Military Culture and Resistance Towards Change. Well – What's the Emergency?

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ABSTRACT

Military innovation, and resistance towards it, comprises a large body of literature. In this paper we examine the question through comparing three investigations of two cases of serious accidents and one case of organizational responses to the revelation of malfunctioning procedures for management of behavioural misconduct in the Norwegian armed forces. In the fall of 2022, it was revealed that several officers who had been reprimanded for misconduct, had experienced no career repercussions as a result. Instead, they had been promoted and redeployed. The two accidents involved a collision between a frigate and a tanker in 2018 and the overturn of a helicopter on the runway in 2017. All the three cases underwent external investigations by a consultancy firm and The Norwegian Safety Investigation Authority. The reports focused on topics such as organization, procedures, regulations, and culture.

In this paper we argue that the investigations revealed that the military organization was indeed innovative and willing to change, but that the changes took a very specific direction. Self-induced pressure towards fulfilment of ongoing and expected future missions created a sense of emergency which determined priorities in the military organization at the expense of safety procedures and knowledge development, which were the prime focus of the civilian recommendations. In the end we discuss the reasons behind these diverging perspectives of the need for change and its everyday practical implications in the military organization.

1.0 INTRODUCTION

Military innovation, and resistance towards it, comprises a large body of literature. In this paper we examine the question through comparing the findings in three recent investigations of the workings of the military organization in Norway. The three investigations concern two cases of serious accidents and one case of malfunctioning procedures for management of behavioural misconduct. The two accidents involved the overturn of a helicopter on the runway in 2017 and a collision between a frigate and an oil tanker in 2018. The origin of the last case was a series of revelations throughout 2022, which showed that several officers who had been reprimanded for misconduct, had experienced no career repercussions as a result. Instead, they had been promoted and redeployed. The three cases underwent external investigations by a consultancy firm and The Norwegian Safety Investigation Authority (NSIA). The reports focused on topics such as training, competence, procedures, regulations, and culture.

In this paper we argue that the investigations revealed that the military organization was indeed innovative and willing to change, but that the changes took a very specific direction that demonstrate what the military culture valued most. In the two accidents, self-induced pressure towards fulfilment of ongoing and expected future missions created a sense of emergency which endorsed change and determined priorities in the military organization. In the 'misconduct-case', a lacking sense of emergency led to a slow response to several reports about a high frequency of sexual harassment among young female military personnel starting in 2018, and to the first revelations about malfunctioning notification procedures in the spring of 2022. We hypothesize that changes that lay at the heart of the functional imperative of the military organization, that is to always prepare and train for being able to fight war, will drive change, whereas changes that require a diversion of attention and resources away from preparing for war, will be resisted, or ignored.

Our research question is:

How can cultural aspects of the Norwegian armed forces (NAF) explain implementation of changes, or lack thereof, in three cases of organizational failure between 2017 and 2023?

The paper proceeds as follows: First, we briefly introduce the three cases under examination. Thereafter we present our methodological approach. We apply a structured comparison of the three cases, not directed by theory, but by a thorough reading of the three examination reports identifying similarities and difference through a grounded theory approach. In the next section, we present the findings from the comparison of the cases. Lastly, we discuss how the findings can be explained by characteristics of military culture in general and the culture of the NAF in particular. But first, we will briefly elaborate on some characteristics of military organizations.

2.0 CHARACTERISTICS OF MILITARY ORGANIZATIONS

Military organizations are large state bureaucracies. As such they are similar (in Norway and other so-called welfare states) to other large public sectors such as health care and social services. At the same time, they also have some unique traits, some of which are listed in the PwC-report (2022, pp. 21–22):

- A hierarchic structure based on command and orders, always made visible by distinctions on uniforms.
- Gender bias (85 % male of military personnel, 80 % male if civilian personnel in the NAF are included).
- High rotation of personnel - about 10 000 personnel, including 9000 conscripts, enter the NAF each year, and are received by less than twice as many (17 000).
- Close ties between personnel and their families who work and live together and move between small communities in partly desolated areas.
- Leadership responsibility at a young age.

One more characteristic should be mentioned as it stands out in the three cases discussed below: Like all public services, the military is funded over the tax bill, and therefore have few direct incentives for cutting back on costs. Balancing ambitions and funding are therefore a constant exercise at both political and military levels, as in other public organizations. However, since the military's ability to produce the desired outcome (to deter or defeat a potential enemy) is not measurable on a daily or even annual basis, it becomes difficult to make an objective judgement on the question of sufficient amounts of funding for the military organization. As a result, all parts of the organization are likely to attempt to expand their ability to deliver operational capacity to maintain or increase their funding. This mechanism creates both a strong incentive for change, and an incentive for a permanent state of underfunding.

3.0 TWO ACCIDENTS AND DYSFUNCTIONAL NOTIFICATION PROCEDURES

Revelation of dysfunctional procedures for notifications of sexual harassment/misconduct in 2022

In the spring of 2022, the Norwegian armed forces were criticised for having dysfunctional alert channels regarding notifications of sexual harassment and misconduct. The issue came to light after surveys (MOST, 2019, 2021) and articles in the media revealed that a high number of women had experienced sexual harassment or assault while serving in the NAF. Widespread media attention and public outrage sparked a

wave of women, still serving or not, making their stories public (see, e.g., Muladal et al., 2022 and Skille et al., 2022). Critics of the Armed Forces pointed out that the military's alert channels for reporting sexual harassment and assault were inadequate. Many of the women who reported incidents felt that their complaints were not taken seriously by their military superiors and that they were not offered adequate support. Moreover, public scrutiny revealed that misconduct had little or no repercussions for the careers of the persons notified, whereas the ones who notified often felt isolated and some chose to leave their jobs and abandon their military career (Higraff et al., 2022).

In response, the Norwegian armed forces commissioned Price Waterhouse Coopers (PWC) to conduct an evaluation of the handling of notifications of sexual misconduct in the Armed Forces. PwC was commissioned in July 2022 and completed its report in November the same year. The evaluation investigated the handling of 56 alerts of sexual harassment and misconduct between 2020 and 2022 through both written documentation and interviews with involved personnel. More cases have surfaced since the PwC report was published, including a serious incident concerning notifications of sexual harassment, misconduct, and dysfunctional alert channels, that was brought to the fore in late February 2023 (Skille et al., 2023).

The collision between the frigate HNoMS "Helge Ingstad" and the tanker "Sola TS" in 2018[1]

The collision between the frigate Helge Ingstad and the tanker Sola TS occurred in Hjeltefjorden, a fjord monitored by a Vessel Traffic Service, four hours after midnight in November 2018. Helge Ingstad, with a crew of 137, was returning from a NATO exercise, whilst Sola TS, with a crew of 24, was departing an oil terminal. Whilst the tanker did not sustain significant damage, the collision resulted in significant damage to the frigate. After the collision, the crew ran the frigate ashore. Despite efforts to save the vessel, it took on water and eventually sank near the shore. On the frigate, seven crew members sustained minor physical injuries, but only luck prevented that the lives of a hand-full sailors, some of them conscripts, were lost.

Considerable resources were invested into the accident investigation, which was conducted by The Norwegian Safety Investigation Authority. The body launched a two-phased investigation into the accident, resulting in two reports. The reports were written with the sole purpose of learning and preventing such accidents in the future. As an apolitical, public investigation body, the Norwegian Safety Investigation Authority is independent from the military chain of command, and the people who testify to the body are legally protected from self-incrimination. The first report dealt with the events leading to the collision, and considered all parties to the accident, i.e., the frigate, the tanker, and the Vessel Traffic Service (NISA, 2019a). The second report concerned the events unfolding after the collision (NISA, 2021).

In a trial that commenced in January 2023, the duty officer on watch on Helge Ingstad stands on trial for "negligently causing damage to the sea, which could easily result in the loss of human life" (Buggeland, 2022).

Helicopter turn-over in 2017

In 2017, a new rescue helicopter of the Norwegian Air Force was involved in a turn-over accident. During a start-up procedure, the helicopter unexpectedly lifted off ground and rolled over. The two pilots did not sustain physical injuries, but the helicopter suffered substantial damage as it rolled onto its right side (NSIA, 2019b, p.5). As with the collision, the incident was evaluated by the independent and apolitical Norwegian Safety Investigation Authority. The body investigated the entire in-phasing process leading up to the accident, including the training provided by the helicopter producer. Again, considerable resources were invested into the investigation. The overall purpose of the evaluation was to improve operational safety in the Norwegian armed forces (NSIA, 2019b, p.5).

[1] The Norwegian versions of the reports remain the authoritative versions, but this article refers to the English versions for the sake of simplicity.

4.0 METHODS

Organizational culture is not easily observed. Neither are the effects of culture. A common research dilemma is that culture and its effects are often indistinguishable. A warrior culture is expressed, and can be observed, by warrior behaviour. In cultural studies, the danger of circle argumentation is therefore imminent.

In this paper we hope to escape the dilemma by conducting a comparative study of the three cases outlined above. In line with the view proposed by Ruffa (2020, p. 5), we argue that what our cases are cases of depend "on the kind of literature and contribution" we are trying to make. Hence, the three cases can be seen as cases of either military change or resistance to change.

A comparative design was chosen for three reasons. First, it is suitable to understand complex phenomenon. Second, comparing cases help us identify similarities and differences in how different branches of the military organization address different types of pressure for change. Third, these similarities and differences, in turn, help us gain a deeper understanding of the more general dynamics, i.e., cultural factors, at play across the three cases.

The case selection was first of all based on pragmatism. Our original plan was to examine only the armed forces' handling of the criticism raised against its handling of notification procedures. However, in our discussion of the case, we immediately began to compare it to other incidents of organizational failure and found the comparison more fruitful than a single case study. Furthermore, instead of doing basic research of each case, we were able to rely on two very thorough and impartial investigations of the two accidents. The PwC-report was somewhat less solid. It was undertaken in a shorter time frame, and written documentation of the cases investigated had been selected by the NAF. The consultancy firm had not had free access to the NAF archives (PwC 2022, p. 16).

A few other cases were considered, most notable the investigation of a fatal accident when a transport plane crashed into Kebnekaise during a NATO and partner exercise in Sweden in 2012 and an almost similar accident in 2021, when a C-130 transport plane almost crashed into the island Mosken during a regular exercise flight. However, since we wanted to include as many branches as possible, only one incident from the Air Force was chosen for this article.

Even though the incidents examined in these reports are quite different, the investigation reports address similar questions and therefore make grounds for an interesting comparison. The two accident incidents have many similarities, which will be further addressed below, but they are also quite different. First, they involved different branches. Secondly, the incident at sea involved communication between many actors, both on the bridge of Helge Ingstad, and with the other involved units. The helicopter accident only involved the two pilots in a routine procedure in which the helicopter was not even in the air. The case about the notification procedures is at the face of it very different since it concerns the undramatic daily routines of the NAF. However, the background for the two accidents can at least partly be found in the same daily routines. As our analysis will show, the three reports address many similar aspects by the military organization, and therefore provide a solid ground for comparison.

In our analysis of the three reports, we applied a grounded theory (Glaser and Strauss, 1967) approach, as it provides a practical method in which data is collected and analysed simultaneously. Initially, we developed a preliminary outline of factors and incidents, based on limited knowledge of the cases. Next, based on a systematic review of the cases, we iterated between theory and cases, and developed a conceptual chart of the main factors emerging from the material. First of all, we identified common themes. We also paid attention the authorship of the reports, their audiences, to blank spots, i.e., what were not covered in the reports, and to biases in what had been recorded. All in all, through this method we were able to identify a set of factors that, we argue, can explain change, or resistance to change, in the Norwegian armed forces.

5.0 EXPLANATIONS OF ORGANIZATIONAL FAILURE

This section presents the main finding of the systematic comparison of the three evaluation reports. Overall, the three reports found that multiple factors contributed to the incidents (NSIA, 2021, p. 4, NISA 2019b, p. 6 and PwC, p. 5). We have identified five organizational explanations that run across the three cases, namely (1) insufficient education and training; (2) lacking, inadequate or false procedures/regulations; (3) pulverized lines of responsibility; (4) too much responsibility placed at the lowest level in the organization/poor knowledge about challenges at the executing level at higher levels/insufficient communication between levels; and (5) "Lean manning" and capacity.

Insufficient education and training on the ground

Education of leaders in the NAF is primarily done through the NAF's internal educational system. In addition, there is a multitude of courses offered. PwC fond that training in handling of notifications of misconduct was lacking in the military system, and that there was no compulsory formal education or courses required for leaders at different levels in the organization (NSIA, 2019b, pp. 60–62). This made handling of notifications a blind spot in many units' competence. To what degree this blind spot was known in the NAF was not clear in the report.

In the event of the frigate accident, the training level of the bridge crew was believed by the NAF to be sufficient. The report found that there had been a slow degrading of the experience required before navigators were authorized as bridge-chiefs. The bridge-chief was cleared as officer of the watch after nine months' training and had held his clearance for appr. eight months when the accident occurred. The evaluation report established that this was a lower level of experience than earlier requirements for being cleared as officer of the watch (NSIA, 2019a, p. 120). Moreover, the bridge-chief was also assigned responsibility for training. At the night of the accident, the bridge chief was responsible for training of two functions on the bridge in addition to being responsible for the navigation of the ship (NSIA, 2019a, p. 120). The reduction of the experience-levels had not been compensated for with extra training or education.

Due to limited experience, the bridge-chief and his crew were also unaware of sailing-patterns in the fjord and retained a flawed situational awareness suggesting that the tanker was a stationary object (NSIA, 2019a, p. 6). With regards to the second phase of the accident, the investigation found that the crew lacked sufficient knowledge of the procedures for shutting down the vessel to ensure her survivability (NSIA, 2021, p. 167).

The helicopter turn-over happened in a period where the NAF was phasing in a new aircraft. This was to happen over a period of several years, and training of personnel var an integral part of the plan. The plan was based on training being bought from the industry that delivered the new aircrafts. The quality of the training was early identified as insufficient, and plans were made for extra training (NSIA, 2019b, pp. 5, 36–38. However, the report found that the identified plan for extra training was not executed before the accident.

Furthermore, due to a rushed training schedule at the production site, the crew had limited experience in performing start-ups of the helicopter. Moreover, the crew had little flying time in the years prior to the accident. Lack of experience also contributed to inadequate responses to the rolling motion that the start-up procedure caused.

Lacking, inadequate or false procedures/regulations

The PwC report found that the regulations and procedures for handling notifications of misconduct in the NAF were unclear and gave little guidance to those who used them (PwC, p. 5). In addition, there were several documents regulating handling of misconduct, issued at different levels in the hierarchy, with different levels of details. They also found variations in routines and procedures across the different units in the NAF. The result was that the recipients of notifications of misconduct had to find their way in a myriad

of regulations, procedures and routines that were not always suited for the situation at hand, rising the risk of similar cases being handled differently across the NAF.

In the frigate accident, the Norwegian Safety Investigation Authority found that the documents (bridge-manual) that was meant to regulate how the bridge-team worked had shortages. The manuals, procedures and regulations did not provide sufficient support for the bridge crew- and chief regarding risk assessment, situational awareness, and safe navigation (NSIA, 2019a, pp. 129–130). The design of the bridge, the technological bridge-systems and the procedures and manuals for how to use them were not optimal for securing situational awareness on the bridge. The procedures that were in place were also partly outdated. The resultant effect, which is well known in research, was that the crew made their own "local" procedures and routines, and the loyalty to procedures that were in place were degraded. This reduced the overall safety level of the frigate.

The report also noted that unit in charge of keeping the frigate manuals and procedures up-to-date had been cut in an effort to find manpower for an extra frigate-crew within current budgets, and the responsibility for updating the procedures had been delegated to the individual frigate-crews as a result of this decision.

The helicopter investigation found that in addition to the lacking training, the operations manual and crew checklist for the helicopter had not been developed sufficiently for operational use (NSIA, 2019b, p. 4). This was a known issue, but the manual was still cleared for use by the unit in the NAF responsible for securing the quality of the manuals provided by the manufacturer.

As in the frigate case, the combination of procedures being immature and lack of training and experience, enhanced by the following lack of trust and loyalty to the procedures, resulted in a "local" procedure being followed which resulted in the accidents.

Pulverized lines of responsibility

Since the early 2000s, the NAF has centralized several support-functions. The reform is aimed to enhance efficiency. This is relevant to HR-management, logistics, cyber, the Military Police, and acquisitions. The reform has implications for all three cases under examination here.

The PwC report found that local leaders did not know who to contact for support in what cases, and as many as five different units had been contacted as 'experts' on the handling of notifications (PwC, 2022, p. 58. In the frigate accident the problem of unclear lines of responsibility is most clearly seen in two findings. The first is the already mentioned the lack of administrative support from land, which was removed to find personnel to man an extra frigate.

Second, the responsibility for the technical status of the frigate is shared between the Navy and the Norwegian Defense Materiel Agency (NDMA), which is not part of the NAF but is organized directly under the Ministry of Defence. However, the captain of the ship must approve the ship with its known technical nonconformities if he wants to take it to sea. This is not an uncommon procedure, but the investigation showed that neither the Navy nor the NDMA had sufficient knowledge about how the sum of nonconformities affected the risk of operating the frigate. Several of the nonconformities had direct impact on the chain of events that led to the frigate sinking (but not to the collision, which was caused by human error). There was a lack of knowledge onboard regarding stability of the frigate. This knowledge was available in NDMA, but they were late to the scene and poorly integrated in the crisis-management staff (NSIA, 2021, p. 175). The report showed that also the NDMA prioritized operations over technical safety.

The organization of the units involved in the in-phasing of the new helicopters was even more complex. At the strategic level there where three major players: The Ministry of Justice and Public Security, The Ministry of Defense, and the helicopter provider (Augusta-Westland). At lower levels, there were several units in the

defense and justice sector with responsibilities that directly and indirectly had an impact on the events leading up to the accident. The complex organization led to poor communication between actors. Some units became over-burdened, and others lacked competence to make independent assessments. None of the units felt an overall responsibility for the overall safety of the project.

Too much responsibility placed at the lowest level in the organization/poor knowledge about challenges at the executing level at higher levels/insufficient communication between levels

The PwC report found that the overarching principle for handling notifications of misconduct in the NAF was that that notifications should be handled at "the lowest competent level" (PwC, 2022, p. 137). The principle was in line with the NAF leadership philosophy of "mission command". However, mission command does not entail that all tasks are to be handled at the lowest level, but at the competent level.

As mentioned above, the principle of local handling, entailed quite different ways of handling notifications in practice, including the repercussions of those found guilty, and the care-taking of the victims, as well as different ways of documenting what had been done. Local leaders had no clear perceptions of how to report up the chain of command, which left the higher echelon of the NAF unaware of the magnitude and details of the problem.

In sum, the principle that alerts are to be handled at the lowest (competent) level, combined with a culture where not handling what comes your way is seen as a weakness and the reorganization/centralization of competence and the included cut in competence and capacity locally can be become a poisonous blend. This is a causal inference that can be read between the lines of the report from PwC but is supported by the other cases.

In the case of the frigate, it is unclear if the challenges with experience, training and the technical status of the frigate was known in the Navy. Anyway, the Navy had decided that it was up to the captain and his crew to accept the ship, assess the crew's competence, do the risk assessments, and meet the required levels of deliveries. As with the handling of the notifications, there seems to have been a gradual push in the organization towards of moving responsibilities for safety towards the lower levels of the organization, which imbued less overall attention to safety, without anyone quite noticing the fundamental change. The combination of a "can-do-attitude" and a high level of trust from the Navy's leadership led to insufficient attention to safety procedures at the frigate.

In the helicopter event, the report found that the pilots concern over insufficient training and flawed manuals, were reported to the next level in the organization. However, the concerns were not passed onto the higher levels of the Air Force or Defence Ministry. Instead, the mid-level accepted the status and continued approving operations, either because of a lacking understanding of the situation, or out of concerns for the effects on the project had they chosen to put the brakes on, or because of high levels of trust in the leadership at the lowest level and the crews. Due to the lacking reactions to the reported concerns, the crews gave up and continued operating and trying to compensate for these shortfalls.

"Lean manning" and capacity

"Lean manning" was also a common theme in the reports. With regards to the handling of notifications of misconduct, the PwC report found a local capacity shortage for handling such cases (PwC, 2022, p. 5). Capacity challenges arose since the task of handling notifications came in addition to military leaders' ordinary duties and, as the report noted, the handling involved "complicated HR-professional and issues regulated in the Working Environment Act" (PwC, p. 108, the authors' translation).

Moving on to Helge Ingstad, the investigation found that the "lean manning" concept had contributed to the accident (NSIA, 2019a, p. 120). To meet the requirements of lean manning, the crew were assumed to hold a

substantial level of competence and experience. This was, as has been detailed above, not the case. Rather, shortage of qualified personnel and "the career ladder for fleet officers in the Navy" had led to a faster route clearance and consequently less experienced officers of the watch than what used to be the case (NSIA, 2019a, p. 120).

Also, in the helicopter turn-over, the investigation found a lack of personnel and vacancies among the pilots, in the project management staff, and in the overall safety chain of responsibility in the Air Force. Trying to compensate for the delays in the deliveries led to a lot of extra work and a great deal of time pressure on Air Force personnel. In addition, many administrative tasks had fallen to the management at the Air base where the helicopter crashed.

6.0 DISCUSSION: EXPLAINING MILITARY CULTURE TO SUPPORT ORGANIZATIONAL CHANGE

This paper started out as an attempt to explain the apparent resistance towards change regarding procedures for notifications of misconduct in NAF. To make our findings less case specific we decided to include two more cases in which accidents had led to a scrutiny of the culture of various parts of the NAF. In the previous section, we identified common organizational explanations behind the two accidents and the deficiencies in the organization's handling of the notification processes. In this section we discuss underlying cultural factors which may explain the findings identified above. Three distinct cultural traits will be discussed: 1) the culture is characterised by a strong will to act, rather than to halt or withdraw, which inadvertently supports change, 2) this willingness to change leads to a tacit or explicit acceptance of inadequate framework conditions, and 3) great distance between situational understanding in top and ground levels hinders organizational oversight, conceals deficiencies, and creates an organization which to some extent rely on blind trust in own and others ability

First, based on the material reviewed, there is no general resistance towards change in the NAF. On the contrary, the culture is supportive of change. The frigate accident (lack of experience) and the helicopter turn-over (deficient training) were both caused by factors that indicate that the organization eagerly pursued change rather than resisted it. With regards to the dysfunctional procedures for notifications, there were not so much a lack of will to change, as a lack of awareness and understanding of the problem and how it could be solved. Before the media pressure mounted, the problem of dysfunctional procedures was not taken seriously by the organization, but in the same vein, neither was the training of the helicopter crew, or the experience of the chief on the bridge. In all three cases, the organizational culture spurred the ground level to carry on despite these deficiencies – and it did not turn out well.

Second, in all three cases, the culture's support for change led to a lacking ability or willingness to put the brakes on in situations in which training, education, and procedures/regulations were inadequate. Military leaders and staff tried to do their best within the means available. Problems were reported, most notably in the helicopter roll-over, but when little happens, the executing level simply carried on. Ultimately, this testifies to a "can do" mentality, underscoring a belief in solving missions with the means available. The other side of the same coin is a strong will to deliver as required. Whilst the level of training was perceived as adequate on the frigate, the opposite was the case regarding the helicopter case – but it was accepted to go ahead anyway. With regards to the dysfunctional procedures for notifications, young and inexperienced leaders who lacked knowledge about work environment regulations, were given responsibility for handling difficult cases of misconduct without clear and unified organizational guidelines. Priority given to warfighting over management in military education, and the centralization of administrative functions added to the problem.

Third, in all three cases, there seemed to have been differing perceptions of the situation at the top and the bottom of the military organization. In the Airforce, complaints from the pilots did not reach the higher

levels, which again resulted in resignation and acceptance of compromised safety procedures among the pilots. Corners were cut to uphold deliverances in both accidents, and competence – defined as a combination of education and training, was simply assumed to be at an acceptable level. In the notification case, the military leadership seemed to be completely unaware of difficulties related to the malfunctioning procedures and appeared at loss about how to address the situation for several months.

7.0 CONCLUSION

In John Kotter's well-known model for how to induce organizational change (Kotter, 1996), the first imperative is to create a sense of emergency. In this paper's title, we therefore asked, well, what's the emergency? Furthermore, we hypothesized that emergencies related to the military organization's core function, to prepare for war, would be given the highest priority, whereas emergencies that were related administrative tasks, held less prestige, and would be prioritized lower.

The empirical analysis showed that in the two accident cases a sense of rush led to acceptance of security requirements being ignored or changed to meet operational requirements. In the case of the notification process, a sense of rush seemed to have been lacking until media pressure mounted in the fall of 2022/early 2023. As late as March 2023, newspapers reported that measures to improve the organization's handling of cases of misconduct were not in place (Furuly, Langved, Olsen and Haugstulen, 2023).

In all three cases, the evidence suggests that there is a cultural element in the NAF to "press on regardless" – of lacking procedures, manuals, knowledge, experience and so on. At the ground level, to press on implies to continue operations despite acknowledged shortages. At the higher levels, to press on implies accepting a lack of oversight and knowledge about the state of affairs in the lower parts of the organization. In such a culture, the challenge is not to induce a culture that support change, but to induce a culture that tempers the desire for change, makes sure that change is diverted in the right direction, and improves the prestige that lays in putting safety and the well-being of its personnel above the constant sense of rush regarding delivery of operational capacity.

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