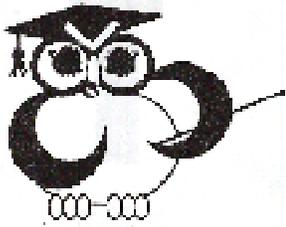


Decision Making Chapter Two Questions

Instructor's Overview

This exercise is designed to elicit discussion and analysis of stories contained in Chapter 2, "Decision Making." There are several questions relating to the Introduction and each story in this chapter. The facilitator can lead a group discussion or establish individual groups of three to seven participants. When smaller groups are used, each group can designate a reporter to brief the entire group on its findings.

The questions are open ended, and, in most cases, there are no right or wrong answers.



Decision Making Chapter Two Questions

Introduction

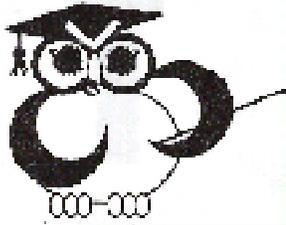
1. Can you think of other reasons that cause managers difficulty in making decisions?
2. Do you agree that a group rather than one person can make better decisions?
3. When do you ask for the opinion of others?
4. Have you ever had to sell a decision?

Challenge: Gracefully Slaying Goliath

1. Was Mr. Simonian doing the smart thing when he arranged a meeting with Anaheim's manager for the purpose of securing their support?
2. Have you ever brainstormed a problem? What are the advantages of brainstorming? What are the disadvantages?
3. What was the purpose of conducting a dress rehearsal of the presentation before LAFCO?
4. What were the critical decision points in this episode?

Blunder: Pigeon Drop

1. Did the city manager proceed in a correct manner in handling this situation?
2. How would you handle this problem? Who would you contact for advice?
3. Should the city manager have changed his travel plans? Why?
4. What responsibility did the public works director have for this disaster?
5. Should the city manager have been fired?



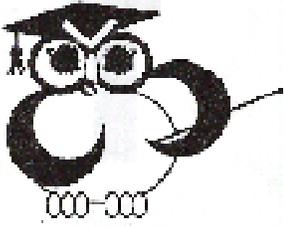
Decision Making Chapter Two Questions

Blunder: The Pilfered Cash Register

1. If you had been in Lieutenant Allen's shoes would you have acted in the same manner with Mr. Morris after he took an envelope from a desk drawer?
2. If Lox had not calmed the lieutenant, do you think Allen would have proceeded to place Morris under arrest? What outcome can you envisage if an arrest had been made?
3. Should Lieutenant Allen have tried to handle the problem himself? Why or why not?

Blunder: Covering for Dumb Mistakes

1. Should Lyle Mikes have left town without placing someone in charge of the organization?
2. Did the public works director take advantage of the situation to rid himself of a disliked responsibility?
3. Should the assistant city manager have inserted himself into the fray?
4. Should custodial services have been maintained in the building that housed the city council chamber?
5. Was Mr. Mikes wrong in trying to insert humor into this situation?
6. Should Mikes have disciplined the public works director for making those changes in his absence?



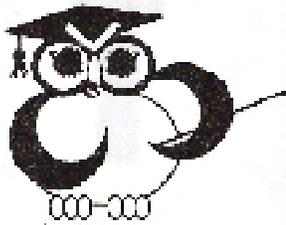
Decision Making Decision Authority Limits Exercise

Instructor's Overview

Decision Authority Limits

Every position from the front-line supervisor to the chief executive officer (CEO) has limits on their decision-making authority. In many cases, the boss has not clearly delineated the amount of freedom a person has when confronted with a decision. In this exercise, participants are asked to indicate their level of freedom in making different types of decisions. If some participants do not have a position, they can interview a local government manager.

The topics follow the chapter sequence in *Tales from the Trenches*, beginning with "Leadership and Management" and ending with "Ethics."



Decision Making Decision Authority Limits Exercise

Decision Authority Limits

As a manager or supervisor, you and your boss should be in agreement on how much authority you have to make a decision. For each of the items listed, indicate your level of decision authority.

- CA: Complete decision authority. Manager can take action without consulting the boss.
- AA: Advisory decision authority. Employee can make decision but must inform the boss of any action taken.
- PA: Prior approval. Employee must consult with boss before action is taken.
- NA: No decision authority. Employee has no authority to take action. Decision making occurs at a higher level.
- UA: Unknown decision authority. Employee is unaware of or unclear on decision authority.

Leadership and Management

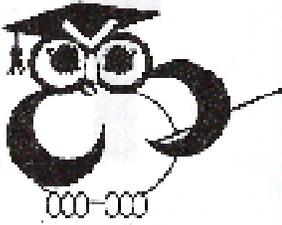
- Make task or project assignments _____
- Make changes in assignments _____
- Rotate employees within the department _____
- Approve overtime requests _____
- Provide nonmonetary rewards to deserving employees (e.g., time off, favorable assignments) _____

Decision Making

- Revise an existing policy _____
- Issue a new policy _____
- Override an existing policy if deemed necessary _____

Communications

- Approve requests for Internet access _____
- Call staff meetings to brainstorm an issue _____
- Conduct staff meetings to make assignments _____
- Sign the boss's name on memos and letters _____



Decision Making Decision Authority Limits Exercise

Human Resources Management

- Prepare job descriptions _____
- Develop the recruitment approach (recruitment plan) _____
- Hire temporary employees _____
- Hire authorized part-time employees _____
- Hire authorized full-time employees _____
- Decide whether a new employee has passed probation _____
- Give oral reprimands _____
- Issue written reprimands _____
- Suspend an employee _____
- Settle an employee grievance _____

Budgeting

- Approve petty cash requests _____
- Purchase a budgeted item costing less than \$5,000 _____
- Purchase a budgeted item costing more than \$5,000 _____
- Access unit's accounting records (online) _____
- Recommend items for unit's budget _____
- Prepare unit's budget _____
- Transfer money from one account to another _____
- Approve overdrafts in line item accounts _____

Citizen Advisory Boards

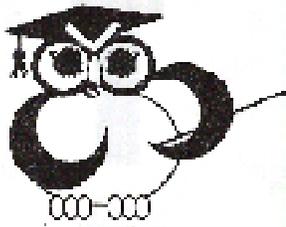
- Prepare written reports for advisory boards _____
- Make presentations to advisory boards _____
- Staff an advisory board _____

Community Relations

- Prepare written communications to residents _____
- Meet with residents and/or community groups _____

Relations with Elected Officials

- Respond to individual elected-official inquiries _____
- Prepare written reports and memos for elected officials _____
- Make public presentations to elected body _____



Decision Making Decision Authority Limits Exercise

Media Relations

Respond to media requests for information _____

Prepare news releases _____

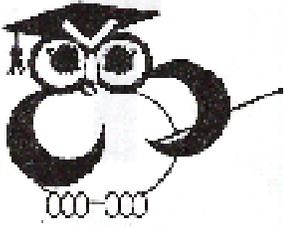
Write a letter to editor justifying an action or decision _____

Hold a press conference _____

Ethics

Take disciplinary action for ethical lapses _____

Issue policies regarding ethical behavior _____



Decision Making Unintended Consequences Exercise

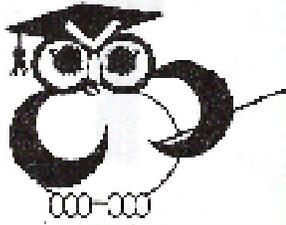
Instructor's Overview

Unintended Consequences

In "Pigeon Drop" City Manager John, in his haste to leave town for an enjoyable weekend, did not think through the consequences of his decision to use corn treated with poison to get rid of bothersome pigeons. That corn not only killed the pigeons, but it also killed song birds and it potentially endangered children. As John later admitted, he should have been fired for the blunder. In this exercise, participants are asked to think of a decision that resulted in unintended consequences and then address five questions.

1. What was the problem or issue requiring the decision?
2. What was your decision?
3. What were the unintended consequences?
4. As you analyze the decision today, what would you do differently?
5. What lessons can you derive from this experience?

Once participants complete the questions, the instructor can set up small groups with two or three members. Participants can share their decisions and identify lessons that appear to apply to other situations. These lessons can be presented to the entire group.

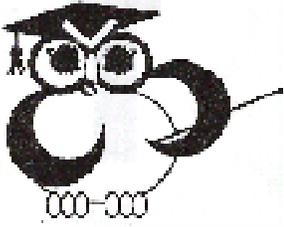


Decision Making Unintended Consequences Exercise

Unintended Consequences

In "Pigeon Drop," City Manager John, in his haste to leave town for an enjoyable weekend, did not think through the consequences of his decision to use corn treated with poison to get rid of bothersome pigeons. That corn not only killed the pigeons, but it also killed songbirds, and it could have harmed children. As John later admitted, he should have been fired for the blunder. Think of a decision that resulted in unintended consequences and address the following questions:

1. What was the problem or issue requiring the decision?
2. What was your decision?
3. What were the unintended consequences?
4. As you analyze the decision today, what would you do differently?
5. What lessons can you derive from this experience?



Decision Making

Forty-Eight Hours of Crisis Case Study

Instructor's Overview

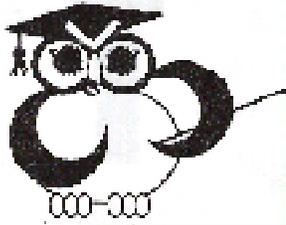
Forty-Eight Hours of Crisis

This tale outlines the inner workings of a crisis as it unfolds, escalates, and is finally abated. Fortunately, there were no casualties associated with this occurrence. However, there were some judgment and management errors that under slightly different conditions might have resulted in widespread health safety conditions.

Listed here are some questions that are useful in assisting the participants to look deeper at action taken.

The questions being offered are only a few of the inquiries that can be made concerning this incident.

- What might be some of the reasons that the dirty water was not reported until four hours after it was discovered?
- When the police services assistant could not reach the water supervisor by telephone, what action should she have taken?
- Should the police sergeant have followed through by informing the police watch commander?
- What could be some reasons why the employees failed to notify the water utility superintendent until after 0900 hours on Friday?
- When should the city manager have been notified of the situation? Who should have notified him?
- If you were the person responsible for damages or injuries, what would have been your reaction when you found that the situation had been in progress for fourteen hours?
- Why was it important to notify other water agencies of the situation?



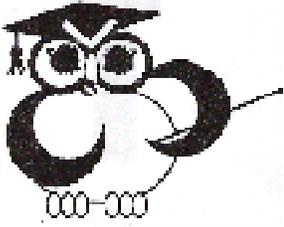
Decision Making Forty-Eight Hours of Crisis Case Study

- How did the city manager respond after being fully briefed on the situation?
- Should the mayor and city council have been notified?
- By time, date, and name of individual, list the critical points where a decision was necessary. Please judge whether the right decision was made. If the decision made was correct, explain why.
- If not, what would you have chosen to do?

After the incident, the city manager requested a report from each department describing the involvement of the department to bring the incident to closure. As an alternate exercise, students can be asked to identify what activities should be included in the report.

Here is what the city manager asked to be included:

- A chronological timetable of each department's response to the incident, including any documentation
- Identification of training points-both positive and negative
- A listing of activities that can be improved upon and what went well during the incident
- Identification of areas of the *Emergency Master Plan Manual* that need to be amended, added, or deleted
- A listing of equipment that might be needed in the future to better cope with other incidents of this magnitude
- Request from each department head to comment on the preparation of a mailer that is descriptive of the incident
- The steps residents should follow to file claims
- Actions that should be taken against the responsible party



Decision Making Forty-Eight Hours of Crisis Case Study

Forty-Eight Hours of Crisis

The Friday before Labor Day weekend found the Coldwater City Hall closed, and most of the city employees were looking forward to a relaxing four-day Labor Day weekend. However, it was mandatory that police, fire, and the water utility service remain operational over the long weekend. Also, personnel of the Parks and Recreation Department were anticipating a very active weekend overseeing all the Labor Day activities at the city's nineteen parks.

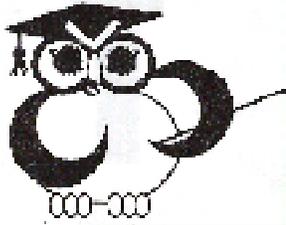
Coldwater, a city of 17,000 people, located in Purdue County, houses more than 1,000 industrial complexes, many of them located atop abandoned oil fields. This latter condition mandates constant vigilance for gaseous or liquid hazardous materials by citizens and employers. It was this vigilance that caused an employee of a company to see brown water being drawn from a faucet. He called the police dispatcher after the water failed to clear.

This sequence of events began with a phone call on August 30, 2002.

Friday, 12:24 A.M. Ms. Eden, the police services assistant, received a telephone call from an employee of Body Processing at 9921 Romandel Avenue. After asking her if the water was okay, he disclosed that the water inside their building was running brown and oily and had been doing so for the last four hours.

Friday, 12:27 A.M. Ms. Eden placed a call to the Coldwater Shift A water supervisor. She connected to his voice mail and left a message to contact the Police Services Center (PSC).

Friday, 12:30 A.M. Ms. Eden contacted Police Sergeant Ron Bryan and requested that he check water wells for signs of tampering. After an interval of time, Sergeant Bryan informed Ms. Eden that the water wells appeared okay.



Decision Making Forty-Eight Hours of Crisis Case Study

Ms. Eden made a second attempt to contact the water supervisor, in case she misdialed the number initially. Again, voice mail responded. Ms. Eden did not leave a message.

Friday, 2:00 A.M. A third unsuccessful attempt by Ms. Eden was made to contact the water supervisor. She prepared a note for the morning crew and the director of police services regarding the information she received about the water.

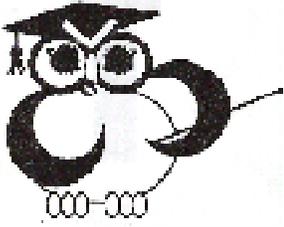
Friday, 5:00 A.M. The water supervisor checked his cell phone and discovered that a complaint regarding possibly contaminated water had been logged on his phone at 12:23 A.M.

Friday, 6:00 A.M. The director of police services, Fern Tarrant, arrived at the PSC and discovered Ms. Eden's note regarding the water problem. After discussing the matter with Ms. Eden, a call was placed to the water supervisor. He was informed of the situation, and it was suggested that he contact the business that reported the problem.

Friday, 6:45 A.M. The water supervisor received a call from Mr. Tarrant informing him of the water problem at 9921 Romandel Ave. He immediately responded to 9921 Romandel Avenue. He also contacted the water production supervisor and arranged a meeting with him at the scene of the incident. While flushing out the water lines at that address, they observed dirty water.

Friday, 7:00-7:15 A.M. PSC received another phone call from a second employee of the company that initially reported the water problem. The director of the PCS advised the caller that the city's water department was responding.

Friday, 7:30 A.M. The two supervisors finished flushing a fire hydrant at 9921 Romandel Avenue. Dirty water flowed for approximately twenty minutes. Chlorine residual at that location was at a normal level.



Decision Making Forty-Eight Hours of Crisis Case Study

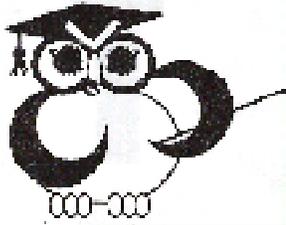
Friday, 7:45–9:00 A.M. Other water department employees were in the area responding to dirty water complaints. The water from all hydrants on Romandel Avenue contained foam. Water samples were collected for the Department of Health Services (DHS). An employee of the water department was dispatched to 9921 Romandel Avenue to inspect the premises.

Friday, 9:05 A.M. The water supervisor notified Frank Bench, water utility superintendent, of the situation at 9921 Romandel Avenue.

Friday, 9:10–9:25 A.M. The water superintendent gave instructions to the water production superintendent to call a specific laboratory and set up a pickup for later that day. He then directed that bacteriological samples be taken from the incident site and that collectors spread out in a circular radius for the purpose of collecting additional samples. He stipulated that the samples be checked for heterotropic plate counts (HPC) if the chlorine residuals were below DHS standards.

Friday, 9:28 A.M. Larry Duet, the city's backflow tester, disclosed to superintendent Bench, upon his arrival at 9921 Romandel Avenue that illegal cross connections had been found during the preliminary inspection. Duet also stated that the building had no backflow protection. Mr. Duet disclosed that he had collected samples of the product believed to have been introduced into the water system.

Friday, 9:40 A.M. Having obtained an analysis on the substance in question, Mr. Bench was able to identify that he was dealing with a nontoxic substance with no known health effects. The analysis stated the chemical was aqua quench 3600 or sodium tetraborate decahydrate. From this information, Mr. Bench concluded that he was dealing with a secondary aesthetic, nontoxic foaming agent. He then gave instructions to the water crews to expand the perimeter and to open hydrants located in the expanded sphere. He also directed that all businesses along Romandel Avenue be informed to flush their water taps and hoses to clear their lines.



Decision Making Forty-Eight Hours of Crisis Case Study

Friday, 10:15 A.M. At this juncture, Mr. Bench wanted to ascertain that:

1. No residual chemical was found in the mains that were being flushed at and around the incident area.
2. No foreign chemicals had been found in the water in any areas being searched where it was anticipated this chemical could travel.
3. Samples being drawn had the proper general physical characteristics as in normal operations.

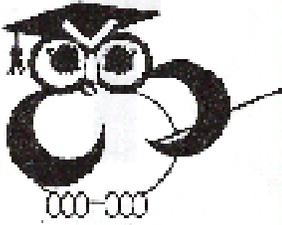
Mr. Bench was advised that the system showed no trace of chemicals in the areas the crew had checked and that the chlorine residuals were at normal levels.

Friday, 10:17 A.M. Superintendent Bench concluded that the incident was isolated in one area, and therefore the incident was over. His assessment was based on the following:

1. No new complaints had been registered since 8:30 A.M. with the PSC, the Fire Department, or the Dispatch Center.
2. The search for any contamination in other parts of the system was negative.
3. Samplings from other areas revealed no contamination; plus the physicals from the samples were normal.
4. The potential for additional contamination from 9921 Romandel had been eliminated because their water meter had been shut down, thereby eliminating their water service.

In the meantime, members of the water crews were contacted to ascertain if they had made further discoveries of contamination, but none had been found.

Friday, 11:30–11:51 A.M. Steve Kacina, the city's DHS engineer for this incident, was contacted by telephone and advised of the situation and the remedial actions that had ensued. Bench informed Kacina that the system was clear of any further contamination.



Decision Making Forty-Eight Hours of Crisis Case Study

Friday, 12:10 P.M. The fire dispatcher informed Superintendent Bench that a complaint had been received from 10119 Gard complaining of dirty water. Water Supervisor Pat Heleo was dispatched to the scene to validate the finding.

Friday, 12:30 P.M. The water supervisor confirmed that the complaint was valid and proceeded to flush the water mains around this area. He confirmed the presence of the contaminant from the taste and odor of the water.

Friday, 12:35 P.M. Complaints of foamy water were received from 10100 and 10300 Gridley. Flushing of water mains continued.

Friday, 1:45 P.M. Complaints of foamy water were received from residents at 11500 Joslin.

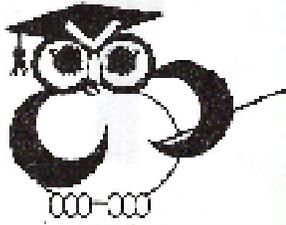
Friday, 1:50 P.M. The city was notified of a complaint of foamy water on Davenrish Street.

Friday, 2:10 P.M. New complaints came from Gridley Street. This area had been checked earlier. At this time, Bench concluded that all the residents must be in the same situation and that all the flushing of the system would not alleviate the complaints. He now realized that notification of the public works director was imminent.

Friday, 2:30 P.M. Superintendent Bench notified John Prince, director of public works, informing him of the situation.

Kacina, of DHS, was informed that the contamination had made its way to the residential area of Coldwater. In the meantime, flushing continued.

Friday, 2:35 P.M. John Prince paged City Manager Frank Healey, who answered after a few minutes. Mr. Prince informed the city manager of a major incident involving an illegal cross connection contamination, and told the city manager that the Community Alert Network (CAN)



Decision Making Forty-Eight Hours of Crisis Case Study

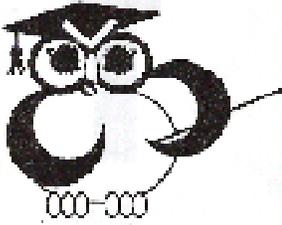
should be activated. The city manager arranges to meet Mr. Prince at the city's Municipal Services Yard.

Friday, 2:45 P.M. Superintendent Bench instructed the water supervisor to call all agencies with which they have emergency connections and inform them of the situation but tell them that their connections were not in problem areas.

Friday, 3:00 P.M. The city manager arrived at the Municipal Services Yard. He directed the activation of the CAN system, which has the capability of calling 1,500 phones per hour with a thirty second message, and the preparation of notices to be hand delivered to residents and businesses. He was informed that arrangements were being made for bottled water to be distributed, and directions were given to bag all drinking fountains at public facilities and place signs in all public restrooms stating that the water was unsafe.

Friday, 3:30 P.M. The city manager met with the fire chief, a battalion chief, the Director of Police Services Fernando Tarrant and Police Sergeant Stevens at the PSC to discuss the situation and plan the city's response. The incident command system was activated and City Manager Frank Healey was designated incident manager. The fire chief and director of police services were assigned to the Emergency Operation Center (EOC). The PSC was designated as the EOC. The director of public works was designated as the incident commander with a field command post established at the city's Municipal Services Yard (MSY). Battalion Chief Good was assigned to assist the incident commander. Three members of the fire department's Environmental Protection Division (EPD) were requested to report to the Municipal Services Yard to assist with the identification of the material in the water system.

Friday, 4:15 P.M. Director Prince and Superintendent Bench briefed the members of the EPD of the fire department on the situation.



Decision Making Forty-Eight Hours of Crisis Case Study

Friday, 4:45 P.M. EPD validated the contaminant as one to ten percent, sodium tetraborate decahydrate. The trade name is Aqua Quench 3600.

Friday, 5:00 P.M. A complaint of foam in the water was registered from 9502 Pioneer.

Carl Boris, environmental health specialist of the Purdue County Health Department was notified of the incident.

EPD, along with body processing managers, conducted an inspection of the plant site.

Geographic parameters of the contamination were identified by John Prince.

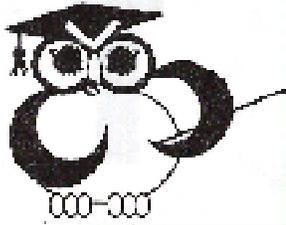
Friday, 6:00 P.M. EPD completed the inspection of the body plant and notified Steve Kacina of the State of California Health Department. Kacina suggested the city notify all users that the water may be contaminated and should not be used for drinking and/or cooking. He further suggested that the water be analyzed for metals.

Fire Captain Chris Crisp was designated as the public information officer (PIO). He reported to the EOC to begin developing information for the media and CAN.

The fire chief was assigned to locate a helicopter to transport water samples to a laboratory in San Rialto. The fire chief delegated this task to the crew of Fire Engine 84.

The city manager completed the script to be used in a message to be delivered to all residents through CAN.

Friday, 6:30 P.M. Planning began for obtaining and distributing information to residents. Susan Berger, director of administrative services, was



Decision Making Forty-Eight Hours of Crisis Case Study

assigned to this task. The community services staff was recalled to the PSC to assist in this endeavor.

Friday, 7:00 P.M. ABC News interviewed the PIO via phone. Other news media were notified (video, radio, newspaper, and newswire).

Food was ordered for all personnel.

Friday, 7:45 P.M. Bottled water was purchased from Smart & Final, Von's, Ralph's, and other markets. Approximately 50,000 gallons of water were purchased, and 30,000 gallons were distributed to residents.

Friday, 8:00 P.M. A water tanker was located at Town Center Hall as one distribution point for water.

The city manager completed the public notification regarding the water incident. The content was translated to Spanish. The PIO continued to work on activation of the CAN program. PSC personnel continued to field questions from the public.

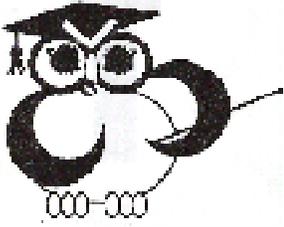
Friday, 9:00 P.M. A second water tanker was located at the neighborhood center.

Friday, 10:00 P.M. Two laboratories were located to conduct analysis of the water samples.

All CAN program notification was lost by the CAN operator. Information once again had to be installed by individual block and street number.

Saturday, 12:00 A.M. The city manager met with the EOC staff members to brief them on the events of the evening and seek input on additional actions that may be required to protect the community.

Saturday, 12:06 A.M. A water sample was delivered to the laboratory.



Decision Making Forty-Eight Hours of Crisis Case Study

Saturday, 12:10 A.M. Residents were alerted to the situation by the first CAN alert message in English and Spanish.

Employees began distribution of the water system advisory flyer to all residential addresses.

Saturday, 12:15–2:00 A.M. The city manager, the director of the PSC, Battalion Chief Good and the PIP met at the EOC to identify questions the city would be asked about the incident.

Saturday, 3:00 A.M. Distribution of the water system advisory flyer to all residential addresses was completed.

Saturday, 8:00 A.M. A second CAN message was sent out to residents of the community through the telephone system.

Saturday, 8:00–11:15 A.M. The city manager and the PIO met with various representatives of the media.

Saturday, 11:30 A.M. The laboratory delivered test results that none of the constituents in the water samples exceeded the maximum contamination limits (MCL) or action levels.

Saturday, 3:00–11:00 P.M. The PIO was interviewed and questioned by the media.

Saturday, 11:35 P.M. Laboratory results arrived too late for 11:00 P.M. newscasts. However, results were negative for bacteria and other contaminants. The incident commander notified the city manager of the laboratory results.

Saturday, 11:40 P.M. The city manager notified the mayor and members of the city council by telephone that the laboratory tests were negative and that the emergency ended without injury or property loss to any residents of the city.