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Leadership or Command Cycle

Leadership or Command Cycle is a risk management tool that can and should be used in conjunction with the Risk Management Matrix. This tool is designed to focus more specifically on events rather than assessing strategically how an agency's assets line up with its operational risks. This concept examines the events themselves with the intent of improving the agency's chances of preventing a similar incident in the future, minimizing the damage such an event may cause, or, handling future such situations with an entirely different organizational mind set. The key is to spread the use of the tool throughout the supervisory and administrative ranks of an agency so that it becomes a second language and is consistently applied to problems by leaders at all levels. We start by visualizing a circle or clock as the background framework. The heading over the clock is "Leadership or Command Cycle".

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At 12 o'clock we put the word "POLICIES" because every bureaucracy has them. Law enforcement, churches, Fortune 500 companies, and the military all have rules and procedures. At about 3 o'clock we write "TRAINING" because it is logical that we need training to support and reinforce the policies. We train on risk management subjects such as suicide preventing, felony stops, SWAT, escapes, and rescues. We should not waste time training on subjects that don't directly support our mission. Rappelling is fun and exciting but it is not as important as properly executing a cell extraction without serious injuries to the inmate or our staff.

At about 5 o'clock we need to put the words "SUPERVISION/ ADMINISTRATION" because we want to examine whether our supervisors and managers are doing their jobs appropriately. To repeat the most common complaint I hear from middle managers in my travels: "I can't get what the executives want me to do because I am too busy with meetings, meetings, and more meetings". Again, the book to read is Sean Covey's "the Four Disciplines of Execution".

4DX Leaders, with all the right intentions, earnestly believe they have to attend to everything all the time with all their waking hours. The result usually is a failure of top management to clearly focus organizational energies on the priorities. For example, in probation there are a half dozen or so readily identifiable risks that can damage an organization or create huge headaches for chiefs.

A sample would include suicides, escapes, excessive force, emergency evacuations, medical emergencies, cell extractions, PREA, and failures to make room or cell checks. That is not to say that evidence-based treatment methods are not important. They are important, but, not to the virtual exclusion of attention to life and death issues.

At about 7 o'clock the word "INSPECTIONS" is inscribed. In my experience this has always been the weakest component of agencies' mantels of risk protection. The old saying "You get what you inspect, not what you expect" is as true now as ever. The U .S. Army had to learn this lesson again after Vietnam. Rick Atkinson's book, "The Long Grey Line" exposed a casualty-inducing practice that required subordinate commanders to report high combat readiness when in fact the units may have been at 50 or 60 per cent of readiness based on available soldiers, training and equipment standards.

Thorough and objective inspections would have put an end to this practice but it did not occur. Likewise, law enforcement and corrections agencies fail to see the criticality of an inspection process that is not prejudiced solely by "chain-of-command" reports destined not to embarrass the stakeholders in those positions.

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Jerry Harper has served the law and justice professions with distinction for the past fifty years. He began his career with the Los Angeles County Sheriff's Department in 1962 and served in a variety of operational, supervisory, management, and executive leadership roles. Because of his leadership ability, along with the strategic vision that he brought to the department, he was promoted through the ranks and eventually accepted an appointment to the serve as the Department's second in command. From 1993 – 1999. Mr. Harper served as Undersheriff for the Los Angeles County Sheriff's Department and oversaw all operational and administrative functions. After retiring from the LASD, he accepted an invitation to serve as the Chief Probation Officer for San Bernardino County, where he served from 2004 - 2009.

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The inspection process must have an independent component, whether internal or external, reporting to the top boss. That type of inspectional process becomes an insurance policy for the organization.

However, I am getting ahead of myself and should instead be writing the word "CRITIQUE" at about 11 o'clock.

We generally find that an agency has handled a crisis in one of three ways: 1) it went well 2) it went "south", or, 3) it was a mixed result. However, we should be able to scrutinize incidents like the North Hollywood Shootout or the Baltimore Freddie Gray Riots objectively to extract lessons. PREA has an initial 30 day standard for when critiques should be convened at the conclusion of an investigation into a sex abuse incident in a jail or prison. We should insist on timely, objective, and thorough evaluations of incidents to take heed of the warning by George Santana: that "those who do not remember the past are condemned to repeat it".

Now, in this next part we understand why we have used the word CYCLE in our title for this tool.

We take what we have learned in the critique and ask,

- Do we need to change the policy?
- Do we need to delete it?
- Do we need to completely rethink and clarify the policy for our line and supervisory personnel?
- Do we need to ask them what THEY THINK the policy means?

We take the same approach to each of the benchmarks on our clock. Are we TRAINING in the subjects that are most likely to reduce our risks? Do our SUPERVISORS have the time to really, personally, face-to-face observe that the officers are taking the necessary safety precautions in their field probation visits? Would a different INSPECTION process have prevented this child's death in that foster home?
Why aren't we getting participation from our officers when we do these CRITIQUES?

Having labored over these and similar issues we begin to understand that if we consistently and objectively use this leadership framework to examine operations, whether looking at positive or negative outcomes, we soon have a whole organization of leaders who are cycling their experiences and learning how to avoid or ameliorate risks. But the cycle must be completed to be effective. The cycles must be repeated every time there is an incident that occurs that we can learn from.

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