
18.	**cxsoc**		Projects have been overspent-now there is more money to spend, so there is a greater emphasis on budget control. There are phases in public administration, different things are emphasised at different times. Its not unlike business in that way.
19.	**leadm**		We recognised vulnerabilities in the system e.g. where everything is now held on PC; we speeded up some projects already ongoing
20.	**leadm**		We reviewed the MAC to make sure all of our management systems are' up to scratch.'. Nothing totally new-all consistent with Mullarkey etc
21.	**leadm**		I was conscious that informality can creep in where you've worked with colleagues for years, including recording of decisions. I'm more conscious of that and have tightened up this area. But you have to retain a level of informality
22.	**leadm**		We checked the legal basis for everything we do; nearly all of our work is based on legislation
23.	**leadm**		The LSC issue raised questions about charging- charging is unusual for the public service, usually we pay out; so we reviewed our charges

Interviewee B

1.	**leadm**		The administration and body politic learned a huge amount from these times (referring to recession of the 1980s). It had a massive impact and resulted in deep learning so that it could ever happen again. It became ingrained in the psyche.
2.	**caadm**		Computerisation for example is very complex. We often have grand plans but not the competency to carry them out.
3.	**cajdg**		Maintaining balance between observing the letter of the law and showing due discretion is always difficult. For example if Revenue gave somebody leeway in paying their company tax in order to protect jobs, they could afterwards be accused of negligence.
4.	**capol**		The Minister appoints the Secretary General. That relationship is unlike any other and when it breaks down it may lead to the removal of the Secretary General.
5.	**cxpre**		There are so many matters competing for attention. In hindsight certain things may look important, but given competing priorities they may not have been important then.
6.	**cocon**		We made huge economic and other mistakes after joining EU. This led to the problems of unemployment, currency devaluations, high debt, emigration in the '80s. Was this a fiasco? There was little hope we could get out of it. It was not labelled so because it took place over such a long period.
7.	**cocri**		How do we measure success? We should not use absolute measures-nobody can be perfect. We should use comparators with the private sector or other good public services-how well are we performing compared to them. The C&AG can only look at absolute performance.
8.	**cqadm**		There is greater transparency and openness now. People are more careful

			about what they write and say-that is a good thing.
9.	**cxpol**		After the event all we see is what is written down but there is a lot in this relationship (Secretary General/Minister) that is not written down.
10.	**cxpol**		The shift to the centre in politics has resulted in more focus now on the mistakes of the public service.
11.	**cocon**		They are inevitable probably but also public perception has changed.
12.	**cxpol**		More scrutiny now from PAC, C&AG, The business of government is more clearly articulated now through strategy statements and business plans. Opposition politics also leads to 'mistakes' being highlighted: the public service becomes the meat in the sandwich.
13.	**cxpsc**		There are often big problems in the private sector but these can be kept quiet.
14.	**cxpsc**		If 5000 airplanes land successfully at Dublin airport that does not make the news. But if one crashes …? That is the problem for the public service.
15.	**cxsoc**		Huge rate of change since '85 but generally since joining EU. EU gave us a wider stage of influence
16.	**cxsoc**		A new financial class rose at that time that fed new thinking that was different from traditional civil service thinking.
17.	**cxsoc**		It was only in the 90s that these inputs and the policies of the administration began to bear fruits. But this happened quickly. Everything turned around, our income went above EU average, and with prosperity came the demand for schools, roads, better health services etc. It is good that people are impatient but we must be realistic.
18.	**cxsoc**		In other countries these transitions happened over a longer period. Many had colonies, and all of this made provision of infrastructure easier. We have chosen a certain type of democracy- a balance- and we cannot for e.g. railroad

			through plans and ignore other concerns.
19.	**cxsoc**		Media scrutiny is a good thing. But in Ireland the media often don't have the resources to research stories well enough.

Interviewee C

1.		**cueint**	The Department and its management should be learning organizations and alive to ways of improving. With LSC there was the immediate reaction and 'there but for the grace of God go I
2.		**cueinq**	Tribunals have a cathartic role part of a healing process but may not lead to long-term improvements
3.		**exsty**	In my previous role the AC threw the book at me and I had to plead guilty. That experience seared me. Staff will tell you I do not tolerate mistakes
4.		**exsty**	But some people are more comfortable dealing with the media while others think 'better not'. It is a matter of style.
5.		**on**	I can assure you when these things happen I look at the records of PAC, at venial rather than just mortal sins-and think: if I was asked that question how would I answer? As Accounting Office you must give a written assurance that you are happy with the systems in place.
6.		**on**	I take mistakes that I see here and elsewhere very seriously. Complacency does not come into it you can never relax. Survival is a day to day issue
7.		**on**	Views on LSC now would be different than immediate aftermath-'if cylinder is leaking you have to fix it', but then reflect. A rush to judgement is not wise.
8.		**socco**	All Secretary Generals would have same general views-collectively we must make the system work. Each year we get together for some stocktaking- an opportunity to reflect without 'the heat'
9.	**caadm**		Over 10 years ago the government fell over the Smyth paedophile case. It was a failure of a file tracking system in the AGs office. The head of the Office had to stand down. The same forces were at work in that case- a failure in administration generated a sense of

			crisis, heads were demanded.
10.	**caadm**		Some fiascos are down to sloppy work-sloppy MAC meetings, or sloppy briefing of Ministers.
11.	**cahlt**		Health is always more prone to crisis because of the nature of the business.
12.	**capol**		Previously no contractual relationship between Minister and Secretary General. Then based on New Zealand model, special advisers were brought in. The theory is that they work as a clearing house across department. It does not mean special advisers become the alter ego of the Minister. But special advisers will go to staff members and say Minister wants this. There is a confusion. But the LSC case made clear that telling a special adviser is not the same as telling a Minister..
13.	**capol**		Ministers of State somewhat similar. If I tell a Minister of State something, even in relation to his or her portfolio, it is not the same as telling the Minister.
14.	**capol**		Ministers will sometimes attend meetings and sometimes not-they need to get more involved in the everyday business because 'its often the housekeeping that causes the fiasco. You need a smooth running machine to deliver the policy. Some Ministers give feedback on Cabinet meetings, some not.
15.	**capol**		This was they issue in the LSC case- KM said he told Ministers entourage but this turned out not to be enough.
16.	**cocri**		These issues easier to deal with if no political fallout. Or if purely political. When they are a mix of administrative and political we have trouble.
17.	**capol**		We are going through a significant period of change in relationships between civil service and political system. Politicians look at the media and want an instant response. But frequently this is not based on reflection and analysis. The electoral cycle puts more pressure on near election time. For example decentralisation is now being considered differently because of the potential electoral backlash

18.	**cocri**		The extent to which it is defined as a failure depends on media attention. For example in Health there are life and death issues, and they are dealing with vulnerable groups. If the system is not seen to have responded adequately, this creates a situation where the Minister can get blamed. If the media don't pick it up you don't.
19.	**cqadm**		Lack of reflection before decisions could build up problems for the future.
20.	**cqpol**		In the UK a Minister is surrounded by a virtual cabinet. There are often breakdowns between his team and the civil service. We are inevitably moving towards the European style of cabinet, with perhaps the top two layers of civil service, in the long run, being political appointments.
21.	**leadm**		Civil servants now much more circumspect
22.	**leadm**		Like with PPARS, after LSC we asked are our systems robust, how do we deal with major projects, and it has forced the system into formal risk management.

Interviewee D

1.		**cueint**	An audit group set up in the '80s identified a lot of the problems in this Department and 'dealt with the low-hanging fruit'-so its only the difficult problems are left now.
2.		**socco**	On XY case we worked with other agencies that had dealt with the same kind of problem –pooled our expertise and learned from each other.
3.		**exsty**	Because of my experience in (mentioned previous role) I am more sanguine about the political system.
4.		**exsty**	Events will be interpreted differently by different Secretary Generals
5.		**on**	After these fiascos you get Laurel and Hardy effect- don't just stand there do something
6.	**caadm**	**cuex**	Circulars from the centre after fiascos only create more procedures to trip us up.

7.	**cahlt**		The Department of Health always have 1000 things to do-they are under incredible pressure
8.	**cajdg**		Secretary Generals job is about relationship management- we are always making decisions 'on the edge' –you have to get the job done.'The perfectible world fallacy'
9.	**cajdg**		There is often ferocious pressure to break the rules.
10.	**caadm**		XY case could have been a fiasco- we got legal advice but took different action. Legal advice can be wrong-maybe this is what the civil servants decided in the LSC case?
11.	**capol**		This Department is slightly different. You get a different type of Minister. The willingness and ability to absorb a brief differs from one Minister to the next.
12.	**cqrsk**		You can't punish people for making mistakes but now the emphasis is on finding scapegoats.
13.	**cqrsk**		Everything is so fast now-thinking is a bad idea. Time is compressed. The consultation process is foreshortened (mentions an example). This could be storing up problems.
14.	**leadm**		All Secretary Generals are more aware now of their accountability role.
15.	**cqrsk**		Legislation now is much more ad-hoc, responsive, and so we may be laying up problems for the future.
16.	**cxpol**		The relationship between Minister and Secretary General sometimes idealized-the reality is different
17.	**cxpol**		The UK model is different (mentions an e.g. Ministers there not so involved with constituency work-here they are and this makes them get involved in specific cases- causes a tension with civil service.
18.	**cxpre**	**cueinq**	In 20: 20 hindsight you can isolate a sequence of events but this does not portray the real world dynamic nature of many things competing for attention.
19.	**cxsoc**		In LSC case economic circumstances were different back then and this shaped the thinking-you have to take account of context.

Interviewee E

1.	**cxpsc**		The Private Sector can write off mistakes –this is the big difference with the public sector
2.	**cajdg**		There is a tension between change and making mistakes-if you want the former you must accept the latter
3.		**cueex**	The centre has an important role in monitoring and managing the civil service
4.	**cocri**		Are these e.g. LSC issue really mistakes? Revisionism is a problem here
5.	**cxpsc**		Public Sector is a very complex system-mistakes in one place have lots of 'knock-on' effects elsewhere
6.	**cxsoc**		Public is now more demanding, but the public sector works under constraints-for example it has to serve all customers, not just ones it chooses to accept
7.	**caadm**		Big bang solutions don't work. Sub optimal solutions that give incremental change are often better (example from own experience provided). Attempts at these grand plans often lead to problems.
8.	**cocri**		Once these affairs get political oxygen they spiral out of control
9.		**socco**	Meetings of Secretary Generals allows for informal networking on issues such as LSC
10.		**cueex**	Role of centre e.g. post PPARS. Messages on good practice disseminated through circulars, Ministers speeches, various networking events.
11.		**cueex**	There sometimes can be different messages communicated from the centre-because there are different sections within the department dealing with it.
12.		**on**	Minister has to report progress to PAC on various issues they have raised-this provides an opportunity to get an update on what has actually changed.
13.	**leadm**		We are poor at managing the media fallout-we do not anticipate the coverage and try to deal with it
14.	**leadm**		There is no single formula that will avoid all such fiascos-we must learn from each one and use it to check problems in our own departments.
15.	**cxadm**		Management systems have changed

			hugely in the civil service over past decade-but in an evolutionary rather than dramatic way.
16.		**socin**	It is inevitable that every Department will have its own response to fiascos such as LSC. The MAC has a very important role-it is there to advise the Secretary General. The Secretary General can then take this advice or not.
17.		**exsty**	How the Department responds may come down to the Secretary Generals priorities and interests e.g. is he a techie and also to personality.
18.		**socco**	The fact that Secretary Generals meet frequently and know each other well means that they are on the same wavelength.

Interviewee F

1.	**cocon**		There have been many recent fiascos e.g. Mini CTC, Lourdes Hospital, PPARS
2.	**caadm**		In LSC case cause was more to do with lack of legal basis than anything else
3.	**cxsoc**		The context changed with LSC –we were in deficit, now we are in plenty. This changed the frame of reference. But is now our capacity to spend the money wisely that frequently causes the problems.
4.	**cxsoc**		For e.g (mentions a case from own Department) the problem here was that the context changed fundamentally-attitudes to authority back then were very different than now.
5.	**cocon**		In LSC case yes there was a failure in administration , but there was also a failure in the interface between the administrative and political system.
6.		**cueinq**	we did not get the full story in case of LSC inquiry
7.		**cueinq**	The inquiry approach of going forensically through files for the past 30 years is not practical in the ongoing work of a department.
8.	**caadm**		we are losing corporate memory-we don't record things in the same way
9.		**cueatt**	We learn partly out of self-preservation, The portrayal of Dept of health was unfair but that does not mean that there are not lessons to be learned. We can be overly defensive.
10.	**cxpsc**		There is a tension between giving agencies the freedom to do what they were set up to do and still retaining some accountability and control
11.	**cqrsk**	**cueex**	A constant stream of guidelines from the centre can end up restricting you from doing anything
12.	**caadm**		One of the problems in the LSC case was that there was not a corporate approach-one part of the department did not seem to know what the other was doing
13.		**leadm**	In my Department I look for regular updates on 'significant issues'-I encourage my managers to share across

			portfolios.
14.	**cxpre**		The sheer range of tasks now means there is greater risk-the pace of life in Departments has changed massively and the demands are great.
15.	**cocon**		These fiascos such as LSC are probably inevitable,
16.	**leadm**		We need early warning systems and to manage things better when they do 'blow up'.
17.	**cxpre**		We deal with so many different people and agencies there is a huge communications overload to keep everybody informed
18.	**caadm**		Technology is an issue, and an issue in LSC was how things were stored, filed, and followed up.
19.	**capol**		How much do Ministers need to know? This was an issue in LSC case and is now an issue (mentions another current fiasco).
20.		**socco**	The Secretary General group probably does not meet often enough to adopt any formal positions on these issues. But it is important that I can learn from my colleagues.
21.		**exsty**	The judgment of the Secretary General is critical in these issues as to what lessons can be drawn for his own Department.
22.		**cueinq**	Inquiries have a useful role in these cases- we (mentioning sector) are setting up a single body one of whose roles will be to carry these out, be a repository of learning, have a standardised approach.
23.		**on**	There should be an onus on Departments to demonstrate what has changed as a result of fiascos.
24.	**leadm**		If we portrayed a more positive image generally we might not get such bad press when we make a mistake

Interviewee G

1.	**cocon**	**cueint**	LSC represented a failure, yes, but whether it was as described by the media or the Inquiry I'm not so sure. I'm not close enough to that system to say for sure
2.	**cocri**		If a system continues on a faulty basis for so long, clearly a failure. And the cost consequences were dramatic.
3.	**capol**		It also represented the systems failure to make explicit the relationship between the administrative and political system –I would include advisers in that.
4.	**capol**		Over years we may have developed 'too cozy' a relationship with the political system.
5.		**cueinq**	The relationship between Secretary General and Minister is based on openness and trust, being able to talk informally before anything is written. The Inquiry put an inordinate emphasis on what is written, but that does not tell the full story.
6.	**cxpre**	**cuexle**	There is so much complexity in the system now I am always thinking 'how many unexploded bombs are around me, and how can I recognize them in time.
7.	**cxadm**		We are now under much more scrutiny because of emphasis on accountability, Freedom of Information, PAC.
8.	**cxsoc**		There is a more educated electorate that wants to know more, and a media that wants to be the arbiter of success and failure.
9.	**cxpsc**		I am dealing with (mentions a project in own Department). This could be portrayed as a fiasco before too long. But it is an innovative project yet we are not allowed make any mistakes. This is unlike private sector
10.	**cajdg**		There is a tension between the drive for change, and delegation of responsibility, and 'doing it by the book' As a result of reform process we have more people willing to push the boundaries. Maybe LSC was partly due to people trying too

			hard to innovate and change and yet 'taking their eye off the ball'.
11.	**cocri**	**cueex**	In the past the Civil Service was good at doing things right, but not much else. LSC was a shock because it was about doing badly what the civil service was traditionally good at.
12.	**cxpre**		Since I started my career the complexity has increased dramatically at senior levels. One person cannot hold it all in their heads-it is about sharing accountability in a structured way
13.	**cqrsk**		. Selling the need for both innovation and accountability to staff now requires a highly nuanced message.
14.		**cueex**	LSC was a 'wake-up call, go back and 'look at the knitting'. There is no point in changing the world if you get something basic wrong back at home.
15.	**cajdg**		LSC prompted us to review legislative base for everything we do in the Department. X (mentioning one area of the Department) is horrendously complex. I know the problems but I don't have the resources to deal with them all. Then it is a matter of deciding which are the most important. But if we had a major problem in one of the other areas I would be blamed because I knew about it and did nothing.
16.	**leadm**		As a result of LSC we identified one area of legislation where something had been omitted-and this was in one of my best Sections! We sorted it out, media never picked it up, but it highlighted for me that it is a combination of small things that can cause problems.
17.	**cqadm**	**cocon**	Fiascos are to some degree inevitable in a large,complex, multimillion euro business like ours. Risk assessment, Internal Audit help reduce risk but not eliminate it. My Minister asked for an assurance that such problems could never happen again-I can tell him what steps we are taking .

18.	**leadm**		LSC threw spotlight on role of the MAC and relationship between MAC and Minister.
19.	**leeval**		Immediately afterwards there is always an 'over the top 'reaction. A year on we have learned a lot, but not in a knee-jerk way.
20.	**cqpol**		LSC case sent a shockwave threw senior civil service. When the chips are down we cannot take that relationship of loyalty for granted any more
21.		**cueatt**	LSC was a frightening experience because it made us feel our own personal vulnerability. MK had to leave office-he was regarded as one of the best in the system
22.		**on**	You have to let it settle to get at the real lessons.
23.		**exsty**	We all absorb information in different ways. There was a discussion at Secretary General level. I also kept an eye on media and the Oireachtas Committee.
24.		**socco**	There is some unease at using the weekly Secretary General meeting for discussions of this nature.
25.		**socin**	I initiated a discussion at MAC level – 'what does LSC mean for us? '. Some Departments had a more structured approach.
26.		**socin**	We have to separate out what are the issues that were unique to that Department from the issues more generally relevant. We had to develop an appropriate response for us.
27.		**socin**	Each Assistant Secretary discussed the issues arising with his/her Principal Officers.
28.		**on**	At TLAC for 6 months afterwards learning from LSC was a standard question. But not anymore.
29.	**cxpol**		Electoral cycle means early stages are best time for innovation and change. Close to an election there is often more caution, a shift from output to process. The electoral cycle also influences fiascos-more politically motivated close to an election.
30.	**cqadm**		One of the responses to LSC and similar

			is a tendency to 'suck power up and into the centre' in the aftermath-but this is the antithesis of what we are preaching through reform process.
31.		**leeval**	The centre does not distil lessons from fiascos in a coherent way and make sure they are disseminated.
32.		**socco**	There was a reluctance to discuss LSC case at senior level because it might mean acknowledging certain things
33.		**socin**	In each Department Secretary General has discussed with his MAC and they have deduced for themselves what are the appropriate lessons.
34.		**socco**	Y (mentioning another Secretary General) did a structured piece of work and sent it to me. The same points came up-this is not surprising as both our Departments share the same roots.
35.		**cuexle**	It created an alertness to danger 'does this have an LSC smell about it'. But you must be careful not just to look for things that are the same and ignore others that do not have the same presenting features.
36.	**cxpre**		So little time at Secretary General level for reflection. Last week (mentions an incident) it took up my entire morning-it could have blown up into something bigger. I identified at least 7 things that need to change as a result, but when do we get the time?
37.		**socin**	We took the whole team away for reflection-you cannot sort all the problems by working faster and harder
38.	**leeval**		A knee jerk reaction is to centralise authority and decision making-but this is wrong
39.		**cueatt**	Something like that goes straight to the gut! It was a frightening experience because it made us feel our own personal vulnerability. Could this be me?
40.	**cxpol**		The political system does not appreciate the strain on the system.

Interviewee H

1.	**cocri**		Much more emphasis and clarity now on what success and failure actually means –with business plans, performance management etc.
2.	**cocri**		Failure can be about a failure to manage change, to reach targets, or to manage systems.
3.	**cocri**		Because of role of Secretary General as Accounting Officer the financial consequences are critical-money lost is certainly a barometer of failure.
4.	**cocri**		There are also political reasons for fiascos, but this cannot be taken as a measure of failure
5.		**on**	You have to get behind the hype to find out what really happened. Was it a systems failure or a skills deficit-this is a big issue- or an administrative failure.
6.		**cueinq**	We took the Inquiry report at face value and considered what the different scenarios might mean for us.
7.		**socin**	We set up a group of volunteers-people interested in the issues- to report on the implications and lessons.
8.		**socin**	Responses to these issues will differ because of differences in management teams. I have a strong management team-it would not be unusual for them to raise issues that would change my views
9.	**leadm**		Yes changes were made-for e.g. nature of interaction with the political system would have changed.
10.		**on**	Now we have a follow-up group-to see if lessons are being applied or more lessons to learn.
11.	**cxadm**		Rise in number of fiascos because of more transparency and visibility, but also increasing complexity.
12.	**caadm**		The skills issue is huge –before we were bean counters. Traditional skills are not enough anymore-project management, regulatory impact analysis etc. now needed and deficiencies in these areas are leading to problems.
13.		**socin**	We draw lesson through discussions at

			MAC. Also Secretary General meetings sometimes discuss (mentioning a case this week) wider learning from issues that come up.
14.		**cueex**	They make us stop and think, be more sensitised, and they act as a catalyst to do things
15.	**cqadm**		But there can be negative consequences- for e.g morale in the Department of Health badly damaged following LSC affair.
16.	**cxsoc**		The media often misrepresent things.
17.	**leadm**		The ongoing learning from business plans is frequently much more significant from learning from these types of issues

Interviewee I

1.	**capol**		The issue of the political/administrative interface played a critical role in LSC case
2.	**cocon**		Clearly what happened was a problem and unacceptable
3.	**leadm**		The key lesson for us was that there has to be a legal basis for everything, and it caused us to review this
4.	**capol**		The political system would have been aware of some of the problems (in LSC case).
5.	**capol**		Why was nothing done for so long? Probably there was an unwillingness to disturb the status quo It raised the issue of civil service being unwilling to raise unpalatable issues.
6.	**cocon**	**cueinq**	I'm making judgments from a distance- I'm not qualified to comment on the details
7.	**capol**		(Mentioned previous fiasco in own area)- perception that we were willing to set rules aside to facilitate government policy.
8.	**leadm**		Top management must protect those who raise these issues- in the past people have been ostracised for doing so and this discouraged others. This is not unique to the civil service-the Banks had the same problem.
9.	**cqadm**		Secretary Generals are now most anxious

			to 'out' all potential problems.
10.		**exsty**	Personality and style of Secretary Generals differ and this will influence the lessons that are drawn.
11.		**cueinq**	Sometimes (mentioning a case) the Inquiry Reports can be based on a flawed logic
12.	**leadm**		The lessons we drew from LSC are distributed across a range of processes and documents-not just in one.
13.	**cxadm**		The distributed nature of our operation increases the risk
14.	**leadm**		We try to encourage people to think smartly-'could this become a bigger issue-who needs to know about it?'
15.		**cueint**	Many deficiencies were rectified after (mentions investigation into a previous fiasco in own Department).
16.		**cueint**	We are a very technically dependent organization and therefore we are particularly interested in fiascos related to technology e.g. PPARS
17.		**socin**	We discussed the issues at MAC. We have a large MAC which makes it a bit more difficult
18.	**leadm**		Much more awareness now of the political issues and implications of action/inaction
19.		**socin**	Only some older members of MAC may be unwilling to share and contribute outside their own portfolio
20.	**prev**		When I speak to staff I try to sensitize them to the importance of letting someone else know about potential problems. I use the words from the song:' I may be the first one to know its raining and the last one to know it's a flood'
21.	**cqrsk**		It (LSC) has discouraged innovation. Some now say better to keep to the rules.
22.	**cqadm**		These reports only highlights what goes wrong-not the majority of things that go right. This is deeply frustrating for civil servants
23.		**socin**	The MAC is critical to drawing lessons
24.		**on**	There is lots of hype immediately after the events but often little structured follow-through
25.		**cueinq**	The Inquiry process is useful but the

			Oireachtas Committee is too political
26.		**socco**	If Secretary Generals could reach a more collective view on these issues it might be useful
27.		**cueex**	A central standards agency may be useful- to centralise learning and standardise inquiry process. Also they could have a preventative role

Interviewee J

1.	**cocri**		There were lots of fiascos in the past but now more media interest, they are more hyped up
2.	**cxsoc**		X area (mentioning an area in own department) used to be seen as an arcane area where competency resided. Now as a result of (mentioned recent fiasco in own Department) it is regarded as a political 'bed of nails'. A change has come about because of increasing questioning of expert authority of the Department.
3.	**caadm**		(Mentions another area of Department where he worked previously). We took a particular technical view. But this increasingly was seen not to take sufficient account of other factors. It was leading to problems. It was a cosy enough system but decisions were filtered through our technical thinking. This role was given to (another agency) which takes a broader range of perspectives
4.	**cxsoc**		The authority of Departments has increasingly been deconstructed and undermined. There are well-organised lobby groups, many internationally based using the Internet. We have to take account of al this but also know when to stand our ground
5.		**socco**	Secretary Generals do not as a group systematically look at each case.
6.		**exsty**	My experience and informal interactions with others informs how I approach each case.
7.	**cqpol**		In LSC case, politicians felt they were 'on the rack' for a problem not of their making. Trust has been damaged.
8.	**cxpol**		Politics is increasingly in the centre, and

			the performance of public service is increasingly a political issue.
9.	**cxpol**		Friction between opposition parties and government can translate into friction between civil service and Minister.
10.	**cocon**		'Policy fiasco'may not be the right term- it is also about policy delivery and implementation.
11.	**cqrsk**		It is sometimes difficult to get the 'accountability message' across to the agencies. The screw of accountability has tightened in the civil service but not so much elsewhere
12.		**socco**	There is more contact now between Secretary Generals and more shared understanding.
13.		**socin**	It is my job to interpret. My MAC would not be aware of views at Secretary General level generally-so I pass on insights.
14.		**socin**	In this Department we do it our way- I presume others are the same.
15.	**cqpol**		Our response to SC was informal-it did not cause convulsions here. It did not change relationships with political system- we decided that it is good to retain some flexibility in this area.
16.		**cueint**	Response also depends on personality of the Minister and the nature of the relationship with him/her
17.		**cueinq**	Z case(mentioning a recent fiasco in own Department) led to a useful, low-key inquiry that helped to clarify a number of things. But (mentions another report) was not so well done –it depends on who carries out the inquiry ad the perceived fairness of the conclusions.
18.	**cqrsk**		We can always do better but we can't make a god of risk management
19.	**cqrsk**		There is somewhat more risk aversion now as a result of LSC case. But maybe this is an appropriate and well-judged adaptation to a changed environment.

Interviewee K

1.	**capol**		LSC case brought the issue of what public administration is about to the fore-that critical nexus of the political-administrative relationship
2.	**capol**		It raised the issue of what options are presented to government-what do they want to hear about?
3.	**cxadm**		All Secretary Generals have 2 distinct roles-as Accounting Officer and as manager of the Department
4.		**socco**	Some issues have been almost undiscussable over the years
5.	**capol**		LSC emphasised communication must be from senior civil service to Minister-not through advisers
6.	**cxpol**		Even though Public Service Management Act defines roles of Secretary General and Minister, in realty they operate in a 'grey area'
7.	**cocri**		Small issues (mentioning another fiasco) can take on inordinate importance not because of their inherent worth, but because of the political implications.
8.	**cahlt**		In Health there are so many issues vying for attention at the same time and results are so public.
9.		**cueint**	I can't comment on cause because I don't know enough about it.
10.		**cuextri**	But I'm amazed the Inquiry could draw so many conclusions. Forensic analysis after the event is easy
11.	**cqadm**		In public service we have to get it right all the time and there is no comment on successes-this is demoralising.
12.		**cuextri**	If you go before PAC you may have 30 people discussing one issue for 3 hours-I may have one person dealing with it on a part-time basis
13.	**cqrsk**		We are operating in a fast moving environment- if we have to dot every I things will take a long time to do
14.	**cxpre**	**cocon**	Failure is a value laden word. Headlines drive the order of business. Before somebody asked for a memo on something in 6 weeks time –now everything is immediate
15.	**cqrsk**		There is more emphasis on

			accountability, more rules from the centre Secretary General has to sign off on everything.
16.		**cuextri**	Oireachtas Committees are hugely political.-officials are an easy target.
17.	**cqpol**		In the civil service there is a huge loyalty and respect for the political system, but this has been tested by recent events
18.	**cxpol**		The political-administrative relationship is a fragile one based on a long history
19.	**cxpre**		I get 150 emails a day most of which I only scan. But the system will record that I looked at one at 8am on Wednesday- if something goes wrong.
20.	**cqrsk**		You can't put everything in writing-you have to tease out ideas
21.	**capol**		LSC raised issues about which MAC meetings Minister attends, are they recorded etc.
22.		**cueinq**	Forensic reports suggest you are just dealing with one issue-this is the most unfair aspect
23.	**cxpre**		Workload has increased drastically
24.	**leadm**		I am just more aware now (post LSC). We track correspondence-but LSC did not prompt major change.
25.		**cueinq**	Findings of Inquiries take on a life of their own and can't be questioned.
26.		**socco**	Post LSC there were lots of informal discussions-but some people could not talk nor was it fair to ask them.
27.		**cueinq**	Inquiries do not contextualise. Too speedy to do proper justice to the issues.
28.		**exsty**	There is not one interpretation-its like a rugby match where everyone sees different things.
29.		**cueint**	For us it was not about what specifically happened in Health, but about more general lessons that can be learned.

Interviewee L

1.	**cocri**		Fiasco when there is perception of damage to confidence in administration of the system
2.	**cxpsc**		Governance framework is different now-much more scrutiny
3.	**cocon**		The issues about success and failure often contested- because for e.g. lobby groups have different interests to the Department
4.	**cxsoc**		There is often a historical context. Looking at legacy issues through the lens of the present day is problematic.
5.	**cxpol**		There are major issues of process. There is always pressure from the political system to get things done quickly but process has to be observed. Politicians can be convinced of this.
6.	**caadm**		There is now a mismatch between the competency of the civil service to deliver and the needs of citizens.
7.	**prev**		I have used process auditors to help people learn from events-this proved very useful. It is a critical role of Secretary General to promote learning on an ongoing basis
8.	**cocri**		Fiascos are not necessarily more frequent-it is just that there is more scrutiny now.
9.	**prev**		My job is anticipating flashpoints, disrupting thinking and conventional logic-challenge people to look at issues in a different way
10.		**cueex**	Circulars from the centre provide the institutional veins to facilitate learning
11.		**socco**	Secretary Generals did not discuss LSC issue formally-there is a nervousness around such discussions
12.		**socin**	I asked for a paper to be drawn up on the issues arising for us 'not just for noble reasons but also to make our actions defensible'
13.		**socco**	(Mentions a new area of operation within the Department)- we are trying to learn how other organizations have dealt with problems in this area
14.	**leadm**		Record management process has been improved as a result of LSC
15.		**cueint**	There will be different learning in each Department because of different nature of work, different cultures, and different

			emphasis by Secretary General
16.		**exsty**	Style of Secretary General is important-the 'visionaries' may not be so good at process and vice-versa
17.		**cueint**	Secretary General has very important role as interpreter of these events
18.	**prev**		Groupthink is always a risk-you need to move people and you must challenge
19.		**cueex**	If the fiasco has been internal the learning will be more vital and ongoing. When it is external it is more difficult to see relevance and 'keep it alive'
20.		**cueex**	There is less ownership if lessons come from circulars than if it is an issue within the Department

Interviewee M

1.	**prev**		I try to read everything that is relevant-I spend a lot of time on this
2.	**prev**		I hold a co-ordination meeting of senior management twice a week-this acts as an early warning system and everyone is aware of what is happening. Also if I identify a potential threat (mentions recent case) I prompt evasive action
3.	**prev**		The trick is to avoid surprises and plan contingencies
4.	**prev**		I communicate with my Minister up to three times per day-that was an issue in the LSC case
5.	**leadm**		After LSC we checked legal basis for all charges
6.	**caadm**		Sometimes people don't lift their heads and continue to administer systems for years without change
7.	**prev**		We have a monitoring and inspection system in place to review systems
8.	**prev**		I chair the Finance and Budgetary Committee it is important that I am seen to be hands-on
9.	**leadm**		I discovered the need for follow-up on certain agreed actions
10.	**prev**		You will always get the unexpected but if you plan accordingly we can counter a lot
11.	**prev**		We identify trends and patterns and put appropriate changes in place
12.	**prev**		We have been seen to be very successful in crisis situations-this involves a lot of inter-

			agency co-ordination
13.		**socco**	There is an annual meeting of Secretary Generals when some of these issues get discussed
14.		**exsty**	Responses and interpretations will be different because of different management teams and different style of Secretary General
15.	**cxsoc**		Society is more litigious now
16.	**cocri**		Failure can arise where there is a perception that the Department is not well-run
17.		**exsty**	(Describes how he rectified a situation previously seen as a fiasco through innovation)
18.		**exsty**	Procurement is a difficult issue maybe I stood back too much in the past. I have to work at it
19.	**prev**		You have to put the right people in the right places –every Department has good, middling and poor. Our team is critical.
20.		**socin**	Every Department has to study the lessons for itself
21.	**prev**		The audit committee here has strong external membership-this external view is important

Appendix 5

Interview Data coded by themes and sub-themes

CONCEPT

A12	**cocon**	We were shocked: It looked like a disaster from the outside; surprising it went on for so long
I6	**cocon**	I'm making judgments from a distance
B6	**cocon**	We made huge economic and other mistakes after joining EU. This led to the problems of unemployment, currency devaluations, high debt, emigration in the '80s. Was this a fiasco? There was little hope we could get out of it. It was not labelled so because it took place over such a long period.
E4	**cocon**	Are these e.g. LSC issue really mistakes? Revisionism is a problem here
G17	**cocon**	Fiascos are to some degree inevitable in a large. Complex, multimillion euro business like ours. Risk assessment, Internal Audit help reduce risk but not eliminate it.
F1	**cocon**	There have been many recent fiascos e.g. Mini CTC, Lourdes Hospital, PPARS
G1	**cocon**	LSC represented a failure, yes, but whether it was as described by the media or the Inquiry I'm not so sure. I'm not close enough to that system to say for sure
H4	**cocon**	There are also political reasons for fiascos, but this cannot be taken as a measure of failure
I2	**cocon**	Clearly what happened was a problem and unacceptable
K14	**cocon**	Failure is a value laden word
J10	**cocon**	'Policy fiasco'may not be the right term-it is also about policy delivery and implementation.
K7	**cocon**	Small issues (mentioning another fiasco) can take on inordinate importance not because of their inherent worth, but because of the political implications.
L3	**cocon**	The issues about success and failure often contested-because for e.g. lobby groups have different interests to the Department
L8	**cocon**	Fiascos are not necessarily more frequent-it is just that there is more scrutiny now.
B11	**cocon**	They are inevitable probably but also public perception has changed.
F15	**cocon**	These fiascos such as LSC are probably inevitable,
C18	**cocon**	The extent to which it is defined as a failure depends on media attention. For example in Health there are life and death issues, and they are dealing with vulnerable groups. If the system is not seen to have responded adequately, this creates a situation where the Minister can get blamed. If the media don't pick it up you don't.
F5	**cocon**	In LSC case yes there was a failure in administration , but there was also a failure in the interface between the administrative and political system.

C16	**cocon**	These issues easier to deal with if no political fallout. Or if purely political. When they are a mix of administrative and political we have trouble.
B7	**cocri**	How do we measure success? We should not use absolute measures-nobody can be perfect. We should use comparators with the private sector or other good public services-how well are we performing compared to them. The C&AG can only look at absolute performance.
J1	**cocri**	There were lots of fiascos in the past but now more media interest, they are more hyped up
G2	**cocri**	If a system continues on a faulty basis for so long, clearly a failure. And the cost consequences were dramatic.
G11	**cocri**	In the past the Civil Service was good at doing things right, but not much else. LSC was a shock because it was about doing badly what the civil service was traditionally good at.
E8	**cocri**	Once these affairs get political oxygen they spiral out of control
H2	**cocri**	Failure can be about a failure to manage change, to reach targets, or to manage systems.
H3	**cocri**	Because of role of Secretary General as Accounting Officer the financial consequences are critical-money lost is certainly a barometer of failure.
L1	**cocri**	Fiasco when there is perception of damage to confidence in administration of the system
M16	**cocri**	Failure can arise where there is a perception that the Department is not well-run
H1	**cocri**	Much more emphasis and clarity now on what success and failure actually means –with business plans, performance management etc.
A10	**cocri**	The scale of it was different; and the financial consequences so great

Cause

B2	**caadm**	Computerisation for example is very complex. We often have grand plans but not the competency to carry them out.
Cc9	**caadm**	Over 10 years ago the government fell over the Smyth paedophile case. It was a failure of a file tracking system in the AGs office. The head of the Office had to stand down. The same forces were at work in that case- a failure in administration generated a sense of crisis, heads were demanded.
C10	**caadm**	Some fiascos are down to sloppy work- sloppy MAC meetings, or sloppy briefing of Ministers.
D6	**caadm**	Circulars from the centre after fiascos only create more procedures to trip us up.
E7	**caadm**	Big bang solutions don't work. Sub optimal solutions that give incremental change are often better (example from own experience provided). Attempts at these grand plans often lead to problems.
F8	**caadm**	we are losing corporate memory-we don't record things in the same way
F12	**caadm**	One of the problems in the LSC case was that there was not a corporate approach-one part of the department did not seem to know what the other was doing
F18	**caadm**	Technology is an issue, and an issue in LSC was how things were stored, filed, and followed up.
J3	**caadm**	(Mentions another area of Department where he worked previously). We took a particular technical view. But this increasingly was seen not to take sufficient account of other factors. It was leading to problems. It was a cosy enough system but decisions were filtered through our technical thinking. This role was given to (another agency) which takes a broader range of perspectives
L6	**caadm**	There is now a mismatch between the competency of the civil service to deliver and the needs of citizens.
M6	**caadm**	Sometimes people don't lift their heads and continue to administer systems for years without change
H12	**caadm**	The skills issue is huge –before we were bean counters. Traditional skills are not enough anymore-project management, regulatory impact analysis etc. now needed and deficiencies in these areas are leading to problems.
D10	**caadm**	XY case could have been a fiasco- we got legal advice but took different action. Legal advice can be wrong-maybe this is what the civil servants decided in the LSC case?
F2	**caadm**	In LSC case cause was more to do with lack of legal basis

		than anything else
A9	**cahlt**	Its easier if you are just dealing with policy or just with delivery; but if you are dealing with both, as was DOHC, increased scope for confusion and mis-interpretation
C11	**cahlt**	Health is always more prone to crisis because of the nature of the business.
D7	**cahlt**	The Department of Health always have 1000 things to do-they are under incredible pressure
K8	**cahlt**	In Health there are so many issues vying for attention at the same time and results are so public.
A11	**cajdg**	The interface between political/admin system is dynamic; they had to cut corners; we all do
B3	**cajdg**	Maintaining balance between observing the letter of the law and showing due discretion is always difficult. For example if Revenue gave somebody leeway in paying their company tax in order to protect jobs, they could afterwards be accused of negligence.
D8	**cajdg**	Secretary Generals job is about relationship management-we are always making decisions 'on the edge' –you have to get the job done.'The perfectible world fallacy'
D9	**cajdg**	There is often ferocious pressure to break the rules.
E2	**cajdg**	There is a tension between change and making mistakes-if you want the former you must accept the latter
G15	**cajdg**	LSC prompted us to review legislative base for everything we do in the Department. X (mentioning one area of the Department) is horrendously complex. I know the problems but I don't have the resources to deal with them all. Then it is a matter of deciding which are the most important. But if we had a major problem in one of the other areas I would be blamed because I knew about it and did nothing.
G10	**cajdg**	There is a tension between the drive for change, and delegation of responsibility, and 'doing it by the book' As a result of reform process we have more people willing to push the boundaries. Maybe LSC was partly due to people trying too hard to innovate and change and yet 'taking their eye off the ball'
B4	**capol**	The Minister appoints the Secretary General. That relationship is unlike any other and when it breaks down it may lead to the removal of the Secretary General.
C12	**capol**	Previously no contractual relationship between Minister and Secretary General. Then based on New Zealand model, special advisers were brought in. The theory is that they work as a clearing house across department. It does not mean special advisers become the alter ego of the Minister. But special advisers will go to staff members and say Minister wants this. There is a confusion. But the LSC case made clear that telling a special adviser is not the

		same as telling a Minister..
C13	**capol**	Ministers of State somewhat similar. If I tell a Minister of State something, even in relation to his or her portfolio, it is not the same as telling the Minister.
C14	**capol**	Ministers will sometimes attend meetings and sometimes not-they need to get more involved in the everyday business because 'its often the housekeeping that causes the fiasco. You need a smooth running machine to deliver the policy.
C16	**capol**	These issues easier to deal with if no political fallout. Or if purely political. When they are a mix of administrative and political we have trouble.
C17	**capol**	We are going through a significant period of change in relationships between civil service and political system. Politicians look at the media and want an instant response. But frequently this is not based on reflection and analysis. The electoral cycle puts more pressure on near election time.
D11	**capol**	This Department is slightly different. You get a different type of Minister. The willingness and ability to absorb a brief differs from one Minister to the next.
E8	**capol**	Once these affairs get political oxygen they spiral out of control
C15	**capol**	This was they issue in the LSC case- KM said he told Ministers entourage but this turned out not to be enough.
F19	**capol**	How much do Ministers need to know? This was an issue in LSC case and it is now an issue (mentions another current fiasco).
G3	**capol**	It also represented the systems failure to make explicit the relationship between the administrative and political system –I would include advisers in that.
G4	**capol**	Over years we may have developed 'too cozy' a relationship with the political system.
I1	**capol**	The issue of the political/administrative interface played a critical role in LSC case
I4	**capol**	The political system would have been aware of some of the problems (in LSC case).
I5	**capol**	Why was nothing done for so long? Probably there was an unwillingness to disturb the status quo It raised the issue of civil service being unwilling to raise unpalatable issues.
I7	**capol**	(Mentioned previous fiasco in own area)- perception that we were willing to set rules aside to facilitate government policy.
K1	**capol**	LSC case brought the issue of what public administration is about to the fore-that critical nexus of the political-administrative relationship
K2	**capol**	It raised the issue of what options are presented to government-what do they want to hear about?
K5	**capol**	LSC emphasised communication must be from senior civil service to Minister-not through advisers

K21	**capol**	LSC raised issues about which MAC meetings Minister attends, are they recorded etc.

Context

E15	**cxadm**	Management systems have changed hugely in the civil service over past decade-but in an evolutionary rather than dramatic way.
G7	**cxadm**	We are now under much more scrutiny because of emphasis on accountability, Freedom of Information, PAC.
H11	**cxadm**	Rise in number of fiascos because of more transparency and visibility, but also increasing complexity.
I13	**cxadm**	The distributed nature of our operation increases the risk
K3	**cxadm**	All Secretary Generals have 2 distinct roles-as Accounting Officer and as manager of the Department
B11	**cxadm**	They are inevitable probably but also public perception has changed. More scrutiny now from PAC, C&AG, The business of government is more clearly articulated now through strategy statements and business plans.
G40	**cxpol**	The political system does not appreciate the strain on the system.
B9	**cxpol**	After the event all we see is what is written down but there is a lot in this relationship that is not written down.
L5	**cxpol**	There are major issues of process. There is always pressure from the political system to get things done quickly but process has to be observed. Politicians can be convinced of this.
A16	**cxpol**	Demand for faster response now from the political system, then on to the next issue
B10	**cxpol**	The shift to the centre in politics has resulted in more focus now on the mistakes of the public service.
D16	**cxpol**	The relationship between Minister and Secretary General sometimes idealized-the reality is different
B12	**cxpol**	Opposition politics also leads to 'mistakes' being highlighted: the public service becomes the meat in the sandwich.
D17	**cxpol**	The UK model is different (mentions an e.g. Ministers there not so involved with constituency work-here they are and this makes them et involved in specific cases-causes a tension with civil service.
G29	**cxpol**	Electoral cycle means early stages are best time for innovation and change. Close to an election there is often more caution, a shift from output to process. The electoral cycle also influences fiascos-more politically motivated close to an election

J8	**cxpol**	Politics is increasingly in the centre, and the performance of public service is increasingly a political issue.
J9	**cxpol**	Friction between opposition parties and government can translate into friction between civil service and Minister.
K6	**cxpol**	Even though Public Service Management Act defines roles of Secretary General and Minister, in realty they operate in a 'grey area'
K18	**cxpol**	The political-administrative relationship is a fragile one based on a long history
D18	**cxpre**	In 20: 20 hindsight you can isolate a sequence of events but this does not portray the real world dynamic nature of many things competing for attention.
G36	**cxpre**	So little time at Secretary General level for reflection. Last week (mentions an incident) it took up my entire morning-it could have blown up into something bigger. I identified at least 7 things that need to change as a result, but when do we get the time?
F14	**cxpre**	The sheer range of tasks now means there is greater risk-the pace of life in Departments has changed massively and the demands are great.
F17	**cxpre**	We deal with so many different people and agencies there is a huge communications overload to keep everybody informed
G6	**cxpre**	There is so much complexity in the system now I am always thinking 'how many unexploded bombs are around me, and how can I recognize them in time.
B5	**cxpre**	There are so many matters competing for attention. In hindsight certain things may look important, but given competing priorities they may not have been important then.
G12	**cxpre**	Since I started my career the complexity has increased dramatically at senior levels. One person cannot hold it all in their heads-it is about sharing accountability in a structured way
K14	**cxpre**	Headlines drive the order of business. Before somebody asked for a memo on something in 6 weeks time –now everything is immediate
K19	**cxpre**	I get 150 emails a day most of which I only scan. But the system will record that I looked at one at 8am on Wednesday- if something goes wrong.
K23	**cxpre**	Workload has increased drastically
B13	**cxpsc**	There are often big problems in the private sector but these can be kept quiet.
B14	**cxpsc**	If 5000 airplanes land successfully at Dublin airport that does not make the news. But if one crashes …? That is the problem for the public service.
E1	**cxpsc**	The Private Sector can write off mistakes –this is the big difference with the public sector
E5	**cxpsc**	Public Sector is a very complex system-mistakes in one

		place have lots of 'knock-on' effects elsewhere
F10	**cxpsc**	There is a tension between giving agencies the freedom to do what they were set up to do and still retaining some accountability and control
G9	**cxpsc**	I am dealing with (mentions a project in own Department). This could be portrayed as a fiasco before too long. But it is an innovative project yet we are not allowed make any mistakes. This is unlike private sector
K15	**cxpsc**	There is more emphasis on accountability, more rules from the centre, Secretary General has to sign off on everything.
L2	**cxpsc**	Governance framework is different now-much more scrutiny
A17	**cxpsc**	Its much more complex now, much more engagement with agencies e.g. Department of Health and Health Boards; web of interaction more complex
A18	**cxsoc**	Projects have been overspent-now there is more money to spend, so there is a greater emphasis on budget control. There are phases in public administration, different things are emphasised at different times. Its not unlike business in that way.
B15	**cxsoc**	Huge rate of change since '85 but generally since joining EU. EU gave us a wider stage of influence
B16	**cxsoc**	A new financial class rose at that time that fed new thinking that was different from traditional civil service thinking.
B17	**cxsoc**	It was only in the 90s that these inputs and the policies of the administration began to bear fruits. But this happened quickly. Everything turned around, our income went above EU average, and with prosperity came the demand for schools, roads, better health services etc. It is good that people are impatient but we must be realistic.
B18	**cxsoc**	In other countries these transitions happened over a longer period. Many had colonies, and all of this made provision of infrastructure easier. We have chosen a certain type of democracy- a balance- and we cannot for e.g. railroad through plans and ignore other concerns.
B19	**cxsoc**	Media scrutiny is a good thing. But in Ireland the media often don't have the resources to research stories well enough.
D19	**cxsoc**	In LSC case economic circumstances were different back then and this shaped the thinking-you have to take account of context.
E6	**cxsoc**	Public is now more demanding, but the public sector works under constraints-for example it has to serve all customers, not just ones it chooses to accept
F3	**cxsoc**	The context changed with LSC –we were in deficit, now we are in plenty. This changed the frame of reference. But is now our capacity to spend the money wisely that frequently causes the problems.

F4	**cxsoc**	For e.g (mentions a case from own Department) the problem here was that the context changed fundamentally-attitudes to authority back then were very different than now.
G8	**cxsoc**	There is a more educated electorate that wants to know more, and a media that wants to be the arbiter of success and failure.
H16	**cxsoc**	The media often misrepresent things.
J2	**cxsoc**	X area (mentioning an area in own department) used to be seen as an arcane area where competency resided. Now as a result of (mentioned recent fiasco in own Department) it is regarded as a political 'bed of nails'. A change has come about because of increasing questioning of expert authority of the Department.
J4	**cxsoc**	The authority of Departments has increasingly been deconstructed and undermined. There are well-organised lobby groups, many internationally based using the Internet. We have to take account of al this but also know when to stand our ground
L4	**cxsoc**	There is often a historical context. Looking at legacy issues through the lens of the present day is problematic.
M15	**cxsoc**	Society is more litigious now

Consequences

B8	**cqadm**	There is greater transparency and openness now. People are more careful about what they write and say-that is a good thing.
C19	**cqadm**	A lack of reflection before making decisions could build up problems for the future.
G17	**cqadm**	My Minister asked for an assurance that such problems could never happen again-I can tell him what steps we are taking .
H15	**cqadm**	But there can be negative consequences-for e.g morale in the Department of Health badly damaged following LSC affair.
I9	**cqadm**	Secretary Generals are now most anxious to 'out' all potential problems.
I22	**cqadm**	These reports only highlights what goes wrong-not the majority of things that go right. This is deeply frustrating for civil servants
G30	**cqadm**	One of the responses to LSC and similar is a tendency to 'suck power up and into the centre' in the aftermath-but this is the antithesis of what we are preaching through reform process
K11	**cqadm**	In public service we have to get it right all the time and there is no comment on successes-this is demoralising.
K13	**cqadm**	We are operating in a fast moving environment- if we have to dot every I things will take a long time to do
C20	**cqpol**	In the UK a Minister is surrounded by a virtual cabinet. There are often breakdowns between his team and the civil service. We are inevitably moving towards the European style of cabinet, with perhaps the top two layers of civil service, in the long run, being political appointments.
G20	**cqpol**	LSC case sent a shockwave through senior civil service. When the chips are down we cannot take that relationship of loyalty for granted any more
J7	**cqpol**	In LSC case, politicians felt they were 'on the rack' for a problem not of their making. Trust has been damaged.
J15	**cqpol**	Our response to LSC was informal-it did not cause convulsions here. It did not change relationships with political system- we decided that it is good to retain some flexibility in this area.
K17	**cqpol**	In the civil service there is a huge loyalty and respect for the political system, but this has been tested by recent events
D12	**cqrsk**	You can't punish people for making mistakes but now the emphasis is on finding scapegoats.
D13	**cqrsk**	Everything is so fast now. Thinking is a bad idea. Time is compressed. The consultation process is foreshortened (mentions an example). This could be storing up problems.

D14	**cqrsk**	All Secretary Generals are more aware now of their accountability role.
A13	**cqrsk**	We have a lot of systems to make sure risk is managed. Also a lot of stuff emanates from central departments that is taken on board
K15	**cqrsk**	There is more emphasis on accountability, more rules from the centre Secretary General has to sign off on everything
A14	**cqrsk**	In the conclusions from the Travers Report there was a lot of emphasis on control and accountability. This is consistent with the trend. But you have to keep a balance between that and the creative, innovating part of our work. Sometimes people say 'play it safe and do nothing' But you have to encourage risk-taking. But maybe risk avoidance is emphasised more now.
C21	**cqrsk**	Civil servants now much more circumspect
D15	**cqrsk**	Legislation now is much more ad-hoc, responsive, and so we may be laying up problems for the future.
G13	**cqrsk**	Selling the need for both innovation and accountability to staff now requires a highly nuanced message.
F11	**cqrsk**	A constant stream of guidelines from the centre can end up restricting you from doing anything
I21	**cqrsk**	It (LSC) has discouraged innovation. Some now say better to keep to the rules.
K20	**cqrsk**	You can't put everything in writing-you have to tease out ideas
J11	**cqrsk**	It is sometimes difficult to get the 'accountability message' across to the agencies. The screw of accountability has tightened in the civil service but not so much elsewhere
J18	**cqrsk**	We can always do better but we can't make a god of risk management
J19	**cqrsk**	There is somewhat more risk aversion now as a result of LSC case. But maybe this is an appropriate ad well-judged adaptation to a changed environment.

Prevention

M1	**pre**	I try to read everything that is relevant-I spend a lot of time on this
M2	**pre**	I hold a co-ordination meeting of senior management twice a week-this acts as an early warning system and everyone is aware of what is happening. Also if I identify a potential threat (mentions recent case) I prompt evasive action
M3	**pre**	The trick is to avoid surprises and plan contingencies
M4	**pre**	I communicate with my Minister up to three times per day-that was an issue in the LSC case
M7	**pre**	We have a monitoring and inspection system in place to review systems
M8	**pre**	I chair the Finance and Budgetary Committee it is important that I am seen to be hands-on
M9	**pre**	I discovered the need for follow-up on certain agreed actions
M10	**pre**	You will always get the unexpected but if you plan accordingly we can counter a lot
M11	**pre**	We identify trends and patterns and put appropriate changes in place
M12	**pre**	We have been seen to be very successful in crisis situations-this involves a lot of inter-agency co-ordination
M19	**pre**	You have to put the right people in the right places –every Department has good, middling and poor. Our team is critical.
M21	**pre**	The audit committee here has strong external membership-this external view is important
L9	**pre**	My job is anticipating flashpoints, disrupting thinking and conventional logic-challenge people to look at issues in a different way
L18	**pre**	Groupthink is always a risk-you need to move people and you must challenge
L7	**pre**	I have used process auditors to help people learn from events-this proved very useful. It is a critical role of Secretary General to promote learning on an ongoing basis

Lessons and Learning

A19	**leadm**	We recognised vulnerabilities in the system e.g. where everything is now held on PC; we speeded up some projects already ongoing
A20	**leadm**	We reviewed the MAC to make sure all of our management systems are' up to scratch.'. Nothing totally new-all consistent with Mullarkey etc
A21	**leadm**	I was conscious that informality can creep in where you've worked with colleagues for years, including recording of decisions. I'm more conscious of that and have tightened up this area. But you have to retain a level of informality
E13	**leadm**	We are poor at managing the media fallout-we do not anticipate the coverage and try to deal with it
E14	**leadm**	There is no single formula that will avoid all such fiascos-we must learn from each one and use it to check problems in our own departments.
F16	**leadm**	but we need early warning systems and to manage things better when they do 'blow up'.
F24	**leadm**	If we portrayed a more positive image generally we might not get such bad press when we make a mistake
G16	**leadm**	As a result of LSC we identified one area of legislation where something had been omitted-and this was in one of my best Sections! We sorted it out, media never picked it up, but it highlighted for me that it is a combination of small things that can cause problems.
F13	**leadm**	In my Department I look for regular updates on 'significant issues'-I encourage my managers to share across portfolios.
H17	**leadm**	The ongoing learning from business plans is frequently much more significant from learning from these types of issues
I14	**leadm**	We try to encourage people to think smartly-'could this become a bigger issue-who needs to know about it?'
G15	**leadm**	LSC prompted us to review legislative base for everything we do in the Department.
I8	**leadm**	Top management must protect those who raise these issues-in the past people have been ostracised for doing so and this discouraged others. This is not unique to the civil service-the Banks had the same problem.
I12	**leadm**	The lessons we drew from LSC are distributed across a range of processes and documents-not just in one.
I18	**leadm**	Much more awareness now of the political issues and implications of action/inaction
K24	**leadm**	I am just more aware now (post LSC). We track correspondence-but LSC did not prompt major change.
L14	**leadm**	Record management process has been improved as a result of LSC

I3	**leadm**	The key lesson for us was that there has to be a legal basis for everything, and it caused us to review this
M5	**leadm**	After LSC we checked legal basis for all charges
A22	**leadm**	We checked the legal basis for everything we do; nearly all of our work is based on legislation
A23	**leadm**	The LSC issue raised questions about charging- charging is unusual for the public service, usually we pay out; so we reviewed our charges
G18	**leadm**	LSC threw spotlight on role of the MAC and relationship between MAC and Minister.
H9	**leadm**	Yes changes were made-for e.g. nature of interaction with the political system would have changed.
B1	**leadm**	The administration and body politic learned a huge amount from these times (referring to recession of the 1980s). It had a massive impact and resulted in deep learning so that it could ever happen again. It became ingrained in the psyche
C22	**leadm**	Like with PPARS, after LSC we asked are our systems robust, how do we deal with major projects, and it has forced the system into formal risk management.
C21	**leadm**	Civil servants now much more circumspect
D14	**leadm**	All Secretary Generals are more aware now of their accountability role
G35	**leadm**	Created an alertness to danger: does this have a Travers smell?
A13	**leadm**	We have a lot of systems to make sure risk is managed. Also a lot of stuff emanates from central departments that is taken on board
A15	**leadm**	But maybe risk avoidance is emphasised more now
G19	**Leeval**	A year on we have learnt but not in a knee jerk way
G38	**Leeval**	A knee jerk reaction is to centralise authority and decision making-but this is wrong
G29	**Leeval**	There needs to be more direction from the centre. I don't remember anything coming after Travers
G31	**Leeval**	The centre does not distil lessons from fiascos in a coherent way and make sure they are disseminated

Extracting Cues

G14	**cueatt**	LSC was a 'wake-up call, go back and 'look at the knitting'. There is no point in changing the world if you get something basic wrong back at home.
F9	**cueatt**	We learn partly out of self-preservation,
A2	**cueatt**	We used it as a reminder to look at our own procedures
A12	**cueatt**	We were shocked:
C1	**cueatt**	With LSC there was the immediate reaction and 'there but for the grace of God go I
H14	**cueatt**	They make us stop and think, be more sensitised, and they act as a catalyst to do things
G39	**cueatt**	Something like that goes straight to the gut! It was a frightening experience because it made us feel our own personal vulnerability. Could this be me?
D6	**cueex**	Circulars from the centre after fiascos only create more procedures to trip us up.
L10	**cueex**	Circulars from the centre provide the institutional veins to facilitate learning
E3	**cueex**	The centre has an important role in monitoring and managing the civil service
E11	**cueex**	There sometimes can be different messages communicated from the centre-because there are different sections within the department dealing with it.
L20	**cueex**	There is less ownership if lessons come from circulars than if it is an issue within the Department
E10	**cueex**	Role of centre e.g. post PPARS. Messages on good practice disseminated through circulars, Ministers speeches, various networking events.
F11	**cueex**	A constant stream of guidelines from the centre can end up restricting you from doing anything
A3	**cueinq**	An independent report is valuable. We can argue about the quality, but it is a good way of highlighting issues. I can't remember much about the Oireachtas Committee- that was more focused on political issues and not that useful.
D18	**cueinq**	In 20: 20 hindsight you can isolate a sequence of events but this does not portray the real world dynamic nature of many things competing for attention.
F6	**cueinq**	we did not get the full story in case of LSC inquiry
F7	**cueinq**	The inquiry approach of going forensically through files for the past 30 years is not practical in the ongoing work of a department.
F22	**cueinq**	Inquiries have a useful role in these cases- we (mentioning sector) are setting up a single body one of whose roles will be to carry these out, be a repository of learning, have a

		standardised approach.
G5	**cueinq**	The Inquiry put an inordinate emphasis on what is written, but that does not tell the full story.
H6	**cueinq**	We took the Inquiry report at face value and considered what the different scenarios might mean for us.
I11	**cueinq**	Sometimes (mentioning a case) the Inquiry Reports can be based on a flawed logic
I25	**cueinq**	The Inquiry process is useful but the Oireachtas Committee is too political
I27	**cueinq**	A central standards agency may be useful-to centralise learning and standardise inquiry process. Also they could have a preventative role
J17	**cueinq**	Z case(mentioning a recent fiasco in own Department) led to a useful, low-key inquiry that helped to clarify a number of things. But (mentions another report) was not so well done –it depends on who carries out the inquiry ad the perceived fairness of the conclusions.
K10	**cueinq**	But I'm amazed the Inquiry could draw so many conclusions. Forensic analysis after the event is easy
K12	**cueinq**	If you go before PAC you may have 30 people discussing one issue for 3 hours- I may have one person dealing with it on a part-time basis
K16	**cueinq**	Oireachtas Committees are hugely political.-officials are an easy target.
K22	**cueinq**	Forensic reports suggest you are just dealing with one issue-this is the most unfair aspect
K25	**cueinq**	Findings of Inquiries take on a life of their own and can't be questioned.
K27	**cueinq**	Inquiries do not contextualise. Too speedy to do proper justice to the issues.
C2	**cueint**	Tribunals have a cathartic role part of a healing process but may not lead to long-term improvements
A1	**cueint**	Did not look at detailed circumstances; not competent to do so; it was very complex
C1	**cueint**	The Department and its management should be learning organizations and alive to ways of improving.
D1	**cueint**	An audit group set up in the '80s identified a lot of the problems in this Department and 'dealt with the low-hanging fruit'-so its only the difficult problems are left now.
G26	**cueint**	We have to separate out what are the issues that were unique to that Department from the issues more generally relevant. We had to develop an appropriate response for us.
G35	**cueint**	It created an alertness to danger 'does this have an LSC smell about it'. But you must be careful not just to look for things that are the same and ignore others that do not have the same presenting features.
G1	**cueint**	LSC represented a failure, yes, but whether it was as described by the media or the Inquiry I'm not so sure. I'm not close enough to that system to say for sure

K9	**cueint**	I can't comment on cause because I don't know enough about it
H6	**cueint**	I'm making judgments from a distance-I'm not qualified to comment on the details
I15	**cueint**	Many deficiencies were rectified after (mentions investigation into a previous fiasco in own Department).
J16	**cueint**	Response also depends on personality of the Minister and the nature of the relationship with him/her
I16	**cueint**	We are a very technically dependent organization and therefore we are particularly interested in fiascos related to technology e.g. PPARS
K29	**cueint**	For us it was not about what specifically happened in Health, but about more general lessons that can be learned.
L15	**cueint**	There will be different learning in each Department because of different nature of work, different cultures, and different emphasis by Secretary General
L17	**cueint**	Secretary General has very important role as interpreter of these events
L19	**cueint**	If the fiasco has been internal the learning will be more vital and ongoing. When it is external it is more difficult to see relevance and 'keep it alive'

Social

A6	**socco**	I would say each Department responded in its own way. I don't recall a collective discussion on the matter; the fact that some people were directly involved made this difficult. There has been for many years a concern in some areas at political level about formal meetings of the Secretary General Group. The culture is that each Department 'runs its own show'
D2	**socco**	On XY case we worked with other agencies that had dealt with the same kind of problem –pooled our expertise and learned from each other
C8	**socco**	All Secretary Generals would have same general views-collectively we must make the system work. Each ear we get together for some stocktaking- an opportunity to reflect without 'the heat'
C9	**socco**	Meetings of Secretary Generals allows for informal networking on issues such as LSC
E18	**socco**	The fact that Secretary Generals meet frequently and know each other well means that they are on the same wavelength.
F20	**socco**	The Secretary General group probably does not meet often enough to adopt any formal positions on these issues. But it is important that I can learn from my colleagues.
G24	**socco**	There is some unease at using the weekly Secretary General meeting for discussions of this nature.
G32	**socco**	There was a reluctance to discuss LSC case at senior level because it might mean acknowledging certain things
G34	**socco**	Y (mentioning another Secretary General) did a structured piece of work and sent it to me. The same points came up-this is not surprising as both our Departments share the same roots.
I26	**socco**	If Secretary Generals could reach a more collective view on these issues it might be useful
J5	**socco**	Secretary Generals do not as a group systematically look at each case.
J12	**socco**	There is more contact now between Secretary Generals and more shared understanding.
K4	**socco**	Some issues have been almost undiscussable over the years
K26	**socco**	Post LSC there were lots of informal discussions-but some people could not talk nor was it fair to ask them.
L11	**socco**	Secretary Generals did not discuss LSC issue formally-there is a nervousness around such discussions
L13	**socco**	(Mentions a new area of operation within the Department)- we are trying to learn how other organizations have dealt with problems in this area
M13	**socco**	There is an annual meeting of Secretary Generals when some of these issues get discussed
A7	**socin**	We all know our own business best;
A8	**socin**	We got a group of people to analyse the report. Also discussion at MAC; internal discussion was very important

E10	**socin**	It is inevitable that every Department will have its own response to fiascos such as LSC. The MAC has a very important role-it is there to advise the Secretary General. The Secretary General can then take this advice or not.
G25	**socin**	I initiated a discussion at MAC level –'what does LSC mean for us? '. Some Departments had a more structured approach.
G27	**socin**	Each Assistant Secretary discussed the issues arising with his/her Principal Officers.
G33	**socin**	In each Department Secretary General has discussed with his MAC and they have deduced for themselves what are the appropriate lessons.
G37	**socin**	We took the whole team away for reflection-you cannot sort all the problems by working faster and harder
H7	**socin**	We set up a group of volunteers-people interested in the issues-to report on the implications and lessons.
H8	**socin**	Responses to these issues will differ because of differences in management teams. I have a strong management team-it would not be unusual for them to raise issues that would change my views
H13	**socin**	We draw lesson through discussions at MAC. Also Secretary General meetings sometimes discuss (mentioning a case this week) wider learning from issues that come up.
I17	**socin**	We discussed the issues at MAC. We have a large MAC which makes it a bit more difficult
I19	**socin**	Only some older members of MAC may be unwilling to share and contribute outside their own portfolio
I23	**socin**	The MAC is critical to drawing lessons
J13	**socin**	It is my job to interpret. My MAC would not be aware of views at Secretary General level generally-so I pass on insights.
J14	**socin**	In this Department we do it our way- I presume others are the same.
L12	**socin**	I asked for a paper to be drawn up on the issues arising for us 'not just for noble reasons but also to make our actions defensible'
L20	**socin**	Every Department has to study the lessons for itself

Ongoing

A5	**on**	We discussed issues arising at the time and put changes in place but we did not go back to discuss it. There is a period of time and you have to take advantage of it. Had we found serious deficiencies, well that would be a different matter. We're very busy so you have to get back to normal business.
G28	**on**	At TLAC for 6 months afterwards learning from LSC was a standard question. But not anymore.
C5	**on**	I can assure you when these things happen I look at the records of PAC, at venial rather than just mortal sins-and think: if I was asked that question how would I answer? As Accounting Office you must give a written assurance that you are happy with the systems in place.
C6	**on**	I take mistakes that I see here and elsewhere very seriously. Complacency does not come into it you can never relax. Survival is a day to day issue
C7	**on**	Views on LSC now would be different than immediate aftermath-'if cylinder is leaking you have to fix it', but then reflect. A rush to judgement is not wise.
D5	**on**	After these fiascos you get Laurel and Hardy effect- don't just stand there do something
E12	**on**	Minister has to report progress to PAC on various issues they have raised-this provides an opportunity to get an update on what has actually changed.
F23	**on**	There should be an onus on Departments to demonstrate what has changed as a result of fiascos.
G19	**on**	Immediately afterwards there is always an 'over the top 'reaction. A year on we have learned a lot, but not in a knee-jerk way.
G23	**on**	You have to let it settle to get at the real lessons.
H5	**on**	You have to get behind the hype to find out what really happened. Was it a systems failure or a skills deficit-this is a big issue- or an administrative failure.
H10	**on**	Now we have a follow-up group-to see if lessons are being applied or more lessons to learn.
I24	**on**	There is lots of hype immediately after the events but often little structured follow-through

Experience and Style

A4	**exsty**	The Secretary General has a very important role because ultimately he is accountable. In the LSC issue the Secretary General was in the firing line. When you become a Secretary General you become aware of these issues.
C3	**exsty**	In my previous role the AC threw the book at me and I had to plead guilty. That experience seared me. Staff will tell you I do not tolerate mistakes
C4	**exsty**	But some people are more comfortable dealing with the media while others think 'better not'. It is a matter of style.
D3	**exsty**	Because of my experience in (mentioned previous role) I am more sanguine about the political system.
D4	**exsty**	Events will be interpreted differently by different Secretary Generals
E17	**exsty**	How the Department responds may come down to the Secretary Generals priorities and interests e.g. is he a techie and also to personality.
F21	**exsty**	The judgment of the Secretary General is critical in these issues as to what lessons can be drawn for his own Department.
I10	**exsty**	Personality and style of Secretary Generals differ and this will influence the lessons that are drawn.
J6	**exsty**	My experience and informal interactions with others informs how I approach each case.
L16	**exsty**	Style of Secretary General is important-the 'visionaries' may not be so good at process and vice-versa
M17	**exsty**	(Describes how he rectified a situation previously seen as a fiasco through innovation)
M18	**exsty**	Procurement is a difficult issue maybe I stood back too much in the past. I have to work at it
K28	**exsty**	There is not one interpretation-its like a rugby match where everyone sees different things.
M14	**exsty**	Responses and interpretations will be different because of different management teams and different style of Secretary General
M14	**exsty**	Responses and interpretations will be different because of different management teams and different style of Secretary General

Appendix 6

Other Source Data Coded By Themes

Oireachtas Inquiry data

cueinq	It is unfortunate that the basic focus of this inquiry is not to find out what happened but to try to do as much political damage as possible
caadm	If the required information had been available to me, action would have been taken immediately to address the issue
cajdg	All of the information which has emerged confirms that the issue was at no stage considered serious enough to merit being raised with me as per normal practice
caadm	What does 'briefing' mean? I am clear in my own mind that I did not receive a briefing
cxpre	The clear focus of the agenda of the MAC meeting was the Health Reform programme
cxpre	I can understand why it happens. People are under great pressure and there are many other activities in train
caadm	It is clear that special advisers are not duplicates of civil servants or are not in the chain of commands in terms of issues of this kind
caadm	It had been sitting there (the relevant file) for 8 months. Why it was not acted upon is just amazing, incredible Minister Harney 19 May
cueinq	Mr. Travers (author of Inquiry report) comes to the conclusion that he does and I have total respect for him. Those who are fair-minded could not but admire the form of the report
cocon	The financial consequences of this are serious with more than €1bn involved
cajdg	The reason for moving the Secretary General out of office are not to carry the can for 29 years of error in this matter. It is only because the truth was not included in that report
leadm	We must learn from what happened and not only in the Department of Health.Other Departments need to learn from this too
cxpol	The reasons for not dealing with the matter in another way were purely financial
cxpre	I do not accept the generalized criticisms of the Department-look at the good things we have done
cueinq	Absence of documentation on certain matters can be interpreted by readers with experience of how the system really works
cxpol	The Department over the years leaned too far in facilitating political manoeuvre
cxadm	The practice (of long stay charging) reflected the state of mind of the Department and the Health Boards at the time.
cxpre	Priorities change from day to day in a fast moving environment
cxadm	People were looking prospectively at how to solve the problem-not retrospectively
cxadm	Legal opinions were conflicting

cxpol	Civil servants are frequently torn between public service duty and the need to maintain constructive relationships with the Minister
cxpre	Big strategic issues took away my time from 'minding the shop'
cahlt	Health is a high risk environment. Its all about judgment
cueinq	You can't just look at the mechanics of a,b,c. Context is critical
cueinq	Its possible to take a benign or malign interpretation of certain events-in this case the interpretation (by the Inquiry) has not been benign.
capol	The Minister deferred a planned briefing
cxadm	The circulars from the Department represented a bona fide interpretation of the law
cxpre	In 2004 priorities were different
cxpol	The Ministers explanation reflects a simplistic view of the Minister and Secretary General relationship. In fact it is dynamic and complex

Media Data

cxpol	The Minister compared Mr. Kelly unfavourable with her previous Secretary General. He was being marginalized and she relied on her political advisers (Irish Times (IT) 11/04)
capol	the role of special advisers is not sufficiently clear (IT 12/04)
cocon	Why should ministers pay for the mistakes of civil servants? Senior public servants are paid phenomenal salaries, they have phenomenal job security. We are entitled to hold them responsible in the departments. All these reports - Quigley, Travers and the Public Accounts Committee [on the indemnity deal with the religious congregations] should be giving rise to a serious debate about the structure of our Civil Service and how to measure its output. No one has even looked at the structure of our departments for years. We have never had leadership in public sector reform.(Irish Times, Carol Coulter, March 11)
cocon cxpol	Why should Ministers pay for the mistakes of the Civil Service (Doorley Irishhealth.com)
cqadm	The Travers report may reverse the trend in the Civil Service of not writing things down (Mansergh IT, 19/03)
capol	It is the responsibility of the Minister to look after the interests of the taxpayer by properly managing the Department (IT, 26/04)
caadm	Documents released by the Minister show the Civil Service had documented the problem over a year ago. This backs her core belief that the failures of officials were much more serious than the failures of politicians (IT 16/04)
caadm	There have been problems over many years in the Department, a number of them relating to disputes over promotions (IT 12/03)
caadm	According to a former Minister the Department was 'utterly dysfunctional'. Another report, the Brennan Report of 2003, revealed spending without authorisation (IT 12/03)
caadm	The documentation trail tells the whole story. Warnings were buried in lengthy reports (Mansergh IT, 19/03)
cajdg	There was no culture of self examination in the Department. According to political sources when there is trouble they (the civil servants) hunker down. 'They are undealable with' (IT 11/04)
caadm	According to sources the culture of the Department is 'sect-like'. They circle the wagons (IT 11/04).
cqadm	Ministers will now be swamped by files so that civil servants can say they were told (Mansergh IT 12/03)
cxpsc	The precise role of the civil service in policy formulation has never been addressed. Travers is a case study in how the issues have become more complex (IT 14/04)
cqadm	Morale at the Department is battered. According to sources within the Department, 'there should be more political accountability' (IT 12/03)
cxpol	Civil service sources say that it had been their practice for years

	to brief ministerial advisers, and now they are being criticised for it (IT 11/04)
cxpol	According to the Union representing senior civil servants, 'the written record never tells the full story. This case raises fundamental issues for the relationship between civil servants and politicians (IT 10/03)
cqadm	The Travers Report is likely to have a major impact not just on the Department, but on the way the civil service functions. It is hoped that the lessons will prevent a future similar debacle (IT 21/03)
cocon **caadm**	Travers points finger at officials over care charges The report into illegal charges for residential health care has found that officials in the Department of Health and Children were responsible a long-term systematic failure that allowed the practice to continue for nearly three decades. (IT 9/03)
cajdg **cocon**	Each of these events are classifiable as critical incidents. For a commercial organisation, they would automatically trigger a critical incident review in which the mistakes would have been openly discussed and thrashed out and at the end of which organisational and other changes would be made. But in the Department of Health there is little, if any, evidence that such a culture of self-examination exists. Instead, the organisation is defined by its defensive reactions (IT 19/03)
cocon **caadm**	The Department of Health failed at the highest levels for almost 30 years to deal effectively with the illegal nursing home charges issue, the Travers report has found. It makes it clear the department was well aware of legal concerns around charging medical card holders for care in public nursing homes as far back as 1976 (IT 13/03)
cocon **cocri**	The Minister said that everybody accepted the situation was a total mess. The consequences are considerable, involving 315,000 people and going back to 1976, the Minister added. Some institutions are closed and no records exist. Besides the huge amount of money involved, this issue represents a mammoth task from an administrative and logistical point of view(O'Regan, Irish Times , March 11).

Travers Report Data

cahlt	The business of the Department of Health is distinguished by its breadth, complexity, and public sensitivity(57)
cxpre	The workload of DOH has increased particularly since the introduction of the health reform process (58)
cajdg	Officials over many years adhered to the principle that charging those who can afford to make some contribution is fair and reasonable. (60)
caadm	A major theme was the perceived importance of maintaining non-Exchequer sources of income and these objectives were wholly admirable (61)
caadm	There was a misinterpretation of the legal basis for the charges (62)
cajdg	Despite the concerns over the legal basis for the charges, the belief that persisting with the charges was the right thing to do 'strengthened with the effluxion of time' (64)
caadm	Dealing with the issues surrounding long –stay charges were given a low priority relative to the many other operational challenges of the Department (64)
cxpsc	The systematic practice of risk assessment is not well formulated in the public service and DOHC is no exception (65)
cajdg	There was a failure to appreciate the potential long-term consequences of maintaining the status quo
caadm	There was a a lack of any clear, insightful analysis of the problem (67)
caadm	There is little of no documentary evidence to support the contention that Ministers were briefed or advised about the issue (67)
cocon	The problem represents a series of failures of judgment over many years (68)
capol	At political level there were undoubtedly some lapses of judgment over the years. The shortcomings in this area are however at a significantly lesser scale, substance, and order of magnitude to that of the system of administration (68)
cxpre	The period 2003/2004 was undoubtedly a period of intense and unrelenting pressure for the Secretary General and other senior managers in the DOH (76)
cocon	The fundamental reason for the period of time that elapsed lies in long-term systemic failure in DOH. That failure is principally a failure of public administration n which failed to identify the difference between actions and practices widely regarded as fair and reasonable and actions and practices that were legally valid (77)
leadm	Get the legal basis for decisions right (79)
leadm	Ensure that the analytical input into important decisions is commensurate with the policy and operational importance of

	the decisions being taken (79)
leadm	Ensure that briefings for Ministers are comprehensive and include all the relevant facts (79)
leadm	Ensure at least a de minimus recording of decisions at official level within the Department (79)
leadm	Ensure a practical and effective system of risk assessment in relation to all areas of activity
leadm	Isolate issues of singular importance and deal decisively with them (80)
leadm	Be aware of issues of political sensitivity , but do not allow them to compromise the integrity of the analysis (80)
leadm	Rebuild the MAC (80)
leadm	Put in place a system for logging and recording file movements (80)
leadm	Ministers should seek assurances from their Department that the management and administration systems recommended here are in place (81)
leadm	Ministers and their special advisers should avoid becoming too involved in the day to day operations and administration of their Departments.(81)
leadm	The briefing of special advisers should not be considered an alternative to briefing the Minister (81)
leadm	Across the civil service there can occur gaps in management competence available to deal with challenging issues. These need to be addressed (85)
leadm	Across all Departments establish a systematic review of legal validity of all charges levied.(85)
caadm	There is a widespread perception that the MAC of the DOH has been dysfunctional for some time (84)
cqadm	This set of events provides a one-off opportunity for change (54)

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