The Role of Communication and Management Inside and Outside Business Organizations When Manufacturing Accidents Occur — Case Examples of Carbon Monoxide Poisoning Accidents Committed by Company M and Company P

In the development phase of new products, quality control checks and safety evaluations are carried out repeatedly from various angles before they are introduced into the market. However, even with doubly sure quality control practices in place, product-related accidents occur. In this chapter, we will be examining cases of carbon monoxide poisoning accidents caused by household products and equipment and ascertain how corporations respond to such matters. In particular, we will be ascertaining the issues and reality of such matters from the viewpoints of "the implementation process for emergency responses" and "the dynamics of organizational PR."

9.1 Occurrences of Accidents Related to Goods for Home Use

Accidents caused by household products are occurring frequently. Familiar and everyday products that are essential to daily living are taking the lives of many consumers. With products that are

traditionally associated with being easily fatal if misused, such as cars, medicines, and medical devices, strong caution is advised and under the supervision of the regulating authorities, strict safety standards have to be met in the designs of such products. Furthermore, in the event such products give rise to any accident, a company is demanded to submit a swift report. However, today, even household products that do not generally give the impression of being hazardous have been tainted with the possibility of causing serious physical harm to consumers. In recent years, the public had even been notified through various media to take precautions in the use of such products. Among the TV commercials, the impressive ones are those running a calm commentary while publicizing the dangers of the products of relevant corporations.

In this report, I would like to elaborate on the cases of two firms (Company M and Company P) to shed some light on the situation of repeating accidents caused by household products. Both of these companies share in common the fact that their products had caused death by poisoning due to the release of carbon monoxide gas from malfunctioning products. We will ascertain how these corporations responded as an organization to the emergency of accidents caused by their products and how they carried out crisis management measures to minimize damage (or in the event of not having been able to carry them out, we will inquire into the causes behind the inaction). In this way, we will ascertain the reality and issues of these matters from the viewpoints of "the implementation process for emergency responses" and "the dynamics of organizational PR."

This report does not end with the ascertainment of crisis management methods carried out by the concerned companies after the occurrence of their respective accidents. Specifically, it does not attempt to qualitatively and quantitatively measure whether their organizational behavior processes that helped them carry out a series

of emergency response systems were strictly valid in society's judgment or not. Instead, you should understand this report to be placing an emphasis on ascertaining the ethics involved in the response the concerned parties should carry out whenever the emergency of a product-related accident occurs. In particular the report will focus on gaining an understanding in how the concerned companies responded in emergency situations and in the organizational attitudes and climate that gave rise to their particular responses as organizations. With these things in mind, I would then like to consider the ideal shape and implementation of an organizational design that could help a company to respond on a functional level even at times of an emergency involving business-related accidents that are mainly due to accidents caused by products.

This book treats information searching for the development of new products as a main objective as well. For developing new products, you should search for information related to the type of product the market will receive and furthermore promote a business plan that is in line with an appropriate financial strategy. Additionally, after having introduced a developed product into the market, an advertising strategy for promoting sales will become necessary. Various types of information searches will become necessary in the product development and sales promotion phases.

To put it differently, this report should be understood as an investigation into how to best organize and release information on products that have been searched and collected whenever an accident occurs. In the course of developing a product, it is desirable to make effective use of information acquired for each development phase. In particular, if information on the aspects of a product undergoing the phase of fundamental development is adequately publicized to users, any potential harm to people and objects can be effectively kept in check.

9.2 Crisis Management in the Cases of Company M and Company P

9.2.1 *Crisis management of Company M*

1) *Summary of the accidents and the causes behind them*

The concerned business received from the Ministry of Economy, Trade and Industry an emergency interim order based on Article 82 of the Consumer Appliances Security Law and expressed its intention to carry out a cost-free recall and exchange program for designated sold components of 25 models of the Forced Draught Balanced Flue type (FF type) oil heater and flat radiant oil heater, which were manufactured from 1985 through 1992. They also expressed that the program was to be carried out for the purpose of securing the safety of the consumers who had bought the products. It was reported on April 20, 2005 that three incidents of carbon monoxide poisoning had occurred. The cause was attributed to the use of an FF-type oil heater, whose safety aspect had been suspect. One person had died as a result, while several others had been hospitalized (including people who were discharged and were recovering, receiving check-ups, and people who had been discharged the next day). The poisoning was said to have been chiefly brought about by a crack that had developed in the secondary air hose made of heat-resisting rubber that supplies air into the combustion chamber of the concerned heater. The crack was said to have been caused by deterioration over time.

2) *Organizational response*

The concerned company went on to set up an emergency market task force for FF models and reported on December 19, 2005 the progress of emergency countermeasures they had put into place for protecting against risks associated with FF-type oil heaters and flat radiant oil heaters. The following points describe the concerned company's

typical post-accident responses, which were found in their news release issued on the same day.

Reexamination advisory for owners of already serviced products

In this advisory, as an emergency safety measure, the company addresses all owners of the products that had already been serviced. Effective from December 8 of the same year, for those who wish to hand over the product, the company reports that it will accept them at a cost of 50,000 yen per unit. For those who wish to continue using the product, the company reports that it will once again replace faulty air hoses with revamped ones while also distributing and installing partial combustion devices.

Complete report on activities aimed at arousing caution in consumers

The measures carried out under the supervision of regional task forces set up in cities and districts were large scale. In this document, Company M reports on having all the employees of its group companies pay visits to nationwide kerosene purchasing routes to carry out a roller strategy that would help them gain an understanding of the buyers of the concerned products and to carry out poster placements and flyer distribution. During December 13 through 16 of the same year, the number of personnel committed to the roller strategy amounted to 6,500 and it did not stop at households but extended to boarding houses, private homes providing lodging for travelers, and country inns as well.

The flyers were distributed to residents by all employees of Company M's group companies and additionally were bundled into the packaging of the company's other products. Furthermore, they were distributed at mass retailers, specialty stores, and showrooms of the company. Even pass-along circulation activities that took place in municipalities were large scale. Additionally, notices ran on top web pages of major Internet providers such as DION, OCN, and So-net.

Progress report on notification activities carried out through the mass media

Newspaper announcements ran in 62 papers nationwide for several days starting from December 4. From December 8–9, an announcement was made by the President in an ad titled "An apology and an announcement." It was 15 columns long. In addition, all advertising on TV (spot commercials and sponsored program commercials) and sponsored radio program commercials were replaced with "An announcement and a request." Additionally, 45 million newspaper inserts were distributed from December 13 through 14 nationwide.

Report on subsequent activities planned

The company expressed their intent to continue their announcement activities with the aid of the mass media. These activities included announcements made through newspapers, TV commercials titled "An announcement and a request," continued distribution of newspaper inserts, placements of announcements in city magazines, and announcements made via other magazines. In addition, the company expressed their intent to carry out mailings of flyers by inspectors of electric meters, announcements to foreign residents, announcements through TV commercials, and mailings of leaflets as enclosures in credit card bills.

After December 20, the recall and repair (or buy back) work based on the number of units found in the customer list was coming to an end, so the company expressed that its recall effort was now going to focus on those products that were difficult to discover and recall.

3) *Investigation*

Reporting of support progress as occasion demands/complete disclosure

The characteristic aspect found in the acts carried out by the company in this accident was its swiftness in supporting the recall and repair

(or buy back) of the product in question after the occurrence of the accident. Additionally, another characteristic was that the company had appropriately reported the progress of the support situation over its corporate website. Since December 5, 2005, I was able to confirm at least nine postings mainly related to the implementation of emergency countermeasures, the results of the accident research, and the situation of current countermeasures.

The particulars of the countermeasures were very detailed, and under the category titled "Stock numbers of the targeted products and their existing quantity," not only were the stock numbers and the quantity of existing units disclosed, but so were the products' manufacture periods. Regarding the cases of products that did not lead to accidents but had dislocated air hoses despite having been inspected and repaired in the course of a second inspection, the company established a "listing for cases of dislocated air hoses" and meticulously disclosed each location where an accident had occurred, stock number, repair history, the content of notices from users (smells of kerosene, fails to ignite, etc.), causes, disposal details, and the date when disposal was completed. There were disclosures of even more particulars.

These series of disclosures obviously cannot be thought of as mere formalities carried out to fulfill legal obligations. They can be instead understood as voluntary and proactive acts aimed at realizing sincere communication with society. Additionally, the series of these disclosures had the effect of showing parties within and outside the organization that the company was pursuing the right course of action in an emergency situation brought about by the occurrence of an accident.

In 1982, Johnson & Johnson's medical product Tylenol was found to have been illegally contaminated with cyanide. It was the so-called Tylenol scare. The company carried out an active information disclosure campaign immediately after the incident occurred. They carried out simultaneous satellite broadcasts to 30 cities, set

up an exclusive toll-free hotline (136,000 inquiries made in eleven days after the incident occurred), ran front-page newspaper ads, and carried out TV broadcasts (exposure frequency of 2.5 viewings per household for 85% of the households in the US). The number of news reports that addressed the company's support information and notification of caution is said to have amounted to more than 125,000.

As a result, by December of the same year in which the incident had occurred, Tylenol sales were restored to its pre-incident level of 80%. It is believed that the company's success in restoring faith in Tylenol at an early stage is attributable to its corporate stance that sincerely prioritized "being responsible to consumers," which is the company's corporate philosophy.

The emergency recall measures carried out and the PR setup established by the concerned company in response to the crisis situation brought about by its products bear a resemblance to Johnson & Johnson's responses to this Tylenol incident.

Organizational risk communication that takes emergencies into account

The features apparently shared in common by all corporate scandals are deficient information analysis, negative attitude toward disclosures, passive support, and the unwillingness to make amends or even face the problems by clarifying responsibility for the scandal or accident in question. However, such drawbacks were not evident in the case of the concerned company. Rather, it can be said that the company had behaved proactively as an organization. In fact, it should be further noted that the company, prior to experiencing the accident, had already built a consensus regarding the organizational response it should make when an emergency strikes. This means that the company had been conscious of its organizational emergency response measures since its normal times and had been putting them into practice since then as well.

The attitude in recent years of the company towards business ethics began with the establishment in 1992 of the "corporate behavioral criteria," but in 1998 they had revised this to reflect their aim to (1) promote business ethics by thoroughly putting their management philosophy into practice, and (2) deal with value standards demanded by the new orientation of the times regarding the environment, human rights, and information. Since then, the company's legal department began to earnestly take measures towards pursuing ethical business practices, and by December 2000, the head of the legal department and all executives in charge of risk management were held in charge of ethical business practices. At the same time, the Business Ethics Room of the Legal Headquarters was also established.

The Corporate Behavioral Criteria clearly indicates the direction to be aimed by the organization as a whole and its sentences characteristically begin with the expression, "We will."[1] In the section titled Safety for Six Products found in its first Chapter, the following items are expressed with clarity: (1) prioritization of safety, (2) provision of information, and (3) responses to make when an accident occurs. These items are understood to have been put into practice as the general will of the company, as were the contents of the preceding section titled "three organizational responses." The traditional organizational behavior guidelines of the company remained clearly valid.

9.2.2 *Crisis management of Company P*

1) *Summary of the accidents and the causes behind them*

Due to a series of accidents caused by vented-type instantaneous water heaters, Company P received a mandate from the Ministry of Economy, Trade and Industry to recall these products. The company subsequently went on to offer support for free inspections, collections, and replacements. The control boxes, which were placed in

these products to prevent impartial combustion, had damaged easily and since they had been shoddily reconfigured, they had caused carbon monoxide poisoning accidents that had led to the deaths of many people.

2) *Organizational response*

In the case of Company P, there was the impression that their response was initially unclear after the product-related accident had taken place, making them appear distrustful. In the case of Company M, at a specific point in time, they had made full disclosure of their progress in dealing with their crisis situation over their website. In the case of Company P, however, regarding their response after the occurrence of the accident and their PR activities, you were only able to come to know about them through newspapers for the most part. What follows below is an account of this company's response after the occurrence of the accident based on information acquired from newspapers.

On July 28, 2006, the company received a mandate from the Ministry of Economy, Trade and Industry to recall their products and the next day, a press conference was held at the headquarters of the company. They appeared to have taken the mandate from the ministry very seriously, but did not acknowledge that the seven models targeted for recall were defective products. In fact, they commented that there was a difference of opinion. At this point, the company did not recognize that they were fundamentally responsible for the accidents caused by their product. Up to the point this press conference was held, the company had been going ahead with product recalls, inspections and repairs in parallel. While the company had made arrangements to allow inspections, collections, and repairs of the concerned products by having its employees pay visits within a few days to users who had requested inspections, the number of units that had been replaced with new ones stopped short at 7,734 as of

August 23. The remaining 10,000 units had been inspected, but they were allowed to be temporarily used until they were to be replaced with new models.

Additionally, like Company M, this company warned users of the possible dangers associated with their certain products through the use of various media. Specifically, in addition to using newspaper and television ads, they carried out leaflet distributions to households using gas supplies, sent out direct mail to users, and announced free inspections via their corporate website. In effect, they addressed the risk of the frequent occurrence of accidents and announced their intent to carry out free replacements for consumers.

In addition to carrying out emergency support for users to restrain the spread of accidents, the company carried out a drastic structural reorganization. They also revealed that they would be setting up a third-party committee comprised of outsider experts to gain advice on organizational conduct.

3) *Investigation*

The unprepared and dysfunctional state of the PR setup

Firstly, there was the impression that Company P was stumbling since the press conference after the accidents took place. It did not have a PR department before experiencing the concerned accidents. As a result, their support for news coverage on the accidents did not advance smoothly. Even competitors who ran smaller operations than Company P had PR departments of their own.

At the press conference held at the company after the accidents took place, the company did not acknowledge that the products targeted for recall were defective. Additionally, they once again asserted that the products in question were not defective at the press conference held two days later. However, they did not present any data or research findings that backed their assertion, making their credibility thin. While the company had completely denied that any of

its employees were responsible for any shoddy modifications, at this press conference, they revised their official stance to "We cannot state definitely that our employees were not involved in the modifications in every case." The basic function of information gathering was not working. Under such circumstances, even if PR functions were working properly, society's confidence in the company cannot be retained.

The decision was reached to establish a new post that would be in charge of managing and collecting information on the problems associated with the products. It should be noted here that the company had started to reinforce their setup for managing accident-related information for the first time in this way only after the concerned accidents had taken place. The current Gas Act stipulates that the duty to report any accidents related to gas appliances rests with not the maker of the appliance, but with the gas supplier. In the case of the carbon monoxide poisoning accidents associated with Company P, on top of the fact that there were omissions in the report from the gas supplier, the information on the accidents that Company P had grasped had not been submitted to the Ministry of Economy, Trade and Industry. This state of affairs, it has been pointed out, had led to the further flaring up of the accidents. However, the PR department is a department that should be in charge of collecting various sets of information in the course of promoting a company's business activities. Such sets of information include "project development information," "product information," "business promotion information," and "financial information." Consequently, in the event a company becomes involved in a scandal or an accident, the department is there to see to it that relevant information based on these collected data are dispatched. The decisive factor in why the post-accident press coverage did not proceed smoothly can be found here.

Originally, there is the general impression that the function of PR is geared toward corporate advertising and brand image. In other

words, it is generally associated with the sales promotion of products that are going to be introduced into the market (or have already been introduced into the market). However, on a fundamental level, PR should be understood for what its initials stand for — public relations. PR is the ideal method for facilitating interactive communication between a company and the public, and in the event any inappropriate incident related to the company's business activities surfaces based on information and indications from outside the company, PR should prove to help in promoting reforms and revisions as necessary.

If the company had made full use of general PR functions (such as reporting the details and causes of the accidents, and the progress of the support situation) and if it were aware of PR's original purpose, it is believed that the company would have been able to control and minimize the damage to itself, and additionally, it is believed that the post-accident news coverage facilitated at public venues would have proceeded smoothly.

Organizational insubstantiality (dysfunctional information transmission)

The concerned company was a family concern and its organizational structure was inadequate. They did not have any monitoring functions that could help them make objective decisions concerning business activities and they were not running their organizational operations in an adequate and correct manner.

Firstly, the company's ability to size up situations and make decisions at the managerial level was insubstantial. There is testimony claiming, "A meeting of the board of directors was like the President's one-man-show." The meeting was not a place for gaining approval for large-scale business developments by carrying out discussions to arrive at objective and appropriate conclusions backed by detailed market research. Nor was it a place to engage in discussions on the

company's role in society or to discuss middle to long-term business strategies. The carbon monoxide poisoning accidents caused by the concerned products became a topic of discussion at board meetings but there were no drastic countermeasures adopted subsequently, and the problem ended up being neglected. Furthermore, despite the fact that it had become necessary to urgently submit reports and proposals from the scenes of the accidents to high-level departments and the management, these types of information remained at the level of the scenes.

Even though there were internal rules, the decision to report or not report on product-related accidents to the President rested with the quality control division manager. Regarding one accident case, this same manager declared, "I did not report it on the grounds of the understanding that shoddy modifications are a problem separate from the problem of quality." However, at a later time, the manager explained that this case, along with others, "should have been reported." Even though no critical defect of the concerned product could be recognized at this point in time, there was no evidence of the company showing solidarity in the cause of preventing the recurrence of these accidents and uncovering their root cause. The organization's information transmission mechanism, which should have been functioning, was in effect malfunctioning.

Additionally, at the level below the quality control department, which is the level of the scene where the actual work took place, basic principles of ethics relating to repair work had not been cultivated. A former employee of a service office of the company says that at the time of his entry into the firm, "A senior colleague taught me how to carry out shoddy modifications as a means to make do when required components were lacking." Additionally, this method for making shoddy modifications was known to repairmen of contracted service shops and repair agents affiliated with the gas companies. However,

when modifying in this way, it was thought to be common sense to inform the user of the dangers involved and the need to ventilate, and make swift repairs again once the required components were procured.

Some have stated that they had made modifications for a countless number of times over several years until an internal memo prohibiting shoddy modifications was issued in January 1992. If the modifications in question were meant to serve as temporary, stopgap measures to protect users from some form of imminent danger, then those modifications, even if they were shoddy, could be considered in the end to have been measures that had taken the safety of the users into account. However, if they were indeed temporary emergency measures, then it should have been necessary to follow through with supplementary work. This would have been critical. Nevertheless, because the work remained inadequate, a catastrophe had been brought about.

In the above sections, I discussed how Company M and Company P responded as an organization to the crisis of accidents being caused by their respective products and how they carried out measures to minimize damage. In other words, I discussed how the two firms carried out crisis management (or if they were not able to carry it out, then I discussed why that was the case). From this point onward, I would like to take those cases into account and add my considerations on the "implementation process of emergency responses" and the "ideal organizational design" that could help realize this process. The concept concerned with the ideal organizational design explained in the following section is not limited to the function of preventing product-related accidents and the function of realizing disaster reduction, but also encompasses the idea of corporate crisis prevention. It also should be understood as a management system for minimizing damage.

9.3 Risk and Crisis Management in Business Organizations

9.3.1 *Thoughts on risk management that should apply throughout an entire organization*

Pure risks are material or immaterial elements that can cause damage to people and materials in the course of running business operations. In business organizations these days, it is said that gaps in awareness exist for this concept between on-site workers, administrators, and top management executives (the decision makers).

In general, the work front personnel (especially the engineers who carry out work at places that are close to production processes) are conscious of the issues of "safety and reliability" on a daily basis and are also highly conscious of the importance of a healthy organizational climate in the sphere of their own business activities.

In the production field, it is likely that revalidations of safety management processes based on reviews of the production process are being repeatedly carried out. Additionally, engineers are not only conscious of product development, but of also safety management measures that need to be put into place after products have been distributed into the market. Meanwhile, at the administrator and top management levels, it has been pointed out that awareness for managing "safety and reliability" issues at present is not as strong as evidenced at the work front level.

In the case of Company M, crisis management measures were recognized in common by everyone in the company, ranging from top management executives to work front workers. These measures would help them carry out safety management and respond to product-related accidents whenever they occurred. On the other hand, in the case of Company P, due to the fact that there were gaps in awareness for risk management between the top management and work front levels, awareness for "safety management" at the work front level was low, just as it was at the top management level as well.

The need for systematically treating the subject of risk management (protection against disasters and reducing disasters — henceforth referred to as RM) as an important part of the theoretical lineage of business administration can be validated by just taking a broad view of the theoretical lineage of the present business administration theory. From the postwar period through the time the industrial structure of the heavy industries was formed around the 1970s, business administration in Japan experienced a time of comprehensively reconstructing German business economics, the US theory of business administration, and also Japanese management practices, which had been traditionally studied. It is thought that the theory of business administration in Japan after the latter half of the 1980s was strongly influenced by the American theory of business administration, which is premised on the construction of methods rooted in scientific observations, measurements, and proofs. The present form of the Japanese theory reflects this influence. In covering RM for this report, the fields that should be emphasized are management engineering, business management theory, and organization theory, which are fields than can prove helpful in implementing product design and safety management. These fields strongly bear the characteristics of American business administration theory in particular.

While the fields of management engineering, business management, and organization theory each deal with the study of risk, they vary in terms of critical thinking processes, the events they cover, and the methods they construct to solve problems. In the case study of Company P mentioned above, it is believed that the escalation of damage had occurred because the company experienced a combination of product-engineering problems, management theory problems, and organization theory problems. Drawing lessons from this case study, it is thought that it is necessary to tie each of these disciplines that had developed on their own into one field that can serve as a field specializing in the study of pure risks surrounding the

business organization. Consequently, there will be a demand for the rise of new analytical structures and, based on such structures, new management system designs for the corporate organization.

9.3.2 *System architecture guidelines/efficacy evaluations*

Now, based on the awareness of the issues mentioned above, I would like to consider how to best apply RM ideas to organizational design — ideas that could be applied as methodologies across the board of all the fields of business administration. In my judgment, towards this end, the Ministry of Economy, Trade and Industry's "JISQ 2001 Guidelines for Building a Risk Management System" is recommendable (see Figure 9-1).

These are guidelines that have been conceived for making RM function as a system without being limited by the scale and form of an organizational entity. In Figure 9-1, the categories titled "risk analysis," "risk evaluation," and "RM target setting" are relevant to the fields of management engineering and business management theory. In the field of management engineering these days, it is often the case that scenario analyses are carried out for every accident model, and in the case of analyzing the probability of occurrences, quantitative considerations are added by applying databases of accident information, accident statistics, and failure rate data.

Additionally, in terms of Figure 9-1's system as a whole (system construction, cultivation of people, construction of the RM framework, creation and implementation of programs), ideas of business management theory [the fields of labor management and personnel management administration (human resources)] are reflected. Additionally, it is believed that it would be ideal to construct a system based on the ideas of this business management theory and have it fit into the framework of the strategic thinking of organization theory.

With this RM system, every department, administrator, and top management executive in a business organization must be conscious

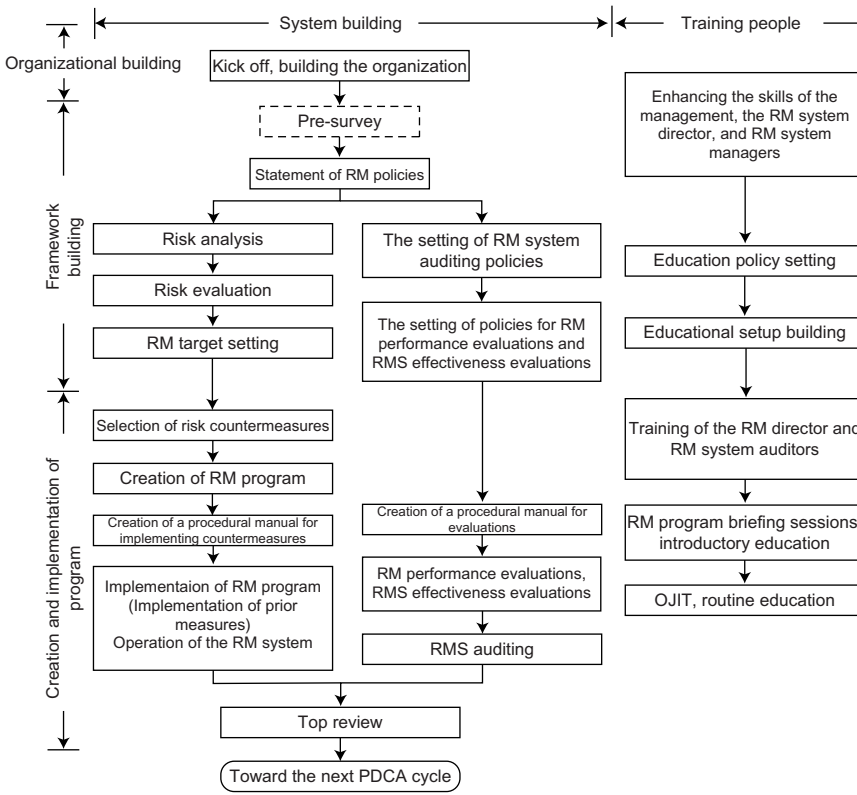

Figure 9-1: Risk Management System

Source: Toshimasa Suzuki & RM Consortium 21's *The One-Stop Guide to Understanding Everything About Risk Management*, Nikkan Kogyo Shimbun, 2002, p. 71, Figure 3-8 (The flow of RM system building for organizations incorporating it for the first time).

of safety management objectives shared in common and must constantly make assessments of their validity[1)] and continue to reexamine the PDCA cycle (Plan-Do-Check-Act cycle). However, the

[1)]This is the so-called cost-benefit analysis and it advocates the implementation of a measure once its benefits have been calculated and the probability of a risk materializing and the consequent damage levels arising after its implementation are deemed to be at acceptable levels. For details, refer to pp. 123–124 of the *Risk Management Guide,* authored by the Engineering Policy Research Section of the General Security Research Center of the Mitsubishi Research Institute. It was published by the Japan Standards Association in 2000.

problem lies in finding out how to carry out system maintenance after building the system. Rather, this is what is important. Risk recognition varies by each department's specialty and in the higher-ranking departments where these other departments are brought together, cross-sectional knowledge and decision making abilities are demanded.

Additionally, in the event of constructing a new RM system, the hierarchization of decision-making will become necessary, and an organic cooperation between high and low departments will also become necessary. The larger an organization grows, the more important this institutional design becomes.

At this point, I would like you to take a look at Figure 9-2. This is an example of an arrangement of RM posts that could be set up at the time of introducing an RM system into a large enterprise. To maintain and develop an RM system, it would be ideal to appoint the people in charge of the RM system (experts) to a departmental level or a management level.

In the case of Company P, the person in charge of the quality control department had failed to convey the situation of product-related

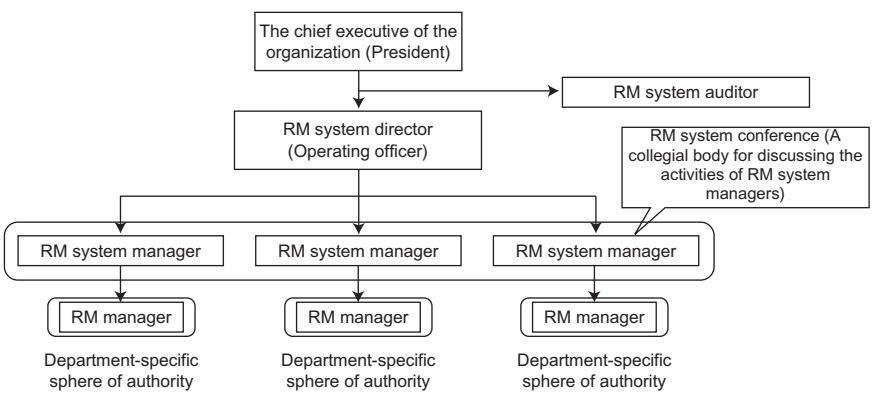

Figure 9-2: The Setup of RM System Building and Maintenance for Large Enterprises
Source: Same source as Figure 9-1, p. 79, Figure 3-13 (The setup of RM system building and maintenance for large enterprises (an example)).

accidents to senior-level executives because the person himself did not realize the magnitude of the events. If this person in charge had been carrying out his duties and appropriately reporting to senior level executives as someone in charge of an RM system that would have made it possible to recognize comprehensive risk management, the further flaring up of the accidents would have been avoided. The task of heading an RM system should ideally be carried out at the level of the department where authority has been transferred. It would then become possible to comprehensively collect and analyze information for resolving problems and negotiate with overseas departments and upper-level management. Additionally, it would become possible to carry out integrated decision-making at the high-ranking managerial level by incorporating policies proposed by lower level personnel. As a result, it would become possible for the organization as a whole to reorganize and develop the RM system.

9.3.3 *Stages of crisis management*

When considering production activities and various business activities of corporations, you will begin to see that there are various factors that serve to make the continuation of such activities difficult. In particular, the occurrences of man-made accidents and incidents, which are caused by an organization's internal factors, tend to be sudden and unexpected, making it difficult to predict the scale of damage that may arise. To minimize human and economic damage after a disaster strikes, you will need to properly design a crisis management plan beforehand and share the same views, system design, and behavioral guidelines regarding crisis management throughout the entire organization. Here, I would like to discuss the guidelines for constructing a corporate crisis management plan, which is a post-disaster response.

At this point, I would like you to take a look at Figure 9-3. This figure indicates management strategies for pre-disaster "disaster prevention measures" (risk management) and post-disaster "disaster

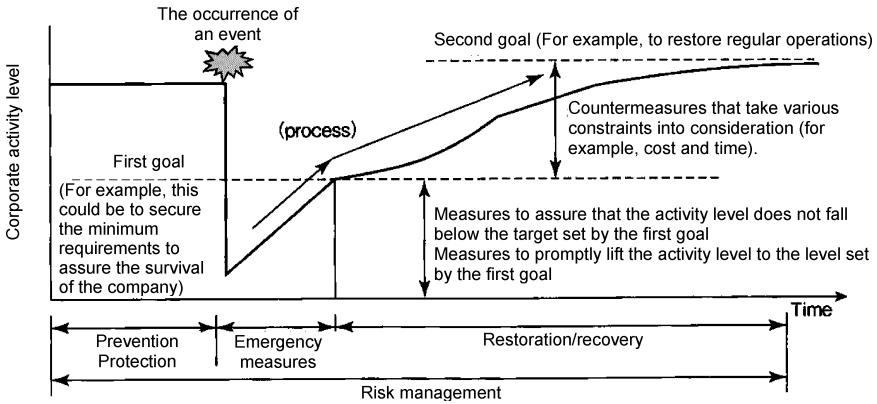

Figure 9-3: The Phases of Risk Management
Source: Same source as Figure 9-1, p. 117, Figure 3-37 (The phases of risk management).

reduction measures" (crisis management) *vis-à-vis* accidents that beset corporations. In general, the figure should be understood to be showing the "stages of risk management" that comprise the concepts of the former and latter.

I would like you to pay particular attention to "emergency measures" and "the restoration and recovery" process (everything to the right of "occurrence of event" in the figure). These are put into place after a disaster strikes and are grounded in the concept of crisis management. At the stage of "emergency measures," disaster has already struck and the survival of the corporation and the safety of consumers using the products in question must be maintained. An "urgent" form of management is demanded to minimize physical damages that include damage to humans and to economic elements. Since the product-related accidents considered in this chapter are assumed to be fatal, this form of management needs to be all the more emphasized.

Additionally, at the stage of "restoration and recovery," which follows the implementation of emergency responses, it is necessary to secure minimum conditions to maintain the continued survival of the corporation. Subsequently, the company should now aim to

bring manufacturing functions and general administrative functions back to their ordinary, pre-crisis levels, taking into account the cost and time invested for putting restoration measures into effect. In the case of Company P, a cost of more than 20 billion yen to cover for inspections of models associated with a series of accidents had to be defrayed. Additionally, due to the fact that these accidents had resulted in many fatalities, the company also had to consider compensating the aggrieved parties. Indeed, they had to shoulder a vast burden of expenses.

Additionally, what the company must be particularly cautious about is being blamed for collateral damages. Responses to any moves that may bring about such an outcome must be carried out with scrupulousness. Since the damage to the image of related products may occur and contribute to a decrease in sales, a reexamination of the production plan must be taken into consideration as well. Additionally, it will be necessary for the organization as a whole to deepen its normal recognition of the business structures of the related departments. If you experience a crisis that directly involves your own department, you must confirm how the damage extension system is assumed to work.

9.3.4 *Implementation process of crisis management*

So how should we build and implement the process of crisis management mentioned above? At this point, I would like you to look at Figure 9-4. This figure shows a timeline of the sequence of events to be implemented when a company is confronted with a crisis situation, beginning with the first report received after an accident or incident takes place. The formation of a group for responding to an emergency situation at an early stage, and seeing to it that the mechanism of the task force's responses function smoothly will become extremely crucial. With Company M, these series of responses were carried out very swiftly and are believed to have functioned effectively.

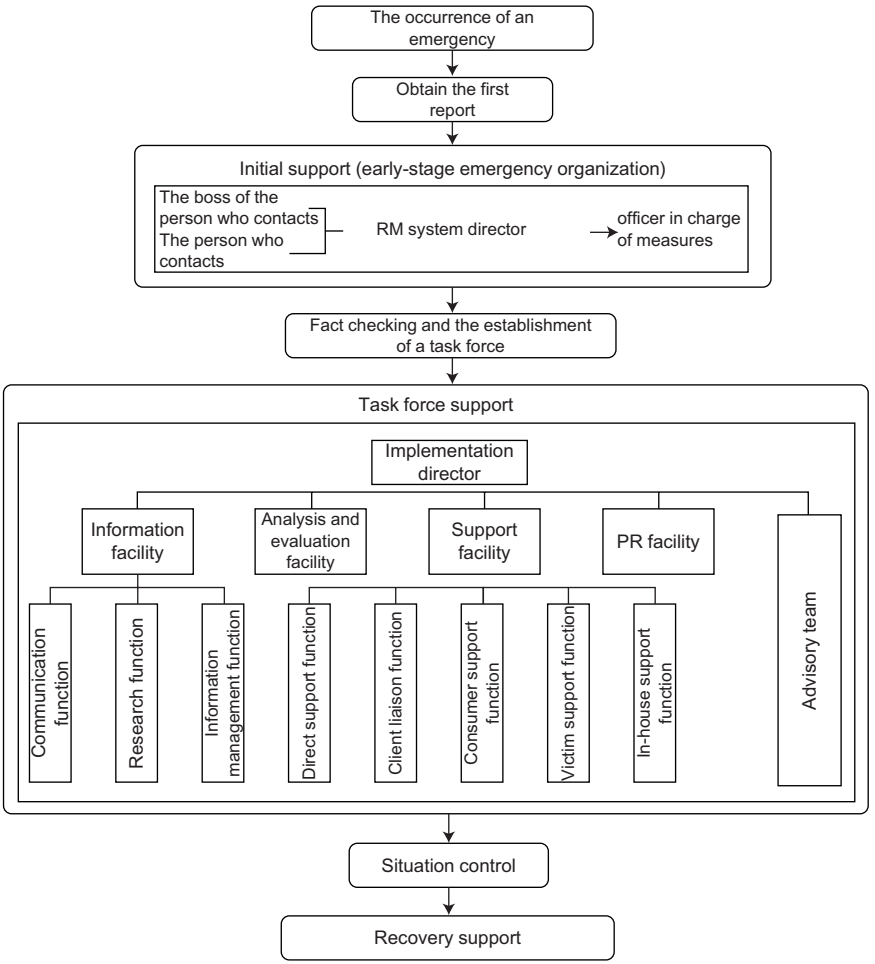

Figure 9-4: Support Chart
Source: Same source as Figure 9-1, p. 171, Figure 4-5 (Support chart).

What becomes important after obtaining the first report is the formation of the "initial emergency responder group." What is key here is to have the person in charge of the risk management system (or the RM System Chief as specified in the figure) also become the person in charge for carrying out the measures. It is preferable for this role to be assumed by an executive officer. This is because such a

person tends to have abundant knowledge of past crisis situations and also tends to be an expert in making responses for disaster reduction. Additionally, such a person can provide a very high-level of analytical and decision-making skills backed by rich experience and also offer the ability to adeptly develop a chain of command. When confronted with a crisis situation, this figure will take central command for the measures to be implemented and helm the task force.

The next important thing to achieve is substantial support for disaster reduction through the formation of a task force. As for the facilities of the task force, it is advisable to set up the following ones under the supervision of a person in charge of implementation — "information facility," "analytical assessment facility," "response facility," "PR facility," and an "advisory team facility." These facilities should be set up as independent operations. They must effectively be linked to each other through a mutually cooperative communication process.

With the "information facility," personnel will be entrusted with the task of carrying out centralized information management to assure that the situation is grasped without any discrepancies. Toward this end, the personnel will repeatedly carry out thorough research regarding the crisis situation and collect relevant information. In the case of Company P, inconsistencies in their official announcements began to surface at press conferences. We cannot therefore avoid judging that this facility had been particularly weak in Company P's case. With the "analytical assessment facility," analytical assessments are carried out on the basis of information provided by the "information facility." With the "response facility," the results of the "information facility" and the "analytical assessment facility" are used as inputs in determining the in-house behavioral criteria and subsequently actions are carried out to get the situation under control.

The "information facility," "analytical assessment facility," and "response facility" need to be structured so that one cycle of their

work process is reached when the stage of emergency or the following restoration/recovery stage is reached. This cycle is similar to the PDCA cycle. The actions taken by the organization to take control of a situation must be conveyed as social announcements to stakeholders through the "PR facility." It will be important to continue reporting on how well a situation is under control and on what problems and issues remain, even if a deadlock has been reached.

9.4 Conclusion

At present, international guidelines for ethical standards of corporate behavior are in the process of being formed. This movement is recognized as an attempt at forming guidelines for sound corporate conduct and for implementing appropriate actions. It is deemed necessary that this movement be repeated — or to put it differently, the practice of international business behavioral guidelines is still undergoing development[4] and has many issues yet to resolve. Regarding the thinking behind corporate governance, which contemplates the sound and adequate ways a corporate organization can function, in the general rules of the Organisation for Economic Co-operation and Development (OECD) that were set forth in 1999, the phrase "important information" was used in relation to an explanation on the kinds of corporate information that should be accessed. However, in the revised general rules (new general rules) set forth in 2004, the expression was changed to "sufficient and reliable information on a timely and regular basis."

In recent years, in socially-responsible corporations, where valuable traditional theories and experiences are seen to be thriving, corporate governance has made strides.[5] For this reason, it is advisable to be open to learning about attitudes and approaches from such corporations. In particular, the response made by Company M to deal with their accidents are sure to become classic examples of crisis

management, along with Company S's response to the "fan heater accident" in 1985.

So what will be important from now on regarding corporate responses to the occurrence of accidents? The answer is believed to be the compilation and classification of the patterns of organizational conduct. If such work progresses, general principles of the best organizational behaviors can be imaged to a certain extent. Consequently, deceptive responses such as concealing or falsifying accident-related information are thought to decrease as well.

What is necessary for this task is the active disclosure of "a detailed accident analysis report." In the event a corporation causes an accident, it is obligated to create a detailed analytical report on the accident under the direction of the regulating authorities. However, these materials tend not to be actively disclosed to third parties. Insurance companies and consultancies that investigate accidents also do not show such reports to third parties. This is because they have a legally binding agreement with their client companies to keep such information confidential.

From now on, it is hoped that the corporation responsible for causing an accident will play a key role in disclosing the accident analysis report. While it is understandable that no one wishes to actively disclose their past mistakes, to prevent similar accidents from occurring again, it is necessary to pinpoint the fundamental causes behind an accident and inspect the patterns of the factors triggering it. Toward this end, the task of compiling "detailed reports" on similar accidents and the task of classifying accidents based on these materials become urgent requirements. Additionally, it is believed that the fruits of classifying accidents can be shared throughout society and largely contribute toward realizing disaster protection and reduction.

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