9 Whistleblowing

Making a Weak Signal Stronger

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Introduction

Whistleblowing cases are high on the public agenda in Norway, as evidenced by the many news reports and articles in Norwegian national and regional news channels. In a commentary, Helle Stensbak, chief economist in a major Norwegian labor union (Stensbak, in *Aftenposten*, 10.9.2018, p. 2), notes that the societal costs are lower when further misconduct is prevented by internal whistleblowing, compared with when it's exposed by external control mechanisms. But, in either case, whistleblowing is problematic. It's estimated that only half of all instances of misconduct are reported, and in 65% of reported instances, no improvements result. It's also estimated that whistleblowing, if acted upon, might save Norway as a society more than one billion USD a year (Stensbak, in *Aftenposten*, 10.9.2018).

But one recurring problem is that blowing the whistle can be risky. Typically, the person accused of misconduct (often a manager) will try to divert the blame away from himself and instead pin it on the accuser. He'll do this by concealing or delaying posting the true information, and also by spreading lies or half-truths about the whistleblower throughout the organization. These tactics can be particularly effective if the credibility of the whistleblower may somehow be questioned (see Chapter 2).

The manager's defensive action may be successful, given that fellow employees, and even the public swayed by sensationalistic media, accept the diversion and direct their indignation at the whistleblower. This may prove fruitful if, as just mentioned, the personal background of the whistleblower can be manipulated into a more catchy story—for example, by portraying him as a sore-headed troublemaker rather than a conscientious and self-sacrificing employee with the greater good in mind. Even if the case goes to court, the accused is seldom found guilty, often because of a lack of incontrovertible evidence. The failure to make the case can happen when, for example, witnesses and experts offer conflicting interpretations of the facts (see, e.g., the Siemens case in Monsen, 2008; the Norfund case in Rafat, 2013; and the Monika case in Schaefer, 2019). An acquittal of the accused can lead to an even bigger tragedy

for the whistleblower. A whistleblower may stand no better chance if his accusations are investigated internally by an ombudsman. In a recent case in which employees reported nine instances of harassment at a large Norwegian hospital, only three instances were accounted credible enough to justify dismissing the accused manager (Skogstrøm, Dommerud, & Olsen, in *Aftenposten*, 3.2.2019, pp. 6–7).

Large-scale, cross-sectional surveys conducted among employees in Norway (e.g., Trygstad & Ødegård, 2016: the FAFO survey) point to worsened conditions for freedom of speech, including blowing the whistle, in the corporate world. Today, a significantly smaller number than five years ago believe that blowing the whistle may improve conditions. Sadly, the conditions for whistleblowing may be even worse in public organizations, according to commentary by Knut Olav Åmås (Åmås, in *Aftenposten*, 16.10.2016, p. 2–3). He cites an informant from the FAFO survey who works in the Norwegian health service and who recounts how management is determined to track down and punish employees it sees as “troublesome.” Consequently, fewer employees consider reporting workplace misconduct, and those who do rightly fear retaliation (see also commentary by Professor Petter Gottschalk in *Agderposten*, 22.8.2018, p. 21).

The whistleblower in this book, Peer Jacob Svenkerud (PJS) in 2007 blew the whistle on Norsk Tipping, the government-owned company operating Norway’s national lottery. Our chapter reviews a theory that provides valuable insights into how a problematic issue can be detected at an early stage while a weak signal and while it’s still possible to correct it using relatively limited company resources. We discuss PJS’s whistleblowing case in light of several streams of research: the literature on weak signals and strategic surprises (e.g., Ansoff, 1975); sensemaking and divergent thinking (e.g., Weick, 1995); organizational and safety culture (e.g., Reason, 1997); and mindful organizing (e.g., Weick & Sutcliffe, 2015). These research streams all have one thing in common: they contend that *being informed* is the most important basis for high-quality decision-making and action-taking in organizations. Perhaps more important than the objective information elements (i.e., the data) is the subjective apprehension of those elements by the management. We need to understand the psychological processes by which (objective) data are transformed into (subjective) perceptions and beliefs (mental models)—and the aforementioned theories are enlightening in that respect. A core point is that the transition from data to perception and understanding is less than perfect, indeed usually a fault-ridden process (see, e.g., Kahneman, 2012). When it comes to PJS’s case, we identify what went wrong when the organization’s upper management failed to interpret correctly and take action on his whistleblowing, and what lessons can be learned to ensure proper handling of similar cases in the future.

During the course of PJS’s story, we find several times when the upper management received information that, had it been properly acknowledged and promptly acted upon, could have prevented an escalation from

signal to crisis. It starts when PJS approaches the chairman of the board and exposes the gross misuse of funds by his charismatic boss, the CEO of NT (Riksrevisjonen, 2008–2009). Apparently, the chairman of the board takes PJS's disclosures seriously and decides to act on them. But when PJS offers to leave the organization for a position elsewhere, the chairman discourages that idea and instead asks him to stay on as NT's Senior Vice President Information and External Relations. The plan is for PJS to remain unidentified as the whistleblower and to assist in the firm's moral recovery. While this might seem a sensible move seen from the chairman's side, the situation worsens a few weeks later when the CEO has been informed that the whistleblower is actually an employee in his own organization. Instead of taking the opportunity to reform his own ways, the CEO starts a witch hunt for the "unfaithful servant" By now, PJS had gone from acting with integrity and autonomy to becoming a hunted man in his own organization—and being unhappily complicit in his own cover-up.

Theory

Whistleblowing can be understood as an employee's attempt to make a "weak signal" stronger—that is, an attempt, early on, to alert the management, the media, or a government agency to problems needing prompt correction (Gottschalk, 2018). It's a "weak signal" because its purpose is more preventive than punitive. It aims to give the organization a chance to correct the wrong before it escalates into a full-blown crisis (see Near & Miceli, 1985, 1995, 2016; Jubb, 1999). Many organizations that have experienced ethical crises have concluded that an early reaction to weak signals might well have prevented a catastrophe.

Since Igor Ansoff coined the idea of "weak signals" with his groundbreaking article about strategic surprises (Ansoff, 1975), we have been able to understand reports from the numerous crises striking organizations everywhere in a different perspective. In a way reminiscent of Murphy's Law, no matter how ingenious the security, safety, and risk-management systems they devise, organizations continue to be surprised by unexpected events that eventually lead to crises (e.g., Schoemaker & Day, 2009a, 2009b). Think, for example, of the petroleum-scarcity crisis in the 1970s, or the global financial crisis in the late '80s, or the subprime lending crisis after the turn of the century. Such crises occur frequently (Ansoff, 1975), and it would be easy to ascribe our failure to foresee them to the world's growing complexity. Is the problem, we wonder, due to the increasing interconnectedness and globalization of commodity, information, financial, and labor markets? Or is it perhaps from our failure to distinguish small signals that spell trouble from other signals that are just unpleasant but harmless "noise" in the background (Gottschalk, 2018)?

Here, we argue that we should look to psychological and cultural explanations for our own managerial blindness. Many systems that are designed to manage risks and avoid unwanted surprises focus on surveillance—the suppression and prevention of adverse “forces” that are *external* to the organization. Might the key to avoiding many such surprises actually lie within the organization rather than outside it? We believe that, more often than not, it is not a lack of comprehensive, detailed information from numerous external sources that is the problem. Rather, it is the lack of (correct) interpretation, prioritization, and action by management that contributes to an emerging, full-blown organizational crisis (Watkins & Bazerman, 2003).

Ansoff (1975) prescribes that an organization, to protect itself from just such a crisis, should actively prepare for the consequences of crises (i.e., effective crisis management) as well as strive to minimize the probability of being stricken by crisis (i.e., effective preparedness and surveillance measures). The latter includes barriers (safety and security systems; Reason, 1997) to prevent minor events (e.g., accidents, failures, and “disturbances”) from escalating into full-blown crises, as well as systematically gathering information to be acted upon early enough to avoid the most severe consequences of them.

A core point in Ansoff’s (1975) theory is that an organization’s response to a potential threat should not be dictated by the information needs of the “strategic planning technology.” Doing so would stifle the formal planning process; it is risky to act on information that is vague and unclear. The solution? The organization should look for feasible courses of action as strategic information becomes gradually available during the emerging phase of a crisis. “Early in the life of a threat, when the information is vague and its future course unclear, the responses will be correspondingly unfocused, aimed at increasing the strategic flexibility of the firm” (Ansoff, 1975, p. 23). For example, if an early, vague signal hints that some kind of misconduct is going on (but without being specific or conclusive), the management could promptly investigate the matter, that is, seek more knowledge. Another possible response could be to review current practices to determine whether they actually comply with generally accepted standards for doing business. In either case, the response to a weak signal would be to gather more information, in order to have a better basis for further decision-making and action. Such strategies are examples of what Ansoff (1975) would call “internal readiness and awareness” strategies.

Researchers (e.g., Nesse, 2016) and practitioners (e.g., Eriksen, 2011; Lunde, 2014) often promote this proactive approach to crisis management. An over-arching dimension of James Reason’s (1997) concept of a safety culture is for an organization to stay informed. It’s essential to have a system for safety management. Within such a system, members of an organization are encouraged—and sometimes even instructed or

obliged by law—to report any incident, large or small, that may indicate deviations from normal practice, and thereby constitute a potential threat to safety. The logic is that most, if not all, critical threatening situations start out as minuscule events, hardly noticeable except to the personnel directly involved. Timely, accurate reporting of local events is therefore necessary for management to take quick, appropriate action. Even “near-accidents” should be reported, because such cases may constitute a vital source of learning, to avoid actual accidents in the future (Dekker, 2012).

Within Weick and Sutcliffe’s (2015) “mindful organizing” theory for managing the unexpected, we find that information gathering, analysis, and action are important for preventing smaller disturbances from escalating into full-blown crises. This perspective is also shared by Beck and Plowman (2009), who propose, and explain, their two-step analysis: “Divergent thinking early in the recognition of a rare and unusual event encourages multiple ways of interpreting and viewing the event. Convergence, in contrast, enables action and adaptation” (p. 909). The discovery and interpretation of rare events should not be reserved exclusively for the top management; middle managers have an important role, too, as they’re more likely to provide a richer interpretation of events and are less likely to make mistakes (Beck & Plowman, 2009). Middle management’s involvement requires that they take an active part in “sense-making,” an important skill when one is exposed to rare and unexpected events. “The cues that get noticed and extracted are the ones that get enhanced with meaning and interpretations,” says Weick (1995, cited in Beck & Plowman, 2009, p. 910). Noticing is particularly relevant with rare and unusual events, for which existing narratives typically fail to provide meaningful or satisfactory interpretations (Beck & Plowman, 2009).

According to Watkins and Bazerman (2003; see also Bazerman & Watkins, 2005), “predictable surprises” arise out of failures by management to recognize, prioritize, or mobilize against unwanted events. To discern in retrospect whether a disaster could have been avoided, they contend, one has to ask the following three questions: (1) Did the leader recognize the threat? (2) Did the leader make the proper prioritizations? (3) Did the leader mobilize effectively? (p. 74). These questions are akin to performing a risk assessment and then developing a plan for contingency management. For the first question, this is usually a matter of having enough resources to scan the environment for emerging threats. In addition, data need to be properly analyzed and interpreted by the management. As for the second question, this is a matter of singling out potential surprises (disasters) from other events that follow a more normal pattern. The key here is to acknowledge that any (unwanted) event has an associated risk, which is a product of probability and potential cost. An analytical leader should prioritize

those unwanted events posing the highest risk. And as for the third question, it requires taking precautionary measures that are appropriate to handle the risks identified. A key point in Bazerman and Watkins' (2005) argument is that a manager who does a reasonable job at risk management—that is, has taken the necessary precautions against unwanted and uncertain events—shouldn't be blamed if such an event occurs despite relevant measures taken.

While Watkins and Bazerman (2003) prescribe a systematic approach to risk management, with preparedness as a main focus, Cunha, Clegg, and Kamoche (2006) offer a typology for how to handle unexpected and potentially harmful events once they've occurred. As such, their approach to handling surprises is closer to crisis management than preparedness. They describe four types of surprising events, ranked by degree of surprise, that organizations may encounter, and then prescribe the different managerial approaches that each requires.

Sometimes a surprise will occur when routines are in place but not followed by employees, so management must simply regain control. Such cases (type 1) are usually predictable, and although they may occur regularly, they don't occur with certainty. For sudden events (type 2), where the issue is unexpected but the process is well known, the event can be a source of learning. Management's task is then to facilitate it. In situations in which a process changes unexpectedly, but the issue is known (type 3, "creeping developments")—for example, when complex and interactive processes lead to unexpected situations ("normal accidents," Perrow, 1999)—the recommendation is to manage by distributing responsibilities and empowering the employees (see Reason, 1997, 2000). In the most profound kind of surprise—situations in which both processes as well as issues are unexpected (type 4, "loss of meaning"), leading to completely unexpected and incomprehensible situations—the recommendation is to engage in sensemaking (see Weick, 1995; Barton, Sutcliffe, Vogus, & DeWitt, 2015) to create a radical and fresh understanding of what is going on.

The Relevance to Whistleblowing

In light of the theory presented so far, whistleblowing contains aspects, or stages, relevant to both preparedness and risk management (Bazerman & Watkins, 2005), as well as crisis management, including sensemaking (Cunha et al., 2006).

Preparedness concerns measures taken to prevent a crisis from happening in the first place and includes surveillance of the environment, detection, and interpretation of anomalies (Barton et al., 2015), as well as acting on weak signals with appropriate actions (Ansoff, 1975). Because employees are a key source of information, it's essential to foster a "generative" organizational culture (Westrum, 2004), which includes high

cooperation among employees (the sources of information), training of messengers, sharing of risks, and encouragement to step forward with critical information. That culture will include the understanding that the organization will reward informants, even when the information is negative or critical, and will also implement changes that prevent similar surprises in the future (Westrum, 2004; see also Dekker, 2012; Mannion & Davies, 2015). In fact, Schein (2016) goes so far as to argue that trust, openness, and personalization make whistleblowing obsolete. But Hussain, Shu, Tangirala, and Ekkirala (2018) contend that too much trust and openness can lead to the opposite effect. They call this “positive organizational climate paradox”: when redundant information reduces the likelihood of voice (“the voice bystander effect”). In social psychology, the so-called bystander effect holds that when some emergency, such as a crime or accident, is witnessed by a number of bystanders, the likelihood of anybody intervening to help the victim(s) decreases as the number of bystanders increases (Darley & Latané, 1968). Many theories purport to explain this phenomenon, but they mainly contend that in the presence of several potential helpers, one’s own felt responsibility to help diminishes.

Crisis management, meanwhile, concerns handling the event in order to minimize damages, once the event has occurred, and success requires that a sufficient understanding of the situation has been developed. Such an understanding could be reached, for example, through processes of sensemaking (Weick, 1995) and situation assessment (Endsley, 1997), and should result in revised mental models of high quality (Brehmer, 2009).

Twice a Surprise—The “Double Trouble” of Whistleblowing

A whistleblowing case may contain two surprises that occur in sequence. The first one is the embarrassing discovery that wrongdoing has occurred in the organization, and that somebody in (upper) management is to blame. This will likely be a surprise of type 1 or 2 in the Cunha et al. (2006) typology, because once the upper management is alerted to the wrongdoing, they will realize that it is in fact a breach of routine or directive, even though they might not react as if they immediately understand the severity of the case.

The second, more intricate surprise involves the reactions of the upper management to the whistleblower’s blowing the whistle. In the PJS case, the surprise here will be that the actions taken by upper management don’t resolve the crisis. If there is a lack of resolution, it’s likely that the surprise will be of a type 3 or 4 in the typology of Cunha et al. (2006). If true, it’s likely that a new understanding is needed, and that employees may indeed be a vital source of information, even though the information they provide may be critical of current practices.

To avoid being surprised by whistleblowing events, we now turn to theory that promotes an organizational culture recognizing the importance of the correct interpretation and handling of weak signals. Weick and Sutcliffe (2015) offer five principles of “mindful management” that provide a foundation for prudent, robust management by placing the discovery and interpretation of small signals at the forefront of managers’ minds. These signals can address potential major disasters while they are still minor incidents—hardly noticeable, but presumably easy and straightforward to handle.

Mindful management is about paying attention to small signals indicating that something is not as it should be and calling for prompt fixing. Weick and Sutcliffe (2015) put it well: “As a problem begins to unfold, weak signals are hard to detect but easy to remedy. As time passes, this state of affairs tends to reverse. Signals become easy to detect but hard to remedy” (p. 3).

In the following section, we discuss aspects of the PJS case, focusing on “what went wrong” and how the organization’s upper management might have successfully corrected it. Our discussion will apply the five principles of mindful management and link each principle to a problematic practice that either caused the initial surprise or contributed to worsening the situation once the whistle was blown.

The PJS Case

Preoccupation With Failure: Placing the Burden on the Whistleblower

The principle of “preoccupation with failure” is about management’s being alert to small signs indicating that undesirable events are occurring (or about to) in the company. Such signs, if overlooked, would then lead to conditions that almost inevitably metastasize.

After PJS blew the whistle on his CEO, the logical response would have been for the chairman of the board to take immediate and decisive action toward the CEO, the target of the whistleblowing. Instead, the chairman of the board placed the burden on PJS by insisting that he keep quiet and develop a Program for defending the organization.

At NT, the outcome might have been far different if internal auditing procedures had been able to catch the illegal use of corporate funds to pay for the CEO’s personal gardening expenses (Riksrevisjonen, 2008–2009), making PJS’s intervention unnecessary. Of course, if taken to the extreme, being “preoccupied with failure” could lead to a ruinously distrustful organizational climate, where everybody is suspicious, skeptical, and critical, alert to even the most trivial breach of commonly accepted (or legally permitted) business practice (see Reason, 1997;

Dekker, 2012). On the other hand, in some industries, even the slightest rule or procedural violation could indeed lead to disaster, such as in the nuclear power industry, aviation, or in space (e.g., Perrow, 2011).

Reluctance to Simplify: Ambiguous Legal Agreements

In the case of PJS's whistleblowing, the CEO had an agreement with the NT board to have some of his gardening needs shouldered by the company caretaker (Riksrevisjonen, 2008–2009). This arrangement sought to compensate him for some of the burdens of having a heavy schedule that also included a lot of traveling. But the agreement was later interpreted (allegedly) to imply that the CEO had the right to hire a gardening company of his own choosing—and have NT pay the hefty bill. Aside from that questionable practice, which borders on corruption, there is also the issue of tax evasion. The expenses paid by the company weren't reported to the Norwegian tax authorities (Riksrevisjonen, 2008–2009).

The principle of “reluctance to simplify” is supposed to prevent unpleasant surprises caused by someone's failure to distinguish a questionable practice from normal, accepted business practice. It would appear that to run their business efficiently, managers should focus on “key issues and indicators” (Weick & Sutcliffe, 2015, p. 8) and avoid getting too bogged down in details. But such simplification can instead lead to overlooking some nuances of doing business—nuances that may prove vital if signs of misconduct are to be discovered early and then promptly corrected.

Sensitivity to Operations: Operating Costs Unjustified With Regard to Core Business

It appears that NT permitted some activities whose costs couldn't be justified in light of its primary mission (Riksrevisjonen, 2008–2009). One example was the yearly report, which had a budget for design and printing far greater than what was needed to communicate the operational and financial status of the organization. Furthermore, high-profile events and parties, like the Viking Party at the Høsbjør Hotel outside the city of Hamar, enjoyed budgets grossly excessive for a government-owned nonprofit.

The principle of “sensitivity to operations” concerns knowing the core activities of an organization and placing them at the forefront in the day-to-day schedule. For a commercial organization, the effort should be directed toward those activities directly related to generating profit. To that end, managerial control philosophies such as “Balanced Scorecard” (Kaplan & Norton, 1996) and “Activity Based Costing (ABC)” (Kaplan & Bruns, 1987) are applied to ensure that daily activities don't drift off

the organization's primary mission. At least, their costs should be justifiable in relation to their purpose and ability to generate income beyond their costs.

When a company appears to be using time and money on activities that can't be justified by their profit-generating potential, managers need to notice such activities and take action, either changing them or abandoning them altogether. Some typical examples: expensive advertising campaigns, lobbying activities that have unmeasurable results, and expensive traveling that doesn't take advantage of low fares and discounts.

Commitment to Resilience: Avoid Taking Charge to Resolve the Situation

One may ask, to what degree did NT exhibit resilience after PJS blew the whistle? It appears that the chairman of the board initially doubted PJS when he first outlined the questionable practices he had discovered. Had the chairman behaved in a resilient manner, he would have taken PJS's story and all the supporting evidence at face value instead of questioning it. Just after PJS's meeting with him, the chairman tried to mitigate the consequences by having PJS promise secrecy instead of actively addressing the problems, thus probably making things worse for both PJS and his fellow employees. Consider, for example, the "witch hunt" that the CEO launched to root out the "prince of darkness." Apparently, PJS's colleagues weren't ready to accept that their CEO exhibited questionable—and even unlawful—practices when managing their organization. Instead of posing probing questions to establish the truth, they remained loyal to the CEO.

The principle of "commitment to resilience" concerns the fact that no matter how *mindful* an organization may be, it occasionally will find itself tested by embarrassing incidents. An organization that's able to withstand such tests, and regain normal operational status within a reasonable time, can be said to be resilient.

The essence of resilience is . . . the intrinsic ability of an organization (system) to maintain or regain a dynamically stable state, which allows it to continue operations after a major mishap and/or in the presence of a continuous stress.

(Hollnagel, 2006, cited in Weick & Sutcliffe, 2015, p. 12)

The hallmark of a resilient organization is not that it is free from errors but that errors don't disable it (Weick & Sutcliffe, 2015).

In many ways, resilience is the opposite of the "reluctance to simplify" principle, since an organization's resilience is often derived from its effort to maintain a control system that mirrors the complexity of the issues to be handled (see Perrow, 1999). Such an organization refrains from

streamlining its structure (e.g., by firing or retiring older employees, while only hiring young, newly graduated candidates) and acknowledges that a broad range of skills and competencies will be needed to solve future issues, both simple and complex.

Deference to Expertise: Avoid External (and Internal) Attention, Keeping Silent

In the case of PJS, he tells us that he sought legal counsel to mitigate some of the burdens he experienced as a whistleblower. He needed to confide in someone he could trust, an expert who had experience with such problems. NT, meanwhile, failed significantly when the board initially elected to keep silent about the allegations. In doing so, it missed an opportunity to put legal and HR expertise on the issues early and thus possibly contain the crisis. Furthermore, by not acknowledging the value of expertise in such complex matters, it also failed to learn and change its ways.

The principle of “deference to expertise” involves acknowledging that decisions in dynamic organizations should be “made on the front line, and authority migrates to the people with most expertise, regardless of their rank” (Weick & Sutcliffe, 2015, p. 14). This principle suggests that rigid, hierarchically structured organizations face particular challenges when it comes to detecting and interpreting worrisome signals. When an issue or error isn’t addressed early on, it tends to become worse (Brehmer, 2002), and a hierarchically structured managerial system is normally incapable of making the necessary quick response or adjustment called for. This is particularly true when the problem is non-routine (Pentland, Hærem, & Hillison, 2010) or not previously experienced (Klein, 1998, 2003). The principle also applies to those cases when warnings, or “signals,” originate from particularly experienced personnel. Such warnings must be taken seriously. For example, it would be a big mistake for a bank to dismiss a financial expert’s opinion on the negative effects of mixing defaulted, high-risk loans with more moderate and low-risk loans when computing the bank’s total risk exposure.

Discussion

Weick and Sutcliffe (2015) have studied a wide range of organizations that must maintain structure and function under uncertainty, where the potential for error and disaster can lead to catastrophe. Their main tenet is that *mindful organizing* helps organizations maintain resilience during critical events through anticipation and containment. Anticipation is all about preparedness (see Watkins & Bazerman, 2003). It involves sensing events early and taking action to ward off their developing into undesirable events. Because not all unwanted events can be anticipated, the containment principles can help in handling those unanticipated or

unexpected events that in fact occur (crisis management; see Cunha et al., 2006). Anticipation is associated with these three principles: preoccupation with failure, reluctance to simplify, and sensitivity to operations. Containment has two principles: commitment to resilience and deference to expertise.

We have discussed several aspects of PJS's whistleblowing story where the story could have been different had NT, and in particular its board of directors, been more mindful when they were presented with the issues that constituted PJS's whistleblowing reports. The *pre-occupation with failure* principle helps us see that the board of directors could have acknowledged PJS's reports of misconduct upfront; also, that the firm's auditing procedures should have been capable of detecting irregular and questionable transactions in the first place. As for *reluctance to simplify*, the company should have taken more care, and been more specific and rule-oriented, when entering into agreements of fringe benefits with the CEO. The principle of *sensitivity to operations* was violated given the excessive resources allocated to activities that clearly were outside the company's core activities. Examples include the CEO's gardening expenses and the company's extensive sponsoring of activities outside its approved strategy. Significantly, the sponsoring strategy was later revised by the board, with a number of limitations and restrictions implemented (Riksrevisjonen, 2008–2009, p. 44).

When it became more or less apparent that PJS's story was citing past events that should have been promptly handled, the principle of *commitment to resilience* becomes relevant. Here we learned that the company failed on several accounts—both in questioning compelling evidence and in delaying action. Even more severe, instead of solving the real problem, a “witch hunt” was initiated by the CEO, effectively diverting attention from the real problem at hand. Finally, and contrary to the *deference to expertise* principle, the company's board of directors initially didn't take the necessary steps to consult experts on the problems they had been alerted to by PJS.

When looking at mechanisms to prevent serious issues from escalating, Reason (1997) takes a more distinct step toward managers being proactive when it comes to detecting and taking action on signals of wrongdoing. He suggests designing a formal information system for the reporting and proper processing of signals that warn of critical incidents in organizations. Furthermore, he suggests that the organization needs to be able to adapt to, and learn from, current problems. Finally, for this to work, good managerial leadership is essential. Managers should act as role models for their employees in all matters that relate to safety and security. For a long time, we have understood that there is a difference between how the routine is written and how it is enacted (Pentland & Feldman, 2008). Still, the intention behind the formal system, and

its corresponding influence on behavior, should not be underestimated (Pentland & Feldman, 2008; D'Adderio, 2008).

Concluding Remarks

Throughout this chapter we have reviewed relevant theory regarding the detection, interpretation, and handling of weak signals and strategic surprises, and applied that theory to a case of whistleblowing. We have seen that a formal risk-management system (e.g., Reason, 1997) may prove especially useful in that respect; so, too, a safety-minded organizational culture (e.g., Westrum, 2004), specifically, mindful organizing (Weick & Sutcliffe, 2015)

Recommendations include taking precautions and preventive measures (e.g., Watkins & Bazerman, 2003) as well as having a capacity to perform crisis management (Cunha et al., 2006; see also Klein, 1998, 2003, 2013), which may include sensemaking (Weick, 1995), situation awareness (Endsley, 1997), and modification and even (re-)creating of mental models (Brehmer, 2009). Without a culture or even a formal system to aid in interpreting and handling weak signals, whistleblowing cases will continue to pose a threat to management rather than an opportunity to curb mismanagement and create a new future for the organization.

References

- Åmås, K. O. (2016). Et kaldere klima for kritikk. *Aftenposten*, October 16, pp. 2–3.
- Ansoff, I. (1975). Managing strategic surprise by response to weak signals. *California Management Review*, 18(2), 21–33.
- Barton, M. A., Sutcliffe, K. M., Vogus, T. J., & DeWitt, T. (2015). Performing under uncertainty: Contextualized engagement in wildland firefighting. *Journal of Contingencies and Crisis Management*, 23(2), 74–83.
- Bazerman, M. H., & Watkins, M. (2005). Airline security, the failure of 9/11, and predictable surprises. *International Public Management Journal*, 8(3), 365–377. <https://doi.org/10.1080/10967490500439677>.
- Beck, T. E., & Plowman, D. A. (2009). Experiencing rare and unusual events richly: The role of middle managers in animating and guiding organizational interpretation. *Organization Science*, 20(5), 909–924.
- Brehmer, B. (2002). *Learning to control a dynamic system*. Unpublished manuscript. Stockholm: Swedish National Defence College.
- Brehmer, B. (2009). *Command without commanders*. Paper presented at the 14th International Command and Control Research and Technology Symposium, Washington, DC.
- Cunha, M. P., Clegg, S. R., & Kamoche, K. (2006). Surprises in management and organization: Concept, sources and a typology. *British Journal of Management*, 17, 317–329.
- D'Adderio, L. (2008). The performativity of routines: Theorising the influence of artefacts and distributed agencies on routines dynamics. *Research Policy*, 37(5), 769–789. <https://doi.org/10.1016/j.respol.2007.12.012>.

- Darley, J. M., & Latané, B. (1968). Bystander intervention in emergencies: Diffusion of responsibility. *Journal of Personality and Social Psychology*, 8(4, Pt.1), 377–383.
- Dekker, S. W. A. (2012). *Just culture: Balancing safety and accountability* (2nd ed.) Farnham, UK: Ashgate Publishing Co.
- Endsley, M. R. (1997). The role of situation awareness in naturalistic decision making. In: C. E. Zsombok & G. Klein (Eds.), *Naturalistic decision making* (pp. 269–283). Mahwah, NJ: LEA.
- Eriksen, J. (2011). *Krise- og beredskapsledelse. Teamtrening*. Oslo: Cappelen Damm.
- Gottschalk, P. (2018). Maktmisbruk kan være et stikkord for KS-advokaters strategi. *Agderposten*, August 22, p. 21.
- Gottschalk, P. (2018). Varsling: Teori om signalgjenkjenning. *MAGMA*, 3/2018, 12–13.
- Hussain, I., Shu, R., Tangirala, S., & Ekkirala, S. (2018). The voice bystander effect: How information redundancy inhibits employee voice. *Academy of Management Journal*, 62(3), 828–849 <https://doi.org/10.5465/amj.2017.0245>.
- Jubb, P. B. (1999). Whistleblowing: A restrictive definition and interpretation. *Journal of Business Ethics*, 21, 77–94.
- Kahneman, D. (2012). *Thinking, fast and slow*. New York: Farrar, Straus & Giroux.
- Kaplan, R. S., & Bruns, W. (1987). *Accounting and management: A field study perspective*. Boston, MA: Harvard Business School Press.
- Kaplan, R. S., & Norton, D. P. (1996). *The balanced scorecard: Translating strategy into action*. Boston, MA: Harvard Business School Press.
- Klein, G. (1998). *Sources of power: How people make decisions*. Cambridge, MA: MIT Press.
- Klein, G. (2003). *Intuition at work*. New York: Doubleday.
- Klein, G. (2013). *Seeing what others don't: The remarkable ways we gain insights*. New York: Public Affairs.
- Lunde, I.K. (2014). *Praktisk krise- og beredskapsledelse*. Oslo: Universitetsforlaget.
- Mannion, R., & Davies, H. T. (2015). Cultures of silence and cultures of voice: The role of whistleblowing in healthcare organisations. *International Journal of Health Policy and Management*, 4(8), 503–505.
- Monsen, P. Y. (2008). *Muldivarp i Siemens. En dokumentar*. Oslo: Spartacus Forlag.
- Near, J. P., & Miceli, M. P. (1985). Organizational dissidence: The case of whistleblowing. *Journal of Business Ethics*, 4(1), 1–16.
- Near, J. P., & Miceli, M. P. (1995). Effective-whistle blowing. *Academy of Management Review*, 20(3), 679–708.
- Near, J. P., & Miceli, M. P. (2016). After the wrongdoing: What managers should know about whistleblowing. *Business Horizons*, 59(1), 105–114.
- Nesse, S. (2016). Et helhetlig perspektiv på rekruttering, seleksjon og utvikling av kriseledelseskompetanse. *MAGMA*, 04/2016, 50–68.
- Pentland, B. T., & Feldman, M. S. (2008). Designing routines: On the folly of designing artifacts, while hoping for patterns of action. *Information and Organization*, 18(4), 235–250. <https://doi.org/10.1016/j.infoandorg.2008.08.001>.
- Pentland, B. T., Hærem, T., & Hillison, D. (2010). Comparing Organizational Routines as Recurrent Patterns of Action. *Organization Studies*, 31(7), 917–940.

- Perrow, C. (1999). *Normal accidents: Living with high-risk technologies*. Princeton, NJ: Princeton University Press.
- Perrow, C. (2011). Fukushima and the inevitability of accidents. *Bulletin of the Atomic Scientists*, 67(6), 44–52.
- Rafat, M. (2013). *Ingen må få vite. En varsler forteller*. Oslo: Z-forlag.
- Reason, J. (1997). *Managing the risks of organizational accidents*. Farnham, Surrey: Ashgate.
- Reason, J. (2000). Safety paradoxes and safety culture. *Injury Control and Safety Promotion*, 7(1), 3–14.
- Riksrevisjonen (2008–2009). *Riksrevisjonens utvidede revisjon av Norsk Tipping AS*. Dokument nr 3:14. Retrieved from www.riksrevisjonen.no
- Schaefer, R. (2019). *Monika-saken. Norges største politiskandale*. Bergen: Vigmostad & Bjørke.
- Schein, E. H. (2016). Whistle blowing: A message to leaders and managers; Comment on “cultures of silence and cultures of voice: The role of whistleblowing in healthcare organizations”. *International Journal of Health Policy and Management*, 5(4), 265–266.
- Schoemaker, P. J. H., & Day, G. S. (2009a). How to make sense of weak signals. *MIT Sloan Management Review*, 50(3), 81–89.
- Schoemaker, P. J. H., & Day, G. S. (2009b). Why we miss the signs. *MIT Sloan Management Review*, 50(2), 43–44.
- Skogstrøm, L., Dommerud, T., & Olsen, O. (2019). Tre mistet jobben ved OUS etter trakassering i fjor. *Aftenposten*, February 3, pp. 6–7.
- Stensbak, H. (2018). Verdien i varslings. *Aftenposten*, September 10, p. 2.
- Trygstad, S. C., & Ødegård, A. M. (2016). *Varsling og yringsfrihet i norsk arbeidsliv*. Fafo-rapport 2016:33. Retrieved from www.fafo.no/index.php/zoo-publikasjoner/item/varsling-og-ytringsfrihet-i-norsk-arbeidsliv-2016
- Watkins, M. D., & Bazerman, M. H. (2003). Predictable surprises: The disasters you should have seen coming. *Harvard Business Review*, 81(3), 72–80.
- Weick, K. E. (1995). *Sensemaking in organizations*. Thousand Oaks, CA: Sage Publications.
- Weick, K. E., & Sutcliffe, K. M. (2015). *Managing the unexpected: Sustained performance in a complex world*. New York: John Wiley & sons, Inc.
- Westrum, R. (2004). A typology of organizational cultures. *Quality & Safety in Healthcare*, 13(suppl. II), ii22–ii27.