
Book Review

The Social Shaping of Commission Reports

Diane Vaughan¹

Report to the President by the Presidential Commission on the Space Shuttle *Challenger* Accident. Vol. 1. Washington, DC: U.S. Government Printing Office. 1986.

The *Columbia* Accident Investigation Board Report. Vol. 1. Arlington, VA: National Aeronautics and Space Administration, 2003.

The 9/11 Commission Report. Final Report of the National Commission on Terrorists Attacks Upon the United States. New York: W. W. Norton, 2004.

We know that conceptual models, or frames, are more than simply angles of vision or approaches. Each is comprised of theories, assumptions, and categories that influence where we look and what we find. Frames shape how questions are asked, what is taken as evidence, the conclusions drawn, and subsequent actions. In this paper, I consider the frame, identification of root causes, and policy recommendations of the 9/11 Commission report by comparing it with two others: The report of the presidential commission that investigated the space shuttle *Challenger* accident (1986) and the investigation board's report on the *Columbia* accident (2003). In making the comparison, I am not equating the three incidents. Terrorist attacks taking the lives of nearly 3000 and resulting in war are vastly different in immediate impact and long-range consequences from the two space shuttle accidents. There is a logic to the comparison, however.

Having analyzed the social causes of the *Challenger* accident (Vaughan, 1996) and subsequently worked on the staff of the *Columbia*

¹To whom correspondence should be addressed at Department of Sociology, Columbia University, 404 Fayerweather Hall, 1180 Amsterdam Avenue, New York, New York, 10027; e-mail: dv2146@columbia.edu.

29 Accident Investigation Board in 2003, I saw striking empirical regularities in
30 the social causes of these three events. First, at the individual level, all three
31 were preceded by a long incubation period during which early warning signs
32 of what was to come were either misinterpreted or ignored. The advantage
33 of a long incubation period is that it provides time to intervene and avoid
34 a tragedy, but that did not happen. Second, at the organizational level, barriers
35 to gathering, disseminating, and interpreting information were rooted
36 in structure, hierarchy, and cultural traditions that were obstacles to inter-
37 vention and effective action in each case. Finally, at the institutional level,
38 historic political and economic decisions and actions of elite leaders con-
39 tributed to all three events.

40 These common empirical patterns notwithstanding, the reports had dif-
41 ferent frames, causal models, and policy recommendations. In each case,
42 the composition and process of the commission shaped the frame, which
43 was directly reflected in the causal model and policy recommendations of
44 the final product. Policies were targeted to—and limited by—the specified
45 causes. Comparing the three throws into broad relief the differences among
46 them, illuminating the frame, causal factors, and recommendations of the
47 9/11 report. Although research on official investigation commissions is ex-
48 tensive (see Zegart, 2004), little comparative work has been done on their
49 internal processes and report construction. Using this convenience sample, I
50 begin with the composition and process of each commission and then show
51 the connection between the investigation frame, causal model, and policy
52 recommendations of each. To clarify analogies and differences among the
53 causal models and policies, I simplify by separating form and abstracting
54 content, sorting investigation findings into individual, organizational, and
55 institutional levels of analysis. This strategy does injustice to the complexity
56 of each report but usefully contrasts each report's major causal factors and
57 policy recommendations in a few pages, highlighting what is included and
58 excluded. The NASA reports are presented in less detail; my emphasis is
on the terrorist attacks and the 9/11 Commission Report.

60 **REPORT OF THE PRESIDENTIAL COMMISSION ON THE SPACE** 61 **SHUTTLE *CHALLENGER* ACCIDENT**

62 The commission was appointed by then-President Ronald Reagan,
63 who named William Rogers, former secretary of state under Nixon, at-
64 torney general under Eisenhower, and chair of the Warren Commission
65 Investigation, to head it. His ties with previous Republican administra-
66 tions made Rogers's appointment controversial. Other commission mem-
67 bers named had aerospace industry experience or had served on previous

The Social Shaping of Commission Reports

aviation or aerospace accident investigations. Several had previous associations with NASA. To deflect charges that the commission was pro-NASA and pro-administration, astronaut and physicist Sally K. Ride, astronaut Neil Armstrong, Charles Yeager, record-breaking test pilot, and Richard Feynman, Nobel Prize-winning physicist, were added. Originally mandated as overseer of NASA’s own internal inquiry, the commission’s role changed to active investigation when it discovered that NASA had launched *Challenger* against the recommendations of its engineers. The commission process affected the report content (Vaughan, 1996:58–72). Commission activities were constrained by the president’s imposition of a 120-day limit for the investigation and the writing of the report. The time limit resulted in the delegation of much investigative responsibility to staff members, with less time available for commission members to do hands-on work. The division of labor resulted in mistakes in interpreting NASA culture—procedures, rules, and norms. Another problem was that the analysis was governed by hindsight: the commission reconstructed what happened with knowledge of the tragic outcome, rather than examining how managers and engineers estimated risk when decisions were made. Thus, actions leading up to the accident took on an intentionality and direction in retrospect that they did not have at the time.

The Rogers Commission, as it became known, adopted an *accident investigation* frame that NASA had been using, following tradition in the aviation and aerospace industries. This frame focuses attention on technical causes and human factors: individual “operator error” due to poor judgment, poor training, lack of sleep, drug use, or incompetence. The report explained NASA’s contribution to the technical failure by a *rational actor/regulatory failure* causal model. The commission’s retrospective lens, along with the inability to grasp NASA culture, reinforced this rational-choice model. Regulatory failure refers to the inability of those with official responsibility for risk surveillance and safety oversight to forestall some harmful outcome. Separating the report’s causal model into the three levels of analysis shows the operation of the frame, the emphasis on individual and regulatory failure, and no identification of causes in the agency’s institutional environment. In an unprecedented break with the traditional accident investigation frame, the report acknowledged some social causes—namely, production pressure and the structure of regulatory relations.

Individual

The report states that the technical failure was the result of flaws in the decision-making process (pp. 82–119). The technical anomaly

107 responsible for the *Challenger* accident occurred early in the shuttle pro-
108 gram and persisted. Yet NASA launches continued, despite more frequent
109 and worsening anomalies involving the same shuttle component. Noting
110 how these early warning signs were ignored, Commissioner Richard Fey-
111 mann argued that middle managers were knowingly taking risks because
112 they “got away with it the last time” (p. 148). The cause was a form of
113 operator error: intentional wrongdoing by individual middle-level NASA
114 managers who, under schedule pressure, violated safety rules, proceeding
115 with the launch despite strong expressions of concern by engineers that un-
precedented cold temperatures made this launch especially risky.

117

Organizational

118 Regulatory failure occurred because of malfunctioning individuals and
119 malfunctioning structures. “Communication failure” was attributed to these
120 same middle managers, who failed to pass engineering concerns and reports
121 of technical problems to their superiors with oversight responsibilities. A
122 chapter entitled “The Silent Safety Program” (pp. 152–162), linked regu-
123 latory failure to a fatal combination of organizational problems: NASA’s
124 reduction in the work force responsible for safety, reliability, and quality as-
125 surance; overloaded problem-tracking systems; absence of trend data; and
126 the fact that “organizational structures . . . [had] placed safety, reliability
127 and quality assurance offices under the supervision of the very organiza-
128 tions and activities whose efforts they are to check” (p. 161). Dependent
upon NASA for authority and resources, the safety units had no clout.

130

Institutional

131 The report made no reference to NASA’s political/economic environ-
132 ment. In contrast, scholars and journalists extensively documented that re-
133 ductions to NASA’s budget by the White House and Congress throughout
134 the shuttle program forced the agency away from its R&D origins toward
135 a business model that had NASA juggling costs and schedules to the detri-
136 ment of safety. Instead of blaming these external elite actors, the Rogers
137 Commission placed responsibility for production pressure and scarce re-
138 sources on NASA: “NASA began a planned acceleration of the Space Shut-
139 tle launch schedule; . . . in establishing the schedule, NASA had not pro-
140 vided adequate resources for its attainment” (p. 164). NASA was not able
141 to meet the launch schedule because “its resources were strained to the
142 limit, strained by the flight rate itself and by the constant changes it was
143 forced to respond to within that accelerating schedule” (p. 164).

Recommendations

144

Policy recommendations addressed the factors identified in the rational actor/regulatory failure causal model. At the individual level, the Rogers Commission took a procedure and process approach designed to control human factors in individual decisions: clean up information-tracking systems, improve risk-classification systems for all technical components of the shuttle, and create new decision rules. At the organizational level, they addressed regulatory failure by recommending separate and independent safety units, with authority and resources. No calls for action were leveled at top leaders in the agency’s institutional environment. Consistent with its causal model, the report charged NASA with keeping its goals and resources in alignment.

THE COLUMBIA ACCIDENT INVESTIGATION BOARD REPORT

156

As mandated by a post-Challenger Shuttle Contingency Action Plan, seven members automatically were named to the Columbia Accident Investigation Board (CAIB) because they occupied specific government posts: all were directors of safety for branches of the U.S. armed forces or transportation departments, so they were experienced accident investigators. Appointed as chair was Admiral Harold Gehman (retired), former Commander in Chief of the U.S. Joint Forces, known as an independent thinker and critic of government. Five other members were named, all Ph.D.s with research experience, including Sally K. Ride; Sheila Widnall, Professor of Aeronautics and Astronautics at MIT; and Douglas Osheroff, Nobel laureate physicist at Stanford. The CAIB had the advantage of access to a research literature on Challenger. Upon joining the staff of the CAIB, I learned that 2 weeks after the accident Adm. Gehman had read my Challenger book and recognized many empirical analogies in the social causes of the two accidents. Prior to the assembly of the full board, Gehman decided with the editor that the CAIB investigation and report would take a sociological frame (for the construction of the investigation and report, see Vaughan, 2006).

In contrast to what happened with the 1986 commission, the admiral took control of the report deadline, extending it. Thus, the board had time to do extensive fieldwork, which resulted in knowledge of NASA culture and structure. Both became central to the causal model and policy recommendations. The decision was made not to blame individuals who made flawed decisions, but to locate the causes in social factors. Also against accident-investigation tradition, the CAIB report gave equal importance

182 (and chapters) to social and technical causes. Stating that the causes of the
183 *Challenger* accident had not been fixed, the report adopted my 1996 book's
184 *organizational-system failure* causal model, which identified causes at the
institutional, organizational, and individual levels.

186

Individual

187 As with *Challenger*, the technical anomaly that destroyed *Columbia*
188 had recurred in the years preceding NASA's second shuttle accident. To
189 explain why managers and engineers failed to act to eliminate the flaw,
190 the commission reconstructed engineering decisions chronologically. They
191 found that the social context affected how early warning signs were inter-
192 preted (pp. 121–77). In retrospect, each seemed to involve a strong signal.
193 At the time, however, signals were perceived as mixed, weak, and routine.
194 Technical deviations became normalized because the volume and pattern
195 of information mediated the seriousness of warnings. For example, the con-
196 text was that because the shuttle was an experimental technology, tech-
197 nical problems were expected; thus, the number of problems diminished
198 the seriousness of each new problem. A successful mission confirmed that
199 anomalies were safe to fly. The result was a cultural belief that the technical
200 anomaly responsible for the *Columbia* accident was a maintenance prob-
201 lem, not a flight risk. Historic managerial definitions of the situation per-
202 sisted, even during the *Columbia* mission when NASA engineers argued
203 that the situation was different and dangerous.

204

Organizational

205 NASA's "Silent Safety Program" was silent again. The CAIB located
206 regulatory failure in organizational structure and culture (pp. 178–94).
207 Safety was compromised by a "broken safety culture" in which structural
208 hierarchies and managerial power silenced engineering dissent. Safety units
209 could not turn things around for the pre-*Challenger* reasons: they were still
210 dependent upon the parent organization and thus incapable of averting the
211 disaster. Further, all final engineering decisions about the technology were
212 in the domain of the Program Management office, which also had responsi-
213 bility for schedules and budgets, so cost, schedule, and safety conflicts were
institutionalized in organizational structure.

215

Institutional

216 Persistent pressure on the schedule at NASA captured the CAIB's
217 attention. In contrast to the Rogers Commission, however, the board

The Social Shaping of Commission Reports

emphasized the role of NASA’s political and budgetary environments, 218
showing how decisions made by top officials at NASA, the White House, 219
and Congress after the *Challenger* accident had perpetuated the very condi- 220
tions that led to the previous accident: an internal culture that gave sched- 221
ule, deadlines, and strict obedience to formal rules and hierarchy priority 222
over safety, ultimately affecting managerial judgments about technical mat- 223
ters (pp. 99–120). 224

Recommendations 225

Concluding that the causes of NASA’s first shuttle accident were the 226
causes of the second, the CAIB stated that the lessons of *Challenger* had 227
not been learned. Policy recommendations targeted the three levels of the 228
organizational system failure causal model. To avoid the normalization of 229
signals of danger at the individual level, the CAIB identified strategies to 230
isolate early warning signs, empower engineers to speak and be heard, 231
and alter hierarchical and bureaucratic proceduralism embedded in cultural 232
patterns. At the organizational level, the “broken safety culture” would 233
be changed by changing the safety structure. Although the report identi- 234
fied both culture and structure as major culprits, no specific guidelines 235
were given for changing culture *per se*. Recommendations included creating 236
an independent safety unit to provide safety oversight and giving decision 237
power over all technical matters to the technical division rather than Pro- 238
gram Management. At the institutional level, the CAIB directly implicated 239
top officials. “The White House and Congress must recognize the role of 240
their decisions in this accident and take responsibility for safety in the fu- 241
ture” (p. 196). “The past decisions of national leaders—the White House, 242
Congress, and NASA Headquarters—set the *Columbia* accident in motion 243
by creating resource and schedule strains that compromised the principles 244
of a high-risk technology organization” (p. 203). 245

THE 9/11 COMMISSION REPORT 246

Whereas the Rogers Commission was created by presidential decree 247
and the CAIB by a NASA contingency plan, the 9/11 Commission had a 248
grassroots birth, brought into being by the active efforts of the families 249
of victims of the terrorist attacks who forced the creation of the commis- 250
sion despite a reluctant Congress and president. Responding in Novem- 251
ber 2002, Congress and the president created a bipartisan commission of 252
five Democrats and five Republicans, most of whom had been prominent 253

254 legislators or government officials. Senator Thomas Keene chaired the com-
 255 mission; its executive director was Philip Zelikow, a lawyer with a Ph.D.
 256 in Law and Diplomacy, then director of the Miller Center of Public Af-
 257 fairs at the University of Virginia. Zelikow's appointment was as controver-
 258 sial as William Rogers's for the same reason: his association with previous
 259 and current administrations.² Responding to e-mailed questions from me,
 260 Zelikow described the investigation's beginnings. Zelikow looked at a num-
 261 ber of commission reports (including the CAIB report) and was influenced
 262 by the tradition of British White Papers, Royal Commission reports, and
 263 some aspects of "official histories, e.g., in the U.S. WW2 series." These he
 264 discussed with historian Ernest May, his coauthor, colleague, and advisor
 265 to the commission. Fundamental decisions about the character of the re-
 266 port were made with Kean and May (structure, style, and how it should
 267 be published), then presented to the commission at its first meeting in late
 268 January 2003.

269 The frame of the 9/11 Commission report is a *historical/war* frame; the
 270 causal model is *regulatory failure*. Compellingly written and documented
 271 in meticulous detail, it is a page-turning historic chronology of events, ac-
 272 tions, and inactions before, upon, and following the September 11 attacks.
 273 The chapters examine the long incubation period leading up to the attack:
 274 "The Foundation of the New Terrorism;" "Counterterrorism Evolves;"
 275 "Reponses to Al Qaeda's Initial Assaults;" "Al Qaeda Aims at the
 276 American Homeland." Like the CAIB, the 9/11 Commission decided not
 277 to blame individuals and to avoid the problems of retrospection. Like the
 278 CAIB, the commission states that the lessons of the past were not learned:

279 The methods for detecting and then warning of surprise attack that the U.S. govern-
 280 ment had so painstakingly developed in the decades after Pearl Harbor did not fail;
 281 instead they were not really tried. They were not employed to analyze the enemy
 282 that, as the 20th century closed, was most likely to launch a surprise attack directly
 283 against the U.S. (pp. 347–48).

284 This paragraph, along with the historical chronology and contents of
 285 the chapters, affirms the historical/war frame by analogy with the attack
 286 that drew the United States into World War II. It also asserts the regulatory
 287 failure causal model, or, in the language of international relations and war,
 288 the failure to deter the enemy. The explanation deployed in the report is
 289 regulatory failure alone, despite evidence of causal factors at all three levels
 290 of analysis.

²Zelikow held three different offices in the U.S. Department of State during the second Rea-
 gan administration; he was on the National Security Council under President George H. W.
 Bush, along with Condoleezza Rice; he served on President George W. Bush's transition team
 in 2000–2001; then he was named to the president's Foreign Intelligence Advisory Board.

Individual

The 9/11 attacks also were preceded by a long incubation period filled with early warning signs that were not acted upon. Difficulty in interpreting intelligence is well documented in the report. Noting the dramatic increase in intelligence about terrorist threats a year before the attacks, Director of Central Intelligence George C. Tenet commented that “[t]he System was blinking red” (p. 278). Richard Clarke, long-time civil servant, head of the Counterterrorism Security Group in the Clinton administration, who urged the Bush administration to make the al-Qaeda network a priority, noted that the volume of “al-Qaeda threats and other terrorist threats was in the tens of thousands—probably hundreds of thousands” (p. 345). In retrospect, the sheer volume would appear to be a strong warning signal. Indeed, the increase did raise concerns in the intelligence community (p. 262).

The challenge was how to separate the serious, the nonserious, and those that were false. The report presents evidence that, analogous to the *Challenger* and *Columbia* accidents, early warning signs were normalized by the characteristics of the information and its context. First, the lack of specification caused many to interpret the warnings as weak signals: “[T]hreats contained few specifics regarding time, place, method, or target. Most suggested that attacks were planned against targets overseas; others indicated threats against ‘unspecified U.S. interests’” (pp. 262–263). Second, cultural beliefs developed that the threat was overseas and suicide hijacking was not a danger, which affected how intelligence was interpreted. Foreign intelligence watched overseas, domestic agencies watched for evidence of domestic threat. There was no perception that the threat was a foreign threat to domestic targets (p. 258). Further, the Federal Aviation Administration (FAA) did not define suicide hijacking as a threat (pp. 84–86, 345). No terrorist had hijacked a U.S. commercial aircraft anywhere in the world since 1986. The view was that sabotage was a greater threat than hijacking, and explosives were more dangerous than hijackings. Acknowledging that the information context affected the interpretation of signals, Clarke said, “A warning about the possibility of a suicide hijacking would have been just one more speculative theory among many, hard to spot in the volume of warnings” (p. 345).

In summer 2001, however, alarm was growing. The CIA briefed Attorney General John Ashcroft about the al-Qaeda threat in July, warning of an imminent, spectacular, and significant terrorist attack. A presidential daily briefing on August 6 included a CIA report, “Bin Ladin Determined to Strike in U.S.” (p. 258), but it was interpreted within the cultural belief that attacks would occur overseas, so this too was a weaker signal at the time than it was in retrospect. Clarke was an exception; like the NASA

332 engineers in 1986 and 2003, he was doing everything possible to get the at-
333 tention of higher-ups. In a statement indicating that the warning conveyed
334 in the August 6 briefing had been normalized at the top of the government,
335 President Bush told the commission that the report was historical in nature
336 and informed him that al-Qaeda was dangerous, which he had known since
337 he came into office.³ What would have constituted an attention-getting,
338 strong signal? “Bush said that if his advisers had told him there was a cell in
339 the United States, they would have moved to take care of it” (p. 260). The
340 report concluded that domestic agencies never mobilized against the threat
341 because of failed understandings: “[T]he institutions charged with protect-
342 ing our borders, civil aviation, and national security did not understand how
343 grave this threat could be, and did not adjust their policies, plans, and prac-
344 tices to deter or defeat it” (p. xvi).

345

Organizational

346 The report found that these failed understandings occurred because of
347 regulatory failure originating in the structure, culture, goals, and division
348 of labor of the agencies charged with safeguarding national security (see
349 pp. 71–107): “We learned of fault lines within our government—between
350 foreign and domestic intelligence, and between and within agencies. We
351 learned of the pervasive problems of managing and sharing information
352 across a large and unwieldy government that had been built in a different
353 era to confront different dangers” (p. xvi).⁴

354 The report gave an even-handed treatment to the lack of pre-9/11 pre-
355 paredness of relevant agencies. None were prepared, none were blamed.
356 Their goals and resources had gone in other directions. The FAA’s
357 pre-9/11 goal was eliminating flight delays and airspace congestion, con-
358 trolling security costs, and limiting the impact of security screenings on
359 schedules in response to pressure from air carriers and Congress, not do-
360 mestic terrorism. The commission found that FAA “intelligence, passenger
361 prescreening, checkpoint screening, and onboard security—was seriously
362 flawed” (p. 83). The North American Aerospace Defense Command (NO-
363 RAD) “faced outward” and was barely able to retain alert bases (p. 352).
364 Very little of U.S. law enforcement was concerned with terrorism. The

³ Indeed, Clinton had received a presidential daily briefing in December 1998 entitled “Bin Ladin Preparing to Hijack U.S. Aircraft and Other Attacks.” Clinton took al-Qaeda warnings seriously and wanted Bin Ladin dead, but efforts to accomplish this were never successfully mobilized (pp. 128–33).

⁴ For penetrating analyses of signals, perception, and misperception in international politics, see Jervis (1970, 1976).

The Social Shaping of Commission Reports

FBI had trouble shifting resources to terrorism from other areas, like violent crime and drugs. Traditionally more reactive than proactive, the FBI intelligence-gathering effort was ineffective, and agency systems for information management lagged behind. New formal procedures for improving information-sharing actually curtailed it. Insiders referred to these procedures as “The Wall” (p. 78). During the Cold War, the CIA had been organized to pursue only a few targets and failed to reorganize to adequately pursue many. It lacked resources to modernize communication systems for a new kind of intelligence. The report concluded that the CIA was “institutionally averse to risk, with its capacity for overt action atrophied, predisposed to restrict the distribution of information, having difficulty assimilating new types of personnel, and accustomed to presenting descriptive reportage of the latest intelligence” (p. 93).

In contrast, the commission’s analysis of the many post-9/11 failures of agency coordination and communication was not so even-handed. The NYPD, FDNY, NORAD, intelligence agencies, and the Executive Branch are presented in a forgiving social context, but not the FAA. For example, the Command Control of the NYPD and the FDNY were described as “understandably lacking in experience in responding to events of this magnitude” (p. 319), with due attention to the extraordinary conditions in which their heroic acts occurred. The FAA administration, similarly lacking in experience, was described as “weak” several times—an adjective not used in reference to other agencies—without equal recognition of the extraordinary conditions they faced (p. 352). FAA HQ and air traffic controllers were dealing with the discovery of four hijacked airplanes in little over an hour, with nearly 5000 other planes in the sky. I was in air traffic control facilities in New England doing ethnographic and interview research on air traffic control during 2000–2002, so I am aware of additional conditions that undermined FAA communication and coordination.

First, the clear, understandable tapes the commission heard of air traffic control communications with the hijackers were computer-enhanced and thus nothing like the transmissions that controllers, supervisors, and HQ struggled to understand that morning. Second, soon after 9:00 a.m., as one of the hijacked planes headed toward the Capitol, FAA HQ was evacuated, as were other federal offices. In the confusion and on the streets, communication was difficult. Third, after the Pentagon was hit at 9:38 am, Washington, DC, cell phones did not work, and standard phone lines were jammed due to heavy volume, increasing communication problems within the FAA and between the FAA and other agencies, including the Department of Defense. Finally, phone lines between all parts of the Air Traffic Control System at the operations level were recorded, but pre-9/11 no recorded lines existed at FAA HQ, so phone calls between FAA HQ and

407 the military were lost data, and interviews relating them were not included
408 in the report.

409 Failures, especially in bureaucracies, are to be expected in unprece-
410 dented situations. Mistakes were made. Praise is duly given in the report
411 for the “out of the box thinking” of the Operations Manager and controllers
412 at the FAA’s Boston Center who, upon recognizing two hijackings in their
413 airspace, dropped bureaucratic protocol to immediately call NORAD and
414 ground-stop all traffic in the region so no more planes could take off, and for
415 the FAA’s unprecedented order to land all aircraft, an unrehearsed action
416 controllers accomplished without incident (p. 31). However, more blame
417 falls on this agency than on other agencies whose responses to the attacks
418 were analyzed. In this regulatory failure model, the FAA becomes the op-
419 erator that erred.

420

Institutional

421 In contrast to the CAIB report and like the report of the Rogers
422 Commission, the 9/11 report does not locate cause in decisions made in the
423 top echelons of the U.S. government. The historic political and economic
424 decisions by this country’s leaders that answer the question our students
425 asked on September 12, “Why do they hate us?” are barely mentioned. In
426 Chapter 2, “The Foundation of the New Terrorism,” the central focus is
427 Usama Bin Ladin and his appeal to his constituents. The chapter is not only
428 historical but expressly sociological, extensively detailing Bin Ladin’s back-
429 ground, Muslim religious divisions, the desperate social and economic situ-
430 ation of Muslim countries, and al-Qaeda’s development and rise to power.
431 However, specific U.S. policies that were the motivation for al-Qaeda’s
432 September 11 attacks appear only in these few sentences:

433 [Bin Ladin] stresses grievances against the United States widely shared in the
434 Muslim world. He inveighed against the presence of U.S. troops in Saudi Arabia,
435 the home of Islam’s holiest sites. He spoke of the suffering of the Iraqi people as
436 a result of sanctions imposed after the Gulf War, and he protested U.S. support of
437 Israel (p. 49). . . .

438 Many Americans have wondered, “Why do ‘they’! hate us?” . . . America had at-
439 tacked Islam; America is responsible for all conflicts involving Muslims. Thus Amer-
440 icans are blamed when Israelis fight with Palestinians, when Russians fight with
441 Chechens, when Indians fight with Kashmiri Muslims, and when the Philippine gov-
442 ernment fights ethnic Muslims in its southern islands. . . . [Osama Bin Ladin] found
443 a ready audience among millions of Arabs and Muslims angry at the United States
444 because of issues ranging from Iraq to Palestine to America’s support for their coun-
445 tries’ repressive rulers. (p. 51)

The Social Shaping of Commission Reports

Nowhere else in the many chapters depicting the long incubation period leading up to September 11 does the report suggest that these historic U.S. policy decisions may have had something to do with it. Long-standing U.S. interests in oil in the Middle East are never mentioned.

Recommendations

The commission’s recommendations are consistent with its historical/war frame and the regulatory failure causal model. They support a “military–political strategy” to (a) attack terrorists and their organizations; (b) prevent the continued growth of Islamist terrorism; and (c) protect against and prepare for terrorist attacks (pp. 363–398).

On attacking terrorists and their organization, the report states that calling this a war is accurate because it requires armies to destroy terrorist groups and their allies, as well as the mobilization of national effort, but insists that the effort be “balanced” by “diplomacy, intelligence, covert action, law enforcement, economic policy, foreign aid, public diplomacy, and homeland defense” (p. 364). To prevent the continued growth of terrorism, the commission urges an ideological war using media and diplomacy to compete with the prevailing negative image of America. Buried in this discussion is a statement of support for the U.S. foreign policy that motivated the attacks, “That does not mean U.S. (policy) choices have been wrong. It means those choices must be integrated with America’s message of opportunity to the Arab and Muslim world” (p. 376). The United States will deploy that message using marketing strategies to convey American values, to establish itself as a moral leader and caring neighbor committed to treating others humanely and abiding by the rule of law. In the aftermath of Abu Ghraib, Guantanamo, the devastation of Afghanistan, and the war on Iraq, this is going to be a hard sell. The report’s recommendations to support antiterrorist governments, build cooperative relations, and reduce illiteracy by building libraries, schools, and exchange programs cannot compete with continuing U.S. actions that reinforce this negative image.

On protecting against and preparation for terrorist attacks, the central strategy is a reorganization of government to prevent another regulatory failure, improve deterrent capability, and thus prevent another terrorist attack (pp. 399–428). The proposed reorganization targets coordination and communication between agencies. It would eliminate the past fragmentation of intelligence by centralizing authority, integrating information, and promoting joint operational planning across formal agency boundaries. Recommendations include a National Counterterrorism Center to overcome the foreign–domestic divide; a new National Intelligence Director;

485 a network-based information-sharing system that crosses government
 486 agency boundaries; congressional oversight; and strengthening the FBI and
 487 “homeland defenders.” The changes are structural and technological but
 488 also cultural, calling for altering long-standing institutionalized practices of
 489 secrecy, autonomy, and independent action (pp. 416–419). The persistence
 490 of organizational-system effects and institutionalized cultural beliefs across
 491 the two NASA accidents shows that changing culture will be an enormous
 challenge, as the 9/11 Commission recognized.

493 COMMISSIONS, POLICIES, AND CATASTROPHES

494 In the wake of surprising, destructive, and disastrous events, fact-
 495 finding commissions are constituted to provide an official explanation of
 496 what happened and why it happened, and to assign moral responsibility
 497 (Tilly, 2006; Zegart, 2004). Comparing these reports shows their social shap-
 498 ing. The frames are not neutral but political in effect. They influence the
 499 causal findings and, in turn, the policy recommendations.

500 In all three cases, the frame was set early: the Rogers Commission
 501 adopted NASA’s accident investigation frame; the CAIB’s sociological
 502 frame and the 9/11 Commission’s historical/war frame were decided in-
 503 formally by Gehman and Zelikow, respectively, in discussion with one or
 504 two others before the full commissions were assembled. The full process—
 505 internal debates and how report contents were negotiated—may never be
 506 known. However, commission composition appeared to matter. The CAIB
 507 located causal responsibility with upper echelon government officials; it was
 508 headed by a retired admiral known as a critic of government and composed
 509 primarily of safety heads automatically appointed by virtue of the safety
 510 office they held. Neither the Rogers Commission nor the 9/11 Commis-
 511 sion allocated responsibility to the White House and Congress: the former
 512 commission was headed by a Republican political appointee, and several
 513 members had previous connections with NASA; the latter was headed by a
 514 Republican political appointee and composed of a bipartisan group of legis-
 515 lators and other government officials, who may not have wanted to attack a
 516 sitting president and U.S. foreign policy while at war (Mednicoff, 2005:113–
 517 114).

518 By focusing on regulatory failure as the cause, the 9/11 Commission
 519 report deflects attention from the institutional level—the historic policy
 520 decisions by political leaders that generate hatred of the United States
 521 among Muslims, discussed earlier. No overt criticism is levied at President
 522 Bush. The report is critical of some current U.S. foreign policy, although
 523 these criticisms are more implicit than explicit: the commission investigated

The Social Shaping of Commission Reports

possible links between Saddam Hussein and al-Qaeda and found none; it recommended a coalition policy for the Middle East, a reversal of current administration policy. The regulatory failure model also deflects attention from failures in scanning and interpreting available intelligence. Although intelligence agencies had the same problems interpreting early warning signs as in the two NASA examples, cultural constructions of risk behind these failed understandings at the micro-level are not a focal point. The commission observed early in the report that it is hard to mobilize a defense when a problem is defined as minor, but it did not recommend strategies to prevent missed signals in the future, as did the other two reports. The recommendation to integrate information across all agencies will succeed in pooling intelligence under the purview of one coordinating authority, but having more information and sharing it only increase the problems of interpreting and classifying risk. What are the mechanisms by which they will systematically separate the wheat from the chaff?

What about the reorganization of government as a strategy to correct regulatory failure in the future? Throughout, the commission was appropriately concerned about the unintended consequences of its recommendations: for example, it warned that bestowing greater powers on government risks incursion into individual privacy and rights (pp. 393–394). We must be concerned about additional unintended consequences. Will centralizing authority and information interfere with the decentralization necessary to respond to specialized problems that are best dealt with by individual agencies? Will cultures persist despite structural changes? What will be the effect of structural changes that add another layer of complexity to an already complex intelligence structure, in the face of social science evidence that increasing structural complexity tends to increase the ways that organizations can fail? Even if changes are carefully implemented, how will we judge their effectiveness prior to another attack? How effective can reorganization of government be when root causes in U.S. policy and international relations are not put on the table for discussion?

The commission observed that Cold War preparedness was for one kind of enemy and that the failure to deter on September 11 demonstrated that agencies needed to change to meet new forms of threat. The commission noted that, since the last budget adopted before 9/11, “total federal spending on defense (including both Afghanistan and Iraq), homeland security, and international affairs rose more than 50%. . . . [T]he U.S. has not experienced such a rapid surge in national security spending since the Korean War” (p. 361).

History repeats itself. This money has gone to defend against one kind of attack by one enemy: Islamist terrorism. As I write, in the aftermath of hurricane Katrina’s devastation of New Orleans, the news is rife with

566 criticism of the lack of government preparedness and the slow, inadequate,
 567 and poorly coordinated federal, state, and local response that contributed to
 568 nearly inconceivable suffering and loss. Further, the pattern of social causes
 569 obvious in NASA's two accidents and the terrorist attacks on the United
 570 States recurred: a long incubation period, with early warning signs about de-
 571 ficiencies in levee engineering ignored, regulatory failure, and institutional
 572 causes located in administrative budgetary and political decisions. Home-
 573 land Security and government efforts to improve agency coordination and
 574 communication after the September 11 terrorist attacks are being harshly
 575 criticized. Correctly, the 9/11 Commission report acknowledged that we can
 576 never predict and defend against all contingencies, but argued that U.S. citi-
 577 zens "should expect that officials will have realistic objectives, clear guid-
 578 ance, and effective organization. They are entitled to see some standards
 579 for performance so they can judge, with the help of their elected represen-
 580 tatives, whether the objectives are being met" (p. 365). This assessment is
 581 still valid.

REFERENCES

Jervis, Robert L.

- 1970 *Logic and Images in International Relations*. Princeton: Princeton University Press.
 1976 *Perception and Misperception in International Politics*. Princeton: Princeton University Press.

Mednicoff, David M.

- 2005 "Compromising toward confusion: The 9/11 Commission report and American policy in the Middle East." *Contemporary Sociology* 34:107-15.

Tilly, Charles

- 2006 *Why?* Princeton, NJ: Princeton University Press.

Vaughan, Diane

- 1996 *The Challenger Launch Decision: Risky Technology, Culture, and Deviance at NASA*. Chicago: University of Chicago Press.
 2006 "NASA revisited: Theory, analogy, and public sociology." *American Journal of Sociology* IV, September, forthcoming.

Zegart, Amy B.

- 2004 "Blue ribbons, black boxes: Toward a better understanding of presidential commissions." *Presidential Studies Quarterly* 34:366-393.