Military decisions carry high consequences, often of life or death. They contain the potential for catastrophic error, from which there can be no recovery. The collateral dead stay dead, the civilian aircraft remains shot down, the trauma of a friendly fire incident persists for a lifetime, promising careers are cut short, units disbanded, capabilities dismantled.

‘High Consequence Decision-Making’ (HCD) is the name of a program whose goal is to minimise the risk of catastrophic error. This is not a risk that can be eliminated altogether, the nature of military action excludes that possibility, but it can be reduced to a minimum through a range of measures. These measures address issues surrounding organisational culture, management systems, decision-making processes, and team and individual performance. HCD offers a framework to guide leadership initiatives, the development of procedures and the design of training courses, with this purpose in mind.

In war, catastrophe can strike from a number of directions. HCD restricts itself to dealing with just one of these—the possibility of a catastrophic error. Narrowing its scope in this manner is what leads HCD to place the question of control at its centre. This is because errors, mistakes and accidents are the result of our own actions and this means that there is the potential to avoid them; and the possibility of exercising control.

This can be seen from both the USS Vincennes incident and the Black Hawk shoot downs, covered in the book, Shoot, Don’t Shoot, published by the Air Power Development Centre, Canberra. In both cases the actions of the adversary was not in any way decisive; the catastrophes that struck were the result of actions taken exclusively by one side. It is true that in both situations there was a real possibility of an enemy presence and the fact that the truth of the matter was unknown at the time was an important element. Nevertheless, the reality was that there was no adversary in the air; there were only friendly forces trying to cope with uncertainty.

If control is the key to avoiding catastrophic error, then it follows that HCD concentrates its attention where control is greatest—one’s own situation. A central lesson from the incidents that have been examined in depth, in the book mentioned above, is the importance of one’s own understanding and relative situational awareness (SA). Situational awareness simply cannot be taken for granted. Case studies highlight the role played by complications surrounding the mission, the rules of engagement (ROE), the commanders’ intent, command-and-control arrangements, intelligence, procedures, motivation and organisational culture. These factors have played themselves out in tactical situations that led directly to catastrophe. But none of them were produced by the immediate situation; they pre-existed the incident by weeks, months and sometimes years. This is the key message. High consequence decision-making need not take place in the heat of battle—it is normally set up in advance.

Here are some examples, described in detail in the book, to illustrate the point.

Organisational culture. This played an important role in the decision-making on board the USS Vincennes and with Tiger Flight. In the case of the F-15s, it was a matter of reconciling their culture with the prevalent operating environment; the squadron was simply out of step with everyone else.

Team processes. This expressed itself in the ‘dysfunctional interactions’ between ships’ captains in the Gulf and between the AWACS crew and the F-15 pilots. Effective communications had ceased between them.
Discipline. Captain Rogers disobeyed a direct order in going after the Iranian patrol boats, his ship’s helicopter violated the ROE, most likely with his approval. The F-15 pilots refused to accept the authority of the ACE, or the legitimacy of altitude restrictions and other constraints placed on them by their chain of command.

Motivation. The crew of the USS Vincennes were keen to prove their Aegis combat information system in actual combat and justify their presence in the Gulf. This led their captain into a surface engagement whose merits were dubious at best, from the perspective of the task force’s mission in the region. The F-15 pilots were undoubtedly influenced by the history of rivalry between themselves and the F-16 squadrons and a sense of feeling ‘discriminated’ against within the campaign in progress.

Oversight. F-15 mission planning drifted along its own path with the pilots making decisions that were out of step with the rest of the force, such as the use of Mode I IFF, or the plan to make a visual identification in case of a ‘low and slow’ target. There was little monitoring or supervision by operations staff to bring the F-15s back into line with the broader mission. This was also the key factor in the airstrike on the Kunduz MSF Trauma Centre.

Alongside these, the two biggest challenges of all are—ensuring understanding and creating situational awareness. The commander has to ensure the team understands completely the overall campaign mission, the particular mission on the day, the extant ROE, the commander’s intent, relevant guidance and procedures, risk tolerance and, if a mistake has to be made, which side to err on. The team needs to have adequate situational awareness within the operating environment, what to expect, the limits to one’s SA, what one does not know and the potential for catastrophic errors.

And finally, there is the decision-making process itself to manage, including:

- the location of decision-making and who will make the critical decisions,
- how time will be managed, as fast or as slow as possible,
- at what point decisions become critical and irreversible,
- making sure the right problem is being solved,
- the anticipation of consequences and the mitigation of negative implications from decisions taken.

None of these challenges are easy to overcome. Nevertheless, the stakes are high and they demand a commitment to do everything possible to minimise the risk of catastrophic error. HCD has been developed under the assumption that such a commitment does exist.

Key Points

- High Consequence Decision-Making (HCD) is the name of a program whose goal is to minimise the risk of catastrophic error.
- Errors, mistakes and accidents in decision-making are the result of our own actions and therefore, there is the potential to avoid them by exercising control.
- High consequence decision-making need not take place in the heat of battle—it is normally set up in advance.