

Episode Five:



Total Meltdowns and the Emergency Planner's Paradox

FINDING THE POSITIVES FROM BIG DISASTERS

POWERED BY:

 **Databarracks**



Tests is no substitute for
the real thing

There are two ways to find out how business continuity plans hold up against reality. One is to test them by performing an exercise. The other is to experience a disaster first hand.

Most business continuity plans spend their lives gathering dust on a shelf. In an ideal world, they're taken down once a year, tested, and then replaced with any necessary amendments, but this is as close as they get to brushing up against reality.

But can test conditions ever truly replicate the panic, urgency and unpredictability of real disasters? And if not, can plans ever be truly reliable if they've only ever been tried in controlled conditions?

It's a phenomenon that Matt Hogan from the London Fire Brigade referred to as "The Emergency Planner's Paradox".

"You don't want there to be incidents - we work day in, day out to reduce the impact and likelihood of them. However, at the same time...

"...the learning you get out of a real incident is really, really valuable..."

...and I make it a priority to capture that learning and build it in to future planning."

Plans are inherently imaginative

There's flip-side of this paradox is that actual incidents seldom fit the plans created for them - disasters have a tendency to ignore your carefully written script.

It's impossible to predict the exact contours of how individual disasters play out, much less reverse engineer the perfect recovery plan ahead of time and then wait for the event to test it.

All plans are necessarily guesswork - educated guesswork, perhaps, but guesswork nevertheless.

As Vicki Gavin at The Economist pointed out, disasters are, by definition, unpredictable and unknowable. The best resource for withstanding the breadth of possible disruption is not an encyclopaedic set of recovery plans, but robust crisis management processes that apply to a multitude of situations.

"There's a popular headline in continuity planning, which is people and publications attempting to predict the next 'Black Swan Event'.

"By definition, black swan events are catastrophic and unexpected. If it's unexpected, you can't expect it, and therefore any proposed black swan event predicted by pundits is by definition not a black swan event. The whole thing is a nonsense.

"What you can do is be ready to respond."

"We know bad things are going to happen. If you've got good, impact-based plans, and practiced crisis management in place, you're ready to respond to any event, any time, and you don't have to guess what it's going to be. Don't waste time and energy creating an encyclopaedic set of plans - nobody will read them, and when you do eventually have an incident, your perfect plan won't be an exact fit anyway."

Resiliency is an operating model, not an emergency state

The remedy to the unknowability of disasters is not to pump endless resources into emergency planning. Improving the standard of crisis management literacy across your organisation is certainly useful, but it's ultimately a reactive strategy.

Actually, the opposite is true, particularly for smaller businesses - continuity and emergency planning can be very instinctive. Rather than regarding continuity planning as some disconnected auxiliary activity, it's far more effective (and efficient) to simply redesign your core processes and be resilient from the ground up. Mel Gosling recounted a story in which a small printing business in the Lake District survived terrible flooding because they had intuitively baked resilience in to their operational model.

"Some friends of mine run a specialised sign printing business in the Lake District, employing about 10 people. During the Christmas period of 2015, the area was hit by terrible flooding, and their site was totally washed out.

That kind of event would have wiped out a large proportion of small businesses, but they survived, and are back up and running again.

"In terms of business continuity, they're an absolute success, but if I'd have said 'business continuity' to them before the floods, they'd have said 'what's that?'"

"They survived because they had the main elements of business continuity in place."

"Their data was backed up, their systems are largely cloud based, they had alternative means of communication in place, and when their premises flooded, they could continue working and liaising with customers from home. They contacted their customer base, explained the situation and made alternative arrangements. That's business continuity in action, but they'd never have passed an audit of something like ISO 27001."

Case Study: The Associated British Ports mega flood

Associated British Ports operate 21 ports around the UK. They employ thousands of people, support 25% of the UK's seaborne trade. It's reasonable to suggest they represent a hugely critical piece of national infrastructure.

It's therefore also reasonable to suggest that flooding is probably quite high on their continuity planning agenda. And yet in December of 2013, they were taken by surprise by a phenomenal low pressure system behaving unexpectedly. As John Robinson's recounting of the story demonstrates, no plan is infallible, and no defences are impenetrable.

"Low pressure systems pass through the north of the UK all the time. In late 2013 however, one instance of particularly low pressure turned right down the North Sea and down the Eastern Seaboard. This was unusual. The effect of a low pressure system is that it sucks up a bubble of water, and as this moved down the coast, it raises water levels dramatically, particularly at high tide - even more so during a spring tide (or 'King Tide') during new and full moons.

"The storm wasn't due to hit the Humber ports particularly hard. But storms are unpredictable and chaotic in behaviour.

"Little movements here and there radically change the outcome."

"So as the evening approached and the tide went out at Immingham, Hull, Grimsby and Goole, the water levels sank so low that the bottom of the loch gates were seen for the first time since they'd been fitted.

"And then the tide came back in, straight over the top of the loch gates and over the coping stones, and flooded the entirety of the ports to about 1.5 metres, which bearing in mind that's about 300 acres of industrial complex, is a huge amount of water. The ports were a lethal place to visit in the aftermath. There are fuel, coal and fertilizer terminals that leaked chemicals, and there were blown out manhole covers underwater."

Case Study: The Associated British Ports mega flood

Possibly more incredible than the sheer unlikelihood of all the different elements of the mega flood aligning to produce one perfect storm, is the fact that it was barely reported at the time.

The ports play a vital role in the UK - not only in terms of trade, but for power too. As John explains, the same forces of luck that make it impossible to predict worst-case scenarios can turn in an instant to work in your favour.

ABP were spared the full attention of the public and press at the time due to another, admittedly tragic, story occupying the news cycle.

The UK operates quite close to the edge in terms of power, and this happened during winter. The whole of UK PLC was implicated.

“So why does no-one know about this? The reason no one knows about it is that Nelson Mandela died earlier that day. And you couldn't get time on the airwaves for anything else. So fortunately for the ports, the media were preoccupied. And for 2 or 3 days after that they stayed preoccupied, to the point that by the time APB could get messages to the media, it was too late.”

“The floods closed down 300 businesses, meaning 4,000 people can't get into work...”

“...and cut off the main biomass fuel supply to DRAX, one of the primary power stations in the country.

Case study: The Suet Pudding Incident

The ABP mega flood was a good example of how small known factors can defy all expectation and escalate familiar disasters far beyond the remit of even the most meticulously prepared continuity plans.

This next case study from Michael Faber demonstrates the opposite: that disconnected and unknown factors can collide in a terrible chain of events that defy all reasonable notions of foresight.

“There’s a really interesting story I refer to as the Suet Pudding incident. And this comes back to what I was saying about Sod’s Law, or Murphy’s Law, that whatever can go wrong, will go wrong.

“There was an investment bank that had designed and built a beautiful new building in the City of London. They had a staff restaurant inside, with two ovens, one for meat, and one for bread. The meat oven was cleaned regularly, as you might expect, whilst the bread oven, because it was presumed to use less fat, was cleaned only cosmetically.

“The trouble is, items like Suet Pudding produce a lot of fat build up over time, and sure enough, eventually maintenance people were called to remove a thick, white block of fat from the exhaust pipes leading out of the bread oven. However, in attempting to break up the blockage and push it out to clear the system, another pipe further down the chain came loose at a join. The dislodged pipe was in one of the basement areas, and it began to leak a few drops of water. Now Sod’s Law kicks in, because that leaking join was directly above a power breaker that was temporarily exposed. The drips cause some sparks and create some smoke, which gets pulled into the ventilation system of an adjacent data centre also in the basement area. This caused all the alarms to go off in the building, set off the gas protection system (which costs £30,000 to fill up again), and required everyone to cease trading and leave the building, losing further money.

“Now, could you ever write a plan about that? Absolutely not.”

How to build an organisational Amygdala

Pursuing continuity in absolute terms is impossible. There will always be surprises, even with events you think you've comprehensively accounted for. A far better use of your time is simply to practice crisis response.

The ability to maintain order and operational effectiveness throughout a disaster isn't a question of exceptional leadership or meticulous planning. More often than not it's the result of having practical experiences to draw from, earned through exercises and real incidents.

Practice responding to different crisis scenarios, and pay attention to the processes, conversations and decision-making that happens throughout. The possible causes of disruption are infinite, but the underlying behaviours and actions that truly influence recovery are constant and replicable.

Vicki Gavin of The Economist has a really interesting analogy that illustrates this point beautifully.

"One thing to improve resilience immediately would be to...

"...sit down as a team and simply talk about it."

'What would we do if...?' You don't need to spend lots of time and money organising crisis exercises. If you're worried about event X, just sit down and say 'What if it happened? What would we do?'

"That'll do a couple of things. First, it'll start to develop a shared risk appetite within the organisation, because everyone who is invited to that discussion will hear what each other's concerns are, and come to a consensus.

"Second, it'll create a central store within your organisation's brain of 'what-to-do-if-this-happens'. In the human brain, this is called the Amygdala. It's where the fight or flight reflex is, and essentially it supports intuitive decision making. It uses all of the information we've ever seen, heard or felt, and it instructs and informs our gut-reaction snap-decision-making ability. The rest of your brain will eventually kick in with rational responses and alternatives that you can discuss and apply as necessary, but the Amygdala informs our immediate actions to events.

"The more risks, events and impacts you talk through with colleagues, the more you can build out a kind of collective Amygdala, which can significantly improve your immediate and long term recovery prospects from a much wider degree of situations."

