Bennett Institute for Public Policy Cambridge

WORKSHOP REPORT

Policy Lessons from Catastrophic Events

UNIVERSITY OF CAMBRIDGE

WORKSHOP REPORT

POLICY LESSONS FROM CATASTROPHIC EVENTS

AUTHORS: Diane Coyle, Gill Kernick, Owen Garling, Martin Stanley, Flora Cornish, David Wales, David Slater

CONTENTS

Published: May 2020
Workshop held on 25 February 2020 at the University of Cambridge, hosted by the Bennett Institute for Public Policy

This work was partially funded by the ESRC through the University of Cambridge Impact Acceleration Account

Publication from the Bennett Institute for Public Policy, Cambridge
www.bennettinstitute.cam.ac.uk

Bennett Institute for Public Policy Cambridge

UKRI Economic and Social Research Council

UNIVERSITY OF CAMBRIDGE

Policy Lessons from Catastrophic Events

Preface

We did not need the coronavirus pandemic to teach us that in the interconnected, technically complex modern world it is easy to make policy mistakes and hard to act on lessons from the past. Still, the current crisis makes it more pressing than ever to consider why it is so hard to learn and apply the policy lessons from past catastrophes and crises.

In crisis response, such as the current context in so many countries, decision-makers face a torrent of often-conflicting advice from different areas of expertise, not synthesised, and sometimes developed in readiness for a different kind of context. One of the elements making for policy responses that later seem clearly inadequate is the regulatory framework. This sits alongside other areas affecting decision-making such as the adequacy of advance planning, information flows, the institutional context and political considerations.

Regulations in technically challenging and safety-critical domains, such as construction, power generation or mining, have accumulated piecemeal over many years. This is often the result of policy reactions to specific events or perceived needs in complex environments. A common criticism is that this accumulation of regulation does not achieve its intended aims, while imposing a large regulatory burden, just as the proliferation of advice in a crisis imposes a large attention burden. This suggests more effective regulation with greater efficiency might be possible, but there are substantial barriers to change. These barriers are high enough, in fact, that there has been a failure on the part of policymakers and regulators to learn and implement the lessons from successive crises – such as fires in tower blocks of the kind that tragically consumed Grenfell Tower in west London in 2017. And, as Bennett Institute research affiliate and former Ofcom board member Steve Unger has written for us,[1] it is hard to sustain attention on such issues in government, once an immediate crisis has passed. A combination of optimism bias and the limitations of attention for complicated issues militate against sustained policy focus on them.

This constant failure means there is an abiding need to think more systemically about regulating and managing complexity, and yet – despite major catastrophes like the Deepwater Horizon explosion or the Grenfell Tower fire – this imperative is not being addressed. And research into policy and policy failures tends to focus on analysis rather than implementation and enforcement. The Bennett Institute was therefore pleased to host with Gill Kernick of JMJ Associates an ESRC-funded workshop bringing together people from different domains of safety practice and research backgrounds to discuss the challenge. Could an interdisciplinary group with different kinds of experience start to

[1] https://www.bennettinstitute.cam.ac.uk/blog/why-we-need-new-office-black-swans/

identify the barriers and even generate some ideas for shifting them? The challenges the group discussed have only become more urgent in subsequent weeks.

One starting point is accountability. Persistent failure to learn appropriate lessons from all sorts of previous tragedies seems to have been a problem for several decades. For instance the Institute for Government's 2017 report on public inquiries found that of the 68 public inquiries that had taken place since 1990, only six had been fully followed-up by select committees to see what government did as a result.[2] Checking whether inquiry recommendations have been implemented seems an obvious starting point.

Our day of discussion led to several areas of consensus, concerning both the failure to learn and ideas for ways forward. For example, organisational cultures may focus on satisfying regulations rather than delivering outcomes. In some policy environments there is a 'blame game' for political or legal reasons.[3] Experts and decision-makers lack cognitive diversity, tending to come from similar social and professional backgrounds. Rule by rule decision making is unsuited to increasingly complex social and technical environments.

The participants' views about potential ways forward, including building in following up on recommendations, are also summarised in the overview. Some of those who took part in the workshop have contributed more detailed perspectives, with suggestions for how we might learn lessons from the past. This is a debate we intend to sustain and take forward in the post-pandemic environment, building on the workshop; and we hope to hear from others who would like to contribute.

Diane Coyle
Bennett Professor of Public Policy

[2] https://www.instituteforgovernment.org.uk/publications/how-public-inquiries-can-lead-change
[3] https://press.princeton.edu/books/hardcover/9780691129952/the-blame-game

Introduction

'We do not know where or when the next global pandemic will occur, but we do know that it will take a terrible toll, both on human life, and on the global economy. It may even cause political instability.'

Dr Tedros Adhanom Ghebreyesus
Director-General of the World Health Organisation, 2018[4]

The need to ensure we learn policy lessons from catastrophic events could not be more relevant as we find ourselves in the midst of a global pandemic with, as yet, unknown consequences.

Professionally I work in high hazard industries partnering organisations to develop their leadership capability and culture to prevent major accidents. From 2011 to 2014 I lived in Grenfell Tower. Seven of my former neighbours died in the fire in June 2017. As I watched it burn, I promised to make sure we learned.

I soon discovered that to fulfil this promise, I had to move beyond a focus solely on Grenfell to explore our chronic inability to effectively learn from catastrophic events in general.

A 2013 Cabinet Office review of persistent lessons from major accidents identified common failures, including no system to ensure that lessons were learned and staff taught; lack of leadership; absence of a no blame culture; and previous lessons/reports not acted upon.[5]

Prior to Grenfell, we knew the dangers of external facade fire spread and breaking of compartmentation; we knew the dangers of stay put and the importance of contingency evacuation plans; we knew the dangers of giving those trapped false hope that firefighters would reach them.[6]

Prior to COVID-19 we knew the danger of a pandemic. Bodies such as the World Health Organisation[7] and World Economic Forum[8] have for years warned that we are unprepared. We knew the capacity of health services would be challenged; we knew the supplies of ventilators would be critical. The UK government knew its preparations around PPE supplies were insufficient.[9]

[4] https://www.who.int/dg/speeches/2018/pandemic-free-world/en/
[5] https://www.regulation.org.uk/library/2013-Pollock_Review.pdf
[6] https://www.bennettinstitute.cam.ac.uk/blog/heroes-villains-narratives-displacing-our-ability-/
[7] https://www.who.int/dg/speeches/2018/pandemic-free-world/en/
[8] http://reports.weforum.org/global-risks-report-2020/shareable-infographics/
[9] https://www.theguardian.com/politics/2020/mar/29/uk-strategy-to-address-pandemic-threat-not-properly-implemented

A pandemic as lethal as coronavirus has, for the past 13 years, been deemed a "level 5" threat. The only other level 5 threat has been large-scale biological or nuclear attack . . . The risk of a pandemic in that time was deemed to be between one-in-20 and one-in-two.

'Why weren't we ready?', New Statesman, 20 March 2020[10]

The desire to hold a multi-disciplinary enquiry was born from wanting to understand why we persistently don't learn lessons: from the realisation that this failure was not technical in nature, and that there was no single expert who had the answer; that this was an adaptive challenge and the solutions lie somewhere in the spaces between our current tramlines of thought.

The workshop

I am indebted to the ESRC for funding and the Bennett Institute for hosting the workshop and publishing this report.

The workshop brought together a range of different perspectives including academics, lawyers, regulators, civil servants and business owners. We held a series of enquiries around five broad areas:

- **Foundational structures** and governance mechanisms intended to protect against catastrophic events (e.g. legal and regulatory frameworks);
- **Behavioural elements** designed to actively prevent and / or respond to failure (e.g. inspections and inquiries);
- **Relational connections** that either disrupt or maintain the status quo (e.g. cross-silo thinking and re-balancing power);
- **Contextual narratives** that inhibit learning (e.g. fixed mindsets, bias and lack of diversity); and
- the role of **Leadership**.

The key themes that emerged from the workshop are presented in the following section, followed by perspectives and reflections from some participants.

My personal experience of the day was moving. The kernel of the idea was born nearly two years ago, I'd waited so long and had no idea how it would go. On reflection three issues stood out for me.

[10] https://www.newstatesman.com/politics/uk/2020/03/why-weren-t-we-ready

First, it was magical watching people engaging with one another, with interest and curiosity. It reaffirmed my belief in the importance of diverse and multi-stakeholder enquiry.

Second, and linked to the first, was the importance of creating safe spaces for these kinds of conversations. We'd worked hard to do this for the workshop, making some tough decisions about not inviting certain 'voices' that are critical to this debate, as we felt it would inhibit conversation. The lack of, and need for, forums for safe, open conversation was raised numerous times during the day.

Finally, I was left hopeful by the breadth of interest and passion for change.

My desire is that the workshop and this report spark further enquiry. Grenfell highlighted the cost of not learning. Watching COVID-19 unfold reaffirms the devastating political, social, economic and human impact of this failure.

Gill Kernick
Master Consultant
JMJ Associates

Workshop Overview

The focus of this ESRC-funded workshop in February 2020 was on why it is so difficult for policymakers and public bodies to put into practice the lessons learnt from catastrophic events, in particular the Grenfell Tower fire. On 14 June 2017, this devastating tragedy killed 72 people - the largest loss of life in a residential fire in a century.

The fire highlighted a chronic inability to learn. Eighteen years before Grenfell, on June 11 1999, a fire engulfed eight floors of a 14-storey tower block at Garnock Court in Irvine, North Ayrshire, killing one resident and injuring four others. In 2000, Westminster Council's Environment, Transport and Regional Affairs Committee carried out an inquiry that highlighted the risks of fire spreading through external cladding systems. The 2009 Lakanal House fire in Camberwell, London killed six people. The inquests into their deaths highlighted issues that were factors in Grenfell eight years later.

The multiple failed opportunities to learn, the extent of bad practice and the lack of meaningful change nearly three years on from Grenfell indicate the need to question the traditional policy and practitioner responses to such events.

In February 2020, the Bennett Institute for Public Policy at the University of Cambridge hosted a cross-disciplinary, multi-stakeholder workshop to identify key barriers to effective learning. Conducted under the Chatham House Rule, invitees included civil servants, regulators, emergency responders, academics, industry safety experts, and representatives from policy think tanks.

This report begins by outlining the findings of the workshop and setting out the reasons why we do not learn from catastrophic events, and then proposes some responses that could enable us to learn. The final sections of the report offer some personal reflections on these themes from workshop attendees. We would like to thank the workshop attendees for their contributions at the workshop and notes of the workshop which have subsequently been provided, and on which this section is based.

Next Steps

The workshop and report have brought together a range of different stakeholders with a common interest in a shared problem. To build on the momentum and connections created, we will continue to

- curate the emerging network of stakeholders, including identifying how the group could contribute to the understanding of the coronavirus crisis.
- create ‘safe spaces’ for different stakeholders to come together to discuss shared problems. We are keen in future discussions to widen the range of voices involved.
- share the knowledge that is being created.

If you are interested in getting involved, please get in contact with us.

What do we learn from catastrophic events?

Focus on regulatory requirements rather than doing what is right for people

Workshop attendees agreed that the focus of industry on meeting its formal regulatory requirements was one of the main reasons for not learning from catastrophic events. There needs to be a **culture shift** to a focus on doing the right thing for the people who may be affected. Attendees identified a gap between the regulatory requirements and the wider expectations of members of the public. Members of the public expect that regulations are designed to keep them safe. For example, residents of a tower block may assume that both they and their property would be kept safe in the event of a small kitchen fire (which triggered Grenfell Tower). Likewise, when patients are admitted to hospital, it is in the assumed knowledge that they will be kept from harm.

> **Example:** Step Change in Safety was founded in 1997 to help create this culture shift in the oil and gas industry. The initial aim was to reduce the UK offshore injury rate by 50 per cent. Since 2014, Step Change in Safety has become an independent tripartite organisation representing the workforce, regulators and employers with the aim of making the UK the "*safest place to work in the worldwide oil and gas industry.*"[11]

Participants questioned the ability of industry to self-regulate and challenge itself if it knows that there are risks in how its members could be operating[12]. They agreed that the construction industry did self-regulate, but that there was always a concern that in a competitive market it would take only one business looking to gain an advantage to undermine any approaches to self-regulation.

The primary focus of businesses on gaining competitive advantage and satisfying their key stakeholders such as shareholders can lead to a lack of empathy with those affected by catastrophic events. Industry needs to show a **greater empathy with those who may be affected** if things go wrong. It cannot care just about competitive advantage and commercial interests. The ongoing public inquiry into the Grenfell Tower fire is vividly demonstrating what happens if the focus is not on people.

> **Example:** The materials testing industry provides several examples of some issues with this focus on regulation rather than people.
>
> - The testing industry is a key part of the regulatory system, but one that could be driven by its own interests following its privatisation in 1997.[13] [14]

[11] https://www.stepchangeinsafety.net/
[12] See, for example, https://www.insurancejournal.com/news/international/2017/06/27/455827.htm
[13] See https://openresearch.lsbu.ac.uk/item/868q4
[14] https://www.insidehousing.co.uk/news/news/government-culpable-for-lack-of-action-post-lakanal-fire-says-mp-59885

- Testing can also take place at too small a scale. For example, tests of cladding materials take place on a scale that does not reflect how the materials are used in practice. Equally 'desktop studies' for insulation and cladding systems are used.[15]
- The costs of testing will proportionately be more of a burden on smaller-scale developments.

Differing perceptions

A **lack of cognitive diversity** can reduce the ability to learn from and prevent catastrophic events with 'leaders' often coming from similar social and professional backgrounds. A recent survey by Inside Housing[16] (see table below) found that whilst there had been a slight increase in female and BME board members between 2017 and 2019, there had been only a small change in the number of board members identifying as LGBT or living with a disability. The survey report also noted that this was from a small, self-selecting sample which was not representative of the whole sector.

Question	2018	2019
What proportion of your board members are male / female?	63.3% / 36.7%	58.9% / 41.1%
What proportion of your board members identify as BME?	6.7%	13.6%
What proportion of your board members identify as LGBT?	2.5%	2.4%
What proportion of your board members identify as living with a disability?	4.3%	4.8%

A lack of diversity could lead to 'group-think' and an inbuilt bias towards optimism when identifying and mitigating risks and reduce the **different perceptions of risk** that a more diverse group might bring.[17] The group wondered whether in a male-dominated industry like the construction industry, risks were managed differently from other industries with a more diverse leadership and workforce.[18]

Finally, it is important to understand whether there is an appetite for change. If there is no appetite for change, then it is unlikely that change will ever happen. Attendees

[15] Judith Hackitt's interim report included a recommendation to significantly restrict the use of these assessments in order to ensure that they are only used in a responsible and appropriate way by competent people. See https://www.gov.uk/government/publications/independent-review-of-building-regulations-and-fire-safety-interim-report

[16] https://www.insidehousing.co.uk/insight/insight/the-housing-diversity-survey-2019-64195

[17] See https://hbr.org/2013/02/do-women-take-as-many-risks-as

[18] https://www.researchgate.net/publication/233614230_Gender_race_and_perceived_risk_The_'white_male'_effect

suggested that the appetite for change could be understood by considering the different viewpoints of the stakeholders involved in the system. This approach enables us to ask questions about who holds responsibility and power. Deepening our understanding of those with power helps us to understand their motivations and behavioural drivers and to get under the skin of why people act in ways that they do.

Lack of diverse voices

There was agreement at the workshop that a lack of involvement of frontline staff and users / customers reduced the ability to learn. These groups provide a valuable source of detailed information which goes to waste if ignored by decision-makers.

> **Example:** Step Change in Safety involve frontline staff in their Leadership Team meetings. *"Since 2011, different members of the group of* [elected safety representatives] *have attended every Leadership Team meeting and speak on behalf of their colleagues on the issues which generate interest or cause concern. Their presence at these meetings is invaluable and ensures our activities are fully aligned with the workforce."*[19]

Before the catastrophe, Grenfell Tower residents' concerns were not listened to.[20] The tacit knowledge of those at the front line is critical for safety. Residents tend to know what the problems are with their building. They are the real experts on how a building works. We lose the opportunity to learn from their lived experience by not listening to them.

Before Grenfell there was no proper connection between community services and the community. After Grenfell the whole social eco-system of the area has changed. The social order has not returned to how it was, and it is still in an environment conducive to change. This shift can be harnessed to drive change rather returning to 'business as usual'.

The opportunity for change can also be seen nationally. For example, the ban on combustible materials brought in by Dominic Raab in December 2018 was driven by a change in national feeling following his appearance on BBC Question Time.[21] It could be argued that this ban has had the biggest impact on the construction industry in 30 years.

[19] https://www.stepchangeinsafety.net/about/
[20] https://www.bbc.co.uk/news/stories-42072477
[21] See https://www.bbc.co.uk/programmes/p067h1sy

Failure to take opportunities to learn

Despite there being plenty of opportunities to learn from previous events, the group felt that these opportunities were not taken. At the conclusion of the inquests into the deaths following the Lakanal House fire, a Rule 43 Letter[22] was sent by the Coroner to the Secretary of State for Communities and Local Government reporting a number of concerns that had been raised during the inquest.[23] However, these recommendations had not been taken forward by successive British governments.[24]

This did not need to be the case. Both the Welsh and Scottish devolved governments responded to the recommendations made by the coroner in the inquest into the deaths at Lakanal House by changing regulations. For example, Welsh legislators enacted new regulations which provide that all new and changed use domestic premises must have an automatic fire suppression system installed which controls and extinguishes fires without human intervention.[25]

It was suggested that the failure to change in Britain may have been because 'political leaders' did not want to be put in a position to fail and so they tend to identify seemingly straightforward 'fixes'. The natural response of individuals and organisations was to go into defensive mode and think that the scrutiny and focus of the Inquest was on them rather than the system. The fragmentation and increasingly complex make-up of the construction industry (and other industries) can also mask the fact that things need to change.

Near misses and examples of best practice are opportunities to learn. What constitutes a near miss needs a clear definition and a shared understanding. The Health and Safety Executive's definition of a near miss is "*an event not causing harm, but* [that] *has the potential to cause injury or ill health*."[26] In other words, a broad definition. The workshop heard examples of the use of a higher-threshold definition of a near miss, which had led to concerns being ignored. This highlights the importance of a common understanding across all parts of the system.

> **Example:** To ensure that the healthcare industry could learn consistently, Healthcare Improvement Scotland have developed a national framework for the reporting of adverse events. The framework "*seeks to ensure that no matter where an adverse event occurs in Scotland:*

[22] Paragraph 7 of Schedule 5, Coroners and Justice Act 2009, provides coroners with the duty to make reports (formerly known as Rule 43 Letters) to a person, organisation, local authority or government department or agency where the coroner believes that action should be taken to prevent future deaths. Recipients have 56 days to respond to the coroner following receipt of a Rule 43 Letter.
See https://www.judiciary.uk/related-offices-and-bodies/office-chief-coroner/https-www-judiciary-uk-subject-community-health-care-and-emergency-services-related-deaths/

[23] https://www.lambeth.gov.uk/elections-and-council/lakanal-house-coroner-inquest

[24] https://fullfact.org/law/fire-safety-regulations-has-government-delayed-reviewing-them/

[25] https://www.newlawjournal.co.uk/content/grenfell-tower-different-perspective

[26] https://www.hse.gov.uk/toolbox/managing/accidents.htm

- *the affected person receives the same high-quality response*
- *any staff involved are treated in a consistent manner*
- *the event is reviewed in a similar way, and*
- *learning is shared and implemented across the organisation and more widely to improve the quality of services*."[27]

Attendees shared a concern that lessons learnt were not disseminated, shared or understood by other sectors. The group questioned whether there were appropriate incentives in place to share information across organisations or whether commercial concerns limit our willingness to admit mistakes and share learnings.

Increasing complexity and a reliance on simple fixes

The construction industry has moved from one using a small number of well understood materials to one using a complex mix of newer materials. The Whole Building Design Guide gives the example of an exterior wall assembly that "*contains materials that keep the rain and wind out, thermally insulate the inhabitants from exterior temperatures, structurally support the building and the associated enclosure system, and provide desired interior and exterior finishes. In addition, windows, doors, vents, and other apertures connect to the interior and exterior of the building*."[28] To manage this complex mix, the industry has become increasingly fragmented with specialist firms involved in specific aspects of the construction process.

This increase in complexity can also be seen in how policy is developed and managed, with responsibility for different policy areas falling across different layers of government authority. A lack of join-up between these different layers has also been a contributory factor.

The workshop identified several related consequences of an increase in complexity:

- A complex operating environment leads to a complex regulatory environment with different materials and stages of the construction process governed by different regulations. This can lead to the layering of regulations on top of one another.
- There is an increased risk that the complicated interdependencies between the different elements of the construction process will lead to accountability and responsibility falling between the cracks.
- Changes in the construction industry and the fast-paced development of new building materials can also lead to knowledge asymmetries between the regulator and industry, with regulators struggling to keep up with changes in the industry.

[27] http://www.healthcareimprovementscotland.org/his/idoc.ashx?docid=968c1d9d-7439-41d7-83d5-531afebaebcc&version=-1

[28] https://www.wbdg.org/resources/materials

- Finally, a complex operating environment also leads to a high turnover of businesses.[29] For example, cladding companies, on average, have a lifespan of only seven years. This high turnover of businesses will also lead to a loss of organisational (and sectoral) knowledge.

Coupled with the increase in complexity, the belief in 'simple fixes' and 'silver bullet' solutions can also hinder the ability to learn. In the aftermath of events there is often a call for a simple fix to be prioritised so that progress is seen to be being made. These simple fixes can have unintended consequences, including masking other more systemic problems that remain unresolved.[30]

Organisational systems, processes and cultures

In the aftermath of catastrophic events and following any subsequent inquiries, the group considered that there can be a lack of accountability or follow through on the implementation of any recommendations made. In 2017, the Institute for Government found that of the 68 inquiries that had taken place since 1990, only six had received a full follow-up by a select committee to ensure that government has acted. [31]

There is no independent process of accountability for ensuring recommendations are implemented and effective. In addition, there is a high turnover of government ministers responsible for the implementation of actions arising from inquiries. For example, in the almost three years since the Grenfell Fire there have been five different housing ministers in post:[32]

Housing Ministers since Grenfell	
Alok Sharma	June 2017 – January 2018
Dominic Raab	January 2018 – July 2018
Kit Malthouse	July 2018 – July 2019
Esther McVey	July 2019 – February 2020
Christopher Pincher	February 2020 – present

[29] See, for example https://www.building.co.uk/focus/cladding-sector-think-youve-got-it-covered/5090763.article, published in November 2017 (ie five months *after* the Grenfell Tower fire)
[30] See, for example https://www.luxreview.com/2019/05/20/grenfell-spotlight-on-cladding-obscures-emergency-lighting/ and https://inews.co.uk/news/uk/grenfell-tower-fire-inquiry-focus-individual-fighters-821716
[31] https://www.instituteforgovernment.org.uk/publications/how-public-inquiries-can-lead-change
[32] https://www.bigissue.com/latest/we-looked-at-the-records-of-the-housing-ministers-in-office-since-2010/

The **political revolving door** can lead to trusted relationships that have been developed being lost when ministers move on. As Housing Minister, Alok Sharma MP listened to social housing tenants as part of the consultation for the Green Paper on Social Housing. Almost 1,000 tenants were able to share their views with ministers at 14 events across the country.[33] However, following a ministerial re-shuffle, these relationships were lost.[34]

The workshop attendees identified **organisational culture** and **knowledge** as barriers to learning. Threat and blame cultures can stifle innovation and change. Poorly designed target cultures can also contribute to the development of threat and blame cultures. When things do go wrong it can lead to a lack of trust rather than a commitment to learn from what went wrong.

Turnover of staff in key roles, or reductions in staffing levels, can lead to the loss of organisational knowledge. This is particularly relevant in the case of the institutional knowledge of checks and balances. These structures and processes can continue operating without a clear understanding of why they exist, which can lead to a lack or avoidance of responsibility.

Finally, the processes in place to plan, such as **economic and financial appraisals,** also contribute to the difficulty to learn. Often the focus of appraisals was purely on short-term economic value rather than taking a longer-term, more person-centred approach and a wider view of value. Decisions taken in isolation in organisational silos reduce the opportunities to take a more systemic view of their intended and unintended consequences.

[33] https://www.gov.uk/government/news/social-housing-green-paper-a-new-deal-for-social-housing

[34] See https://www.insidehousing.co.uk/insight/insight/what-alok-sharma-was-really-told-by-tenants-54149

What can be done?

Ensure clarity of purpose

Ensuring that there is a **clarity of purpose and shared sense of endeavour** will provide a focus for the many different agents involved. There was a consensus that the key question that organisations need to ask is '*have we made things safe for people?*' To support this, regulations should focus more on the **needs of the public** rather than on regulating the individual elements of what is an increasingly complex system. Monitoring and inspection systems should also focus on these broader questions rather than just ensuring compliance with individual parts of the whole. The group felt that increasing complexity and fragmentation mean no person or organisation holds an understanding of the whole end-to-end experience, with perhaps the exception of the 'user'. The use of human-centred design (HCD) approaches[35] [36] in developing regulations could ensure that the perspective of the user was considered in all stages.

> **Example:** The New Zealand Building Code "*states how a building must perform in its intended use rather than describing how the building must be designed and constructed. In other words, it is a performance-based Building Code*."[37] The building code sits alongside a Construction Sector Accord which sets out a shared commitment between government and industry to transform the construction sector.[38]
>
> As well as setting out a series of shared goals, the Accord also outlines the outcomes for New Zealanders and states that: "*Achieving our shared goals will deliver benefits across the sector and for all New Zealanders*" including "*safe, healthy and durable homes,* [and] *buildings and infrastructure that support the wellbeing of our communities.*"[39]

Develop a culture and processes for learning

There needs to be a **focus on learning not blame**.[40] As Gill Kernick has argued in a blog for the Bennett Institute, "*a blame narrative considers who's at fault, is highly personal and assumes that removing the individual(s) will solve the problems. However, simply replacing someone with another person operating in the same context will likely lead to little change or learning.*

---

[35] See https://www.designkit.org/human-centered-design
[36] https://www.bennettinstitute.cam.ac.uk/blog/centering-human-design/
[37] https://www.building.govt.nz/building-code-compliance/how-the-building-code-works/
[38] https://www.constructionaccord.nz/
[39] https://www.constructionaccord.nz/the-accord/
[40] See also: Hood, C. 2010 *The Blame Game: Spin, Bureaucracy, and Self-Preservation in Government*. Princeton University Press. 2010.

An accountability narrative instead considers what structures (e.g. job roles and assurance mechanisms) were in place and how these were fulfilled or not."[41]

> **Example:** The investigation of air accidents has seen a learning culture supported through safety recommendations being made "*with the intention of preventing accidents or incidents and which in no case has the purpose of creating presumption of blame or liability for an accident or incident.*"[42]

Developing **proper systems for investigating near misses** will help us all to learn where things could go wrong. Industries can learn lessons from the medical profession which has developed a best practice approach to investigations. This approach ensures that there is a consistent approach to investigations and avoids the development of a blame culture.

> **Example:** The NHS Just Culture Guide[43] notes that:"*The fair treatment of staff supports a culture of fairness, openness and learning in the NHS by making staff feel confident to speak up when things go wrong, rather than fearing blame.*
>
> *Supporting staff to be open about mistakes allows valuable lessons to be learnt so the same errors can be prevented from being repeated. In any organisations or teams where a blame culture is still prevalent, this guide will be a powerful tool in promoting cultural change."*

Often our processes for learning focus on what has gone wrong or what could go wrong. Our focus is on risk management. However, the workshop considered that **learning can also come from reflecting on what has gone right** and through celebrating good practice. Learning cultures need to develop a balance between studying what went right ('safety') as well as what went wrong ('not safety').

Ensure recommendations are not lost[44]

Members of the workshop felt that **public inquiries should have a life beyond the publication of a final report**. This could be by running a series of seminars or

---

[41] https://www.bennettinstitute.cam.ac.uk/blog/heroes-villains-narratives-displacing-our-ability-/

[42] https://www.gov.uk/government/publications/what-is-a-safety-recommendation/what-is-a-safety-recommendation

[43] https://improvement.nhs.uk/resources/just-culture-guide/

[44] These suggestions echo the recommendations made by the Institute for Government, which were for:

- "*government to systematically explain how it is responding to inquiry recommendations*
- *select committees to examine annual progress updates from government on the state of implementation*
- *public inquiries to publish interim reports in the months, rather than years, after events expert witnesses to be involved in developing the recommendations of inquiries.*"

See https://www.instituteforgovernment.org.uk/publications/how-public-inquiries-can-lead-change

consultations to gain feedback on implementation, through to providing select committee chairs with the powers to re-convene inquiries so that those responsible for implementing recommendations are held accountable.

> **Example:** In the final report of his Inquiry, Sir Michael Bichard announced "*that I shall reconvene the Inquiry in six months' time to review publicly the progress that has been made against these various recommendations. I am aware that because of the speed with which we have worked, some of the recommendations need further detailed work, but I am confident that all those who have a part to play will respond urgently.*"[45]

The US National Transportation Safety Board (NTSB) was given as a possible model for a new body to provide ongoing support to inquiries. In taking a fact-based approach to investigations, the NTSB has been able to investigate accidents and issue safety recommendations aimed at preventing future accidents.[46] The NTSB model has also been proposed as a model for regulation in other industries, including the financial sector.[47]

Create Safe Spaces

The **creation of safe spaces or forums** to share and experience learning, and effective practice could make a difference. To ensure that they did not replicate existing silos any safe spaces should be led as a cross-disciplinary forum involving a range of different stakeholders.

Attendees at the workshop see a **role for leaders to hold a space where people can bring their concerns, provide advice and empower individuals.** A safe space could also be a mechanism to develop a new shared narrative along with a more compassionate leadership approach.[48]

A possible issue with this approach is that it relies on voluntary participation. You cannot force someone to create safe spaces. For example, the construction sector as a whole might not want to engage in creating safe forums for learning and sharing. If a sector or industry-wide approach is not agreed, you could start simply, for example, by sharing learnings.

---

[45] https://dera.ioe.ac.uk/6394/1/report.pdf

[46] https://www.ntsb.gov/Pages/default.aspx

[47] See Fielding, Eric and Lo, Andrew W. and Yang, Jian Helen, The National Transportation Safety Board: A Model for Systemic Risk Management (November 14, 2010). Available at SSRN: https://ssrn.com/abstract=1695781 or http://dx.doi.org/10.2139/ssrn.1695781

[48] Compassionate leadership in practice means "*leaders listening with fascination to those they lead, arriving at a shared (rather than imposed) understanding of the challenges they face, empathising with and caring for them, and then taking action to help or support them.*" See https://www.kingsfund.org.uk/blog/2019/05/five-myths-compassionate-leadership

Develop a complexity-informed view

In acknowledging the increasing complexity of the world, attendees agreed that a **whole system view** needs developing. This view will need to include a range of different viewpoints including frontline staff and those members of the public who are affected. Those people holding power in the system need to trust members of the public to come up with solutions to problems. It is likely that 'users' are the only group who will experience, and therefore truly understand, the consequences of how the system operates.

There also needs to be **a shift in power and governance** arrangements as they are not keeping up with the ever-changing complexity of the world. A function of this changing complexity is that we can no longer rely on government to drive change. Issues are no longer simple and hierarchical, and the old frames of leadership no longer fit.

To support this approach there needs to be an investment in customer service approaches. Properly listening to people and what services mean to them makes it very difficult to accept the norm and avoid the desire to change. This can create groundswell. Alongside this, mechanisms for reporting that enable everyone to engage are important.

Developing a sense of chronic unease and understanding the risks associated with low probability, high impact events

The expression '**chronic unease**' is used by industries such as the oil and gas industry to describe the state of mind required to "*avoid complacency about major accidents* . . . [that] . . . *rarely happen.*"[49] Chronic unease is generated by asking the question *"How would it look if a serious incident happened?"*.[50] For any circumstances where there may be a risk of low probability, high impact incidents happening, stakeholders need to develop a sense of chronic unease. Leaders who practice chronic unease in their work learn to think flexibly, not jump to conclusions, encourage employees to speak up, listen to others, be receptive to bad news and show a commitment to safety.[51]

There needs to be clarity around who decides what levels of risk are tolerable. Risks have a personal impact rather than being purely technical. As well as thinking about the risks of events happening, risk management approaches need to also consider consequential risks, including human consequences. These often have longer-term and further reaching

[49] https://www.risktec.tuv.com/risktec-knowledge-bank/culture-and-behavioural-safety/chronic-unease-the-hidden-ingredient-in-successful-safety-leadership/
[50] https://www.thechemicalengineer.com/features/maintaining-chronic-unease/
[51] https://www.risktec.tuv.com/risktec-knowledge-bank/culture-and-behavioural-safety/chronic-unease-the-hidden-ingredient-in-successful-safety-leadership/

impacts.[52] A particular area of focus could be on how impact assessments could capture these. Another approach discussed was whether an organisation's compliance with minor issues can be used as a key indicator of overall compliance.

Use data and behavioural insights

The group discussed whether a more **data-driven** approach to regulation would help. The Hackitt Report noted "*almost unanimous concern surrounding the ineffective operation of the current rules around the creation, maintenance and handover of building and fire safety information*"[53] and made a number of recommendations in relation to the creation of a digital record, or 'golden thread' for both new build and existing higher risk residential buildings.

Whilst the introduction of a 'golden thread' is a positive development, it was felt that more could be done now, rather than waiting to develop the perfect system. For example, is there an opportunity to use crowdsourcing as a way of gathering information about buildings and filling in the gaps in the information record. Alternatively, the cladding industry could be involved in mapping where buildings with cladding are located. Finally, data from different sources could be pulled together into one location.

Where data was gathered centrally – for example through the RIDDOR process[54] – the ways in which it is disseminated could be improved to increase the visibility of the data. Further work could be done looking at how best to engage with different industry sectors.

Simple changes or use of behavioural insights could help to change behaviour. For example, the introduction of a statutory or voluntary system of displaying safety certification in buildings. This could make a difference to both perceptions of safety and the completion of these documents.[55] The impact of this approach was likened to the introduction of the display of hygiene ratings in food establishments. It is interesting to

---

[52] One model that could be adapted is that set out by the Health and Safety Executive in developing process safety indicators. The guidance states "*most systems and procedures deteriorate over time, and system failures discovered following a major incident frequently surprise senior managers, who sincerely believed that the controls were functioning as designed. Used effectively, process safety indicators can provide an early warning, before catastrophic failure, that critical controls have deteriorated to an unacceptable level.*" This leading and lag indicator approach could form the basis of a more system-focused way of managing risks.
See https://www.hse.gov.uk/pubns/books/hsg254.htm

[53] https://www.gov.uk/government/publications/independent-review-of-building-regulations-and-fire-safety-final-report

[54] "*RIDDOR puts duties on employers, the self-employed and people in control of work premises (the Responsible Person) to report certain serious workplace accidents, occupational diseases and specified dangerous occurrences (near misses)*" https://www.hse.gov.uk/riddor/

[55] One of the recommendations made by the Coroner after the Inquest into the Lakanal House fire was that the "*Government give consideration to requiring high rise residential building owners or occupiers to provide relevant information on or near the premises, such as premises information boxes or plates." See* https://www.lambeth.gov.uk/elections-and-council/lakanal-house-coroner-inquest

note that research into the display of hygiene ratings found that: "*around a third of establishments . . . say that displaying their rating has had a positive impact upon their business* . . . [and] . . . *customer assurance continues to be the main motivation for display in England followed by being proud of their rating.*"[56]

Finally, the current mortgage crisis faced by people living in properties with external cladding[57] could be the beginning of a movement to engage people differently. For example, homeowners who have been affected by the presence of cladding have taken time to learn about fire safety and have self-organised and are acting as a pressure group.[58] As these groups continue to develop, their role in relation to the regulator and their relationships with managing agents are both areas of interest.

[56] https://www.food.gov.uk/research/research-projects/display-of-food-hygiene-ratings-in-england-wales-and-northern-ireland-2017-wave-of-research

[57] See https://www.theguardian.com/society/2020/feb/24/half-a-million-people-in-uk-live-in-flats-with-unsafe-cladding-report

[58] See https://twitter.com/ukcag?lang=en

Power – Gill Kernick

In this piece, Gill Kernick focuses on issues of power and accountability after a catastrophic event.

If we were as obsessed with accountability before a disaster happened, we'd prevent more of them. What was the process of accountability for stockpiling PPE as recommended in the 2019 National Security Risk Assessment?[59] What was the process of accountability for ensuring that known issues with building regulations were addressed prior to Grenfell?[60]

Accountability should not be threatening. It is best used proactively to ensure those in positions of power think hard about decisions and their consequences and consider the range of decisions available, and the fairness, appropriateness and proportionality of each possibility. Concepts such as *exploratory thought*[61] and *chronic unease*[62] emphasise the importance of understanding multiple viewpoints, ensuring cognitive diversity and considering potential unintended consequences.

The Institute for Government expressed concern about current failures to address "*fundamental gaps in accountability*" and ensure it keeps "*pace with the increasing complexity of modern government*" so that accountability has become a reactive blame game, rather than a proactive means of ensuring good governance.[63] This piece accordingly focuses on the effectiveness (or otherwise) of accountability *after* a catastrophic event.

Current responses tend to fall short in the public's eye. Based on my own experience after the Grenfell Tower fire, I argue that leading politicians should accept accountability for the psychological contract with citizens, and that this would improve the quality and impact of responses to catastrophic events.

I consider the psychological contract, its key elements, and the barriers to accepting accountability for it.

---

[59] https://www.theguardian.com/world/2020/apr/24/revealed-uk-ministers-were-warned-last-year-of-risks-of-coronavirus-pandemic

[60] https://social.shorthand.com/insidehousing/3CWytp9tQj/the-paper-trail-the-failure-of-building-regulations

[61] https://civilservant.org.uk/the_westminster_model-accountability.html

[62] https://www.newcivilengineer.com/latest/hackitt-engineers-must-feel-chronic-uneasiness-to-improve-safety-22-04-2020/

[63] https://www.instituteforgovernment.org.uk/sites/default/files/publications/IfG%20accountability%20discussion%20paper%20april%202018.pdf

The psychological contract

We have a 'psychological contract' with those in power. Typically applied in employment relationships, although intangible, such contracts can be more influential than formal rules.[64]

We expect that the police will treat the dead and bereaved with respect, that councils will listen to tenants about safety concerns, that both the regulators and supply chains involved in refurbishing a tower block will put the safety of residents above profit, and that the government will ensure that key workers at the front line of a pandemic will have enough PPE.

After a catastrophic event those in positions of power have an accountability to attend to and restore this psychological contract.

And yet, many leaders' response is sadly lacking. Examples include Theresa May's private visit to Grenfell the day after the fire, when she failed to meet Grenfell survivors or bereaved;[65] or Robert Black, Chief Executive of the company that managed Grenfell who, while watching the tower burn, wrote a memo to colleagues saying, *"We need to pull some of this together pretty fast in terms of health and safety compliance;"*[66] or Health Minister Matt Hancock's warning to the NHS to not overuse PPE.[67]

By contrast, leaders who understand that they are accountable for this psychological contract with citizens respond to crises in a way that builds trust. The outstanding example is New Zealand Prime Minister Jacinda Ardern, both in her response to COVID and the 2019 Christchurch terrorist attack.[68]

I recently re-read the *'The patronising disposition of unaccountable power'*[69], a report commissioned by Teresa May when she was home secretary to ensure the perspective of the Hillsborough families is not lost. It highlights how reputation is prioritised over *"the citizen's right to expect people to be held to account for their actions"* and concludes that what is needed is a cultural condition, and "*a change in attitude, culture, heart and mind*".[70]

---

[64] https://www.cipd.co.uk/knowledge/fundamentals/relations/employees/psychological-factsheet

[65] https://www.independent.co.uk/news/theresa-may-grenfell-fire-victims-no-visit-security-concerns-tobias-ellwood-a7792686.html

[66] https://www.theguardian.com/uk-news/2018/nov/15/grenfell-tower-management-company-chief-sent-warning-memo-during-fire

[67] https://www.theguardian.com/society/2020/apr/10/matt-hancock-urges-public-not-to-overuse-ppe

[68] https://www.washingtonpost.com/world/2020/04/20/female-world-leaders-hailed-voices-reason-amid-coronavirus-chaos/

[69] https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/655892/6_3860_HO_Hillsborough_Report_2017_FINAL_WEB_updated.pdf

[70] https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/656130/6_3860_HO_Hillsborough_Report_2017_FINAL_updated.pdf , page 6, para 4 and 5

Accepting accountability for tending to and restoring the psychological contract with citizens after a catastrophic event would go a long way to shifting this patronising disposition and would require:

- transparency
- immediate acceptance of responsibility
- swift correction of issues
- appropriately borne consequences and
- timely and effective learning

Key elements

Whilst viewing accountability in this way may fly in the face of how career politicians view their job, it could change how we respond to and learn from tragedies. It would require a fundamental shift in the role of politicians in responding to catastrophic events.

Transparency

Attempts to spin the narrative do little more than inflate already heightened emotions and increase distrust. It might seem counterintuitive, but practising radical transparency is what is required.

The government's reporting of COVID19 deaths is a good example. There was little transparency when initial figures only included those who died in hospital after testing positive, and deaths in care homes or in the community were not included.[71] Likewise, the government spending time and energy during the pandemic to defend itself against criticism in a Sunday Times article,[72] [73] and the lack of transparency in what counted as a 'test', have done little to build trust.[74]

While bold promises may make sense, when these are ungrounded they damage trust. This was clearly illustrated by Theresa May's promise that those left homeless by Grenfell would be re-housed in 3 weeks.[75] Nearly three years after the fire not everyone has yet been re-housed.[76]

[71] https://www.independent.co.uk/voices/coronavirus-uk-cases-death-toll-statistics-hospital-nhs-a9472036.html
[72] https://www.thetimes.co.uk/article/coronavirus-38-days-when-britain-sleepwalked-into-disaster-hq3b9tlgh
[73] https://healthmedia.blog.gov.uk/2020/04/19/response-to-sunday-times-insight-article/
[74] https://www.bbc.co.uk/news/uk-52508836
[75] https://www.bbc.co.uk/news/uk-40496029
[76] https://www.rbkc.gov.uk/grenfell-response-and-recovery/grenfell-tower-and-grenfell-walk-housing-policy-and-progress

Being transparent, no matter how bad the news, is critical to the psychological contract.

Immediate Acceptance of Responsibility

After a catastrophic event, there are inherent tensions between the desire by those most impacted for 'heads to roll', the time formal processes take to reach conclusions and the need to ensure systemic versus individual failings are identified. A willingness by both politicians and heads of key organisations to accept responsibility because 'this happened on my watch' versus 'it's my fault' would go some way to easing these tensions.

Those most impacted by a catastrophic event understandably want there to be consequences for those in power. Justice, at an emotional level, is often equated with 'heads rolling'. But, formal processes (such as Public Inquiries and civil and criminal investigations) can take years to play out and the outcomes are not guaranteed to equate to justice in the eyes of those most impacted.

A focus on blaming individuals is also problematic and it hides deeper systemic issues and does not lead to significant change or learning.

Doing nothing whilst waiting for formal processes to reach conclusions further damages the psychological contract. Watching those in power continue as usual is untenable and contributes to both suffering and increasing calls for retribution.

Accepting responsibility, because it happened on my watch, and implementing actions consistent with this, give those in power access to restoring the psychological contract. There is a perfectly correlated dance of the symbolic resonance or dissonance of actions with either restoring or further damaging the psychological contract.

For example, Benita Mehra's appointment to the Grenfell Inquiry Panel when she had run an organisation that received a grant from the charitable arm of Arconic, the manufacturer of the Aluminium Composite Material (ACM) panels used on Grenfell, was a symbolically dissonant action. Her subsequent resignation was resonant.[77]

Or, former Housing Minister Gavin Barwell's appointment to the board of the country's largest housing association, Clarion. Barwell, the Housing minister in 2016 and 2017 failed to act on seven letters from a group of MPs responsible for scrutinising fire safety rules. Warning of the risk of a deadly fire, they called for the promised review of building regulations to be carried out. He is expected to appear as a witness in Phase II of the

[77] https://www.bbc.co.uk/news/uk-51252297

Inquiry.[78] The issue is not whether he is guilty or not but about the symbolic dissonance of this action and how it impacts the psychological contract.

Swift Correction

Grenfell revealed systemic issues with the UK's building stock.

Hundreds of high-rise residential buildings have ACM cladding similar to that on Grenfell. Thousands are clad in other flammable façades. Post-Grenfell fire safety inspections revealed systemic issues such as non-compliant fire doors and missing or incorrectly fitted cavity barriers which can compromise compartmentation. Social housing landlords estimate that the cost of making their buildings safe will exceed 10 billion pounds.[79]

The Ministry of Housing, Communities and Local Government (MHCLG) has said all high-rise residential buildings with ACM cladding similar to Grenfell must be remediated. It released funding for this for public (in October 2018) and private (in May 2019) sector buildings. As of March 2020, 144 (32 per cent) of the 457 buildings had completed remediation. 150 (33 per cent) had not started work.[80]

The construction industry itself has so far shown little ability to correct the faulty building practices that contributed to the Grenfell disaster. Eighteen months after conducting an Independent Review of Building Rgulations, its author Judith Hackitt criticised the slow pace of change, saying the industry lacked the leadership to make the necessary changes to make itself safe and describing common practices as "jaw dropping."[81]

Failing to make buildings safe promptly is a gross violation of the psychological contract that citizens should be safe in their homes.

---

[78] https://www.insidehousing.co.uk/news/pms-chief-of-staff-did-not-act-on-multiple-warnings-about-fire-safety-in-months-before-grenfell-new-letters-show-61883

[79] [79] https://www.theguardian.com/society/2020/mar/02/social-landlords-face-10bn-bill-to-fix-fire-safety-problems

[80] https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/879610/Building_Safety_Data_Release_March_2020.pdf

[81] https://www.bdonline.co.uk/news/hackitt-attacks-industry-for-excuses-she-hears-over-slow-pace-of-change/5104389.article

Appropriately borne consequences

Linked to the issue of correction is where consequences are borne.

This cannot be more tragically evidenced than the consequences being borne by those at the front line of care for government failings to stock appropriate PPE in preparation for a pandemic.

Redressing such imbalances in consequences is key to restoring the psychological contract. This is not a legal argument, but a moral one.

In the wake of Grenfell, thousands of leaseholders, who bought apartments in good faith, are being asked to pay to make their buildings safe. Estimates are that 500,000 people are caught in flats that are unsellable while work is carried out to identify cladding and other fire safety issues.[82]

The government could have worked with industry to create a fund for making buildings safe. They could have diverted money away from the law courts and toward ensuring people are safe in their homes.

When there is a divide between who caused and who bears the consequences for events, the psychological contract gets further broken. It leads to those most impacted having to campaign tirelessly to 'fight for justice'. Nearly three years after Grenfell, the government in its 2020 budget assigned £1bn to the removal of cladding, taking to £1.6bn what it had allocated to the removal of cladding. In the same budget £2.5bn was allocated to fixing potholes.[83]

28 years after Hillsborough when the ruling of 'accidental death' was changed to 'unlawful killing by gross negligence' one mother said *"Grief is just beginning as we have been fighting to get to the truth."* [84]

Timely and Effective Learning

The ineffectiveness of current systems for learning, such as public inquiries, has long been identified.[85] There is no process for ensuring that recommendations from public inquiries are either implemented or effective.

---

[82] https://twitter.com/gillkernick/status/1235635493955448833/photo/1

[83] https://www.independent.co.uk/news/uk/politics/budget-2020-potholes-chancellor-rishi-sunak-council-spending-a9392816.html

[84] https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/655892/6_3860_HO_Hillsborough_Report_2017_FINAL_WEB_updated.pdf p.2.

[85] https://www.instituteforgovernment.org.uk/summary-how-public-inquiries-can-lead-change

As much as they want some form of justice, those closely impacted by catastrophic events want to prevent similar tragedies. They want to prevent others from experiencing the loss and grief they have endured.

Until those in power take learning from previous events seriously, they will fail to restore the psychological contract with citizens. Justifying inaction 'until the Inquiry is over' creates a narrative that these formal systems are designed to effectively sustain the status quo.

Until those in power accept accountability for ensuring lessons from catastrophic events are identified, implemented and effective in a timely manner, the psychological contract with citizens can't be fully restored.

Barriers

Behaviour is context dependent. To understand systemic issues rather than look for what people did wrong or ascribe failings to a few bad apples we need to understand why decisions made sense.

Politicians and others in power are navigating complex trade-offs between irreconcilable goals.[86] Four barriers to those in power accepting accountability for the psychological contract are:

- Blame versus learning
- Power versus transparency
- High probability versus low probability, and
- Blunt versus sharp end voices

Whilst presented as dichotomies, they present a network of tensions that frame the context inside which decisions get made and actions taken.

Critically, we collectively create this space and it is incumbent on us all to create a context that pulls for those in power to be accountable for our psychological contract.

Blame versus learning[87]

As a society we are fixated on blame. We seek out bad apples and remove them.. This does not equate to learning.

We operate from an old view that complex systems are inherently safe, and failures result from human error. You make things safer by controlling human behaviour through tighter

[86]Dekker, S. 2014. *The Field Guide to Understanding Human Error*, Ashgate. page 6
[87] Dekker, S. 2014. *The Field Guide to Understanding Human Error*, Ashgate. page 6

procedures, automation and supervision. When something goes wrong, find and remove the bad apple.

> *A culture of blame can develop because it is often easier, cheaper, and more emotionally satisfying to hold an individual responsible for an accident than to acknowledge more fundamental problems… A culture of blame prevents the identification of other underlying causes.*[88]

The new view of failure suggests rather than look for what people did wrong you need to understand the context within which they acted. People, rather than being the problem, are needed to create safety by navigating complex trade-offs between irreconcilable goals.

We can either have blame or learning. Not both.

Power versus transparency

At the heart of learning is the willingness to admit mistakes and errors. To learn, you must be willing to be transparent about failures. At the heart of politics, whether at an international, national, local or organisational level, is gaining and holding onto power. There is an inherent tension when faced with something that could diminish this power. Whilst truth and transparency are laudable, when the potential consequences include loss of power, choices will be less clear cut.

In an adversarial political context, where honour and value driven leadership are notably lacking, and the media is obsessed with blame, being transparent about mistakes and failures would take both enormous courage and a willingness to lose power.

High probability versus low probability

In a world of limited resources and short term, siloed thinking, it is easy to justify ignoring lower probability risks.

In the context of COVID-19, it's easy in hindsight to judge poor decisions about the failures. Resilience to catastrophic events requires an in-built adaptive capacity which is at odds with demands for efficiencies and savings. To be prepared for a low probability, high impact event you must be willing to stand accused of over-reacting.

Until politicians, key stakeholders, the public and the media are educated about and supportive of investing in mitigating low probability events, we will continue to be unprepared. Until we are willing to work collaboratively and invest sufficient resource in

[88] Reason, S. 1991. *Human Error,* Cambridge University Press.

understanding, preventing and responding to such events we must be willing to accept the political, economic, social and human cost of them.

Blunt versus sharp end voices

History tells us that the interplay between those at the top and bottom of the power ladder is critical to both learning and prevention. Whether it be failing to listen to residents' safety concerns in the lead up to Grenfell; train drivers' reports of the difficulty in seeing signals in the lead up to the Ladbroke Grove Train crash; or frontline health workers' concerns about PPE in the current Covid-19 crisis.

The tacit knowledge of those at the sharp end is critical to preventing catastrophic events. Rules, regulations and experts will not guarantee good outcomes. Old notions of elitist power where the few dictate the rules for the many to follow are not only outdated, they fail to take into account that the knowledge of the 'many' is critical in increasingly complex environments.

We need to create a context in which there is equality of life and equality of voice. All lives matter and all voices count. The job of those in power is to ensure the voices of those with less power are both heard and count. The job of those with less power is to keep speaking until we are heard.

Gill Kernick works with senior executives in high hazard industries to develop the culture and leadership to prevent catastrophic events. She lived on the 21st floor of Grenfell Tower from 2011 to 2014. Seven of her former neighbours died. Gill writes and speaks to bring the thinking of major accident prevention to Grenfell. She edits "The Grenfell Enquirer" dedicated to learning and preventing such events.

Politicians and regulation – Martin Stanley

In this piece, Martin Stanley sets out some reflections on the way government ministers learn, or fail to learn, from catastrophic events.

Their first reaction of government Ministers to a tragedy will of course be defensive. "*We couldn't have foreseen it, and our preparations were anyway sensible and proportionate to the risk.*" There may then be some responsive regulation, not always wise or well considered. And then . . . progress gets slower and slower, partly for good reasons, and partly because of politicians' incentives and personalities.

Good Reasons for Delay - Probably

It is generally a mistake to rush to legislate, whatever the reason. The causes of catastrophe are usually many and complex and need to be addressed following sensible consultation and analysis. Here are some of the issues that need to be considered:

- It is often necessary to 'think small, first'. There is no point in introducing new regulations which are incomprehensible to the public or SMEs.
- If regulation is necessary, might it be sensible to put the onus on employers, or an industry, to decide the best way to meet regulatory objectives? Or does the nature of the risk mean that detailed regulations are required, and if so, how soon can we build and fund an inspectorate to enforce them?
- Should any new/expanded regulator be funded by industry? Will that incentivise efficient, targeted regulation? Or will we end up with a tame mouse of a regulator, far too scared to upset its paymasters?

More generally, there is a balance to be struck between under- and over-regulation. The current government requires the cost to business of many (not all) new regulations to be calculated and then existing regulations costing three times as much to be repealed. Crucially, the benefits of the new regulation are not to be taken into account in calculating the net cost. This is a major disincentive to the introduction of worthwhile new regulation and may have led to delays in improving the building regulations before the Grenfell disaster.

More generally still, ministers are never free from pressure to introduce new policies or improve old ones. They can get pretty punch drunk from incessant lobbying, and they would hardly be human if they didn't occasionally get quite sick of their more persistent critics, even if those critics are making very valid points. Sadly, therefore, even the best proposals can come to be regarded as yet another element in a long wish list.

So ... designing and introducing new laws and regulations need not take many years, but it can't be done in months. Unfortunately, even a few months delay can cause the issue

to slip a long way down any government's priority list. This has been a particular problem as the UK spotlight has swung from Grenfell Tower to Brexit and Covid-19.

Incentives

None of us are entirely free always to do what we regard as the right thing. We all have to bear in mind the views of our bosses, boards and/or shareholders. Quite properly, by analogy, ministers cannot totally or forever ignore the views of the electorate that appointed them.

And many voters are loss averse. They are generally reluctant to face immediate loss (more taxation), or regulatory constraints on their behaviour even if these will lead to intangible benefits such as safety or a healthier environment.

Voters will also punish ministers whom they suspect of over-reaction to real or perceived threats. Lives would have been saved at Grenfell if there had been fierce enforcement of the rule that doors should slam closed once they were not being used. But who is going to support such intrusive regulation?

One example of more current relevance was the lampooning of French Health Minister Roselyne Bachelot. She was portrayed in cartoons as a fat idiot and accused of waste and scaremongering, and of exaggerating a problem so as to give money to big business. Her crime? Ordering large quantities of (ultimately unused) vaccines and masks in advance of the feared H1N1 pandemic.

Finally, in this section, ministers are all too aware that they are likely to move to a new job – or be sacked – quite soon, and their performance is anyway assessed by voters at least every five years. They therefore have no incentive to consider the long-term costs or benefits of their policies, and their planning is almost inevitably short-term and not strategic. Put more sharply, any deaths arising from their inaction will most likely occur on someone else's watch.

Ministers' Character

Last, but not least, we need to remember that our highly adversarial system creates politicians who are not at all like the rest of us, and this has consequences for their behaviour in office.

It makes no sense, for instance, for one minister to help a rival minister achieve that minister's objective. All ministers are fierce rivals, whatever they may say. The most immediate victim is the cross-department cooperation that should be tackling the most complex problems.

More insidiously, politicians' precarious career paths mean that most of them are, deep down, true risk takers. Also, once in office, they are inevitably forced to take some

unpopular decisions, so they develop a fairly thick skin and are not predisposed to display imagination or 'chronic unease'. This in turn means that they seldom react like the rest of us if asked to imagine a disaster that has yet to take place. Deaths on railways over many decades, for instance, all too often followed debates in which the industry and ministers pointed out that "no-one has died from that yet". Similarly, the authorities seemed unconcerned by the numerous pre-Grenfell cladding fires which had failed to make the headlines.

And then, rightly or wrongly, most politicians hold the following to be true:

- Voters like optimism, positivity and good news. Ministers thus become predisposed to clutch at straws and to suggest that all is going swimmingly when it isn't. Much the same happens to officials who, in a crisis (and without any explicit pressure from above), will quickly report anything that looks promising even if the information or analysis is highly uncertain. But these rose-coloured spectacles reduce the pressure to take action to avoid future calamity.
- Most (not all) voters hate complexity. Black and white is good. This drives even clever ministers to take little interest in complex issues. There is no reward for putting in the time and effort necessary to fully understand expert advice. It is much easier to speak in clichés and soundbites. In the regulatory sphere, this results in ministerial preoccupation with cutting – or making bonfires of – red tape.
- Voters punish mistakes, and mistakes will be loudly trumpeted by the media and the Opposition. Ministers must therefore spend much of their time in defensive mode and certainly cannot publicly entertain the possibility that their preparation for any crisis might have been inadequate, or their previous decisions might have been inadvisable. If they are honest (and foolish) enough to admit error, the media will move on to pursuing their resignation. This impacts the speed at which they learn from disasters, for why should anything change if we already live in the most perfect of worlds?

Finally, most ministers are nowadays career politicians who have never worked within a large organisation. They can't understand why their policy statements do not immediately translate into action on the ground, nor why cuts to the resources of regulatory bodies cannot follow several previous sets of cuts without serious consequences. Eventually, of course, there is another serious regulatory failure, but no-one is likely to blame a minister for the later performance of what was, after all, an 'independent' regulator.

Unless, of course, Sir Martin Moore-Bick, the chairman of the Grenfell Tower Inquiry, does just that.

Martin Stanley was the Chief Executive of the predecessors of the Better Regulation Executive and the Competition and Markets Authority. He edits the Understanding Government (including Understanding Regulation) website[89] (based on his experience as an adviser to ministers) and has a particular interest in looking at the ways in which failures of regulation may have contributed to the Grenfell Tower tragedy.

[89] https://www.understanding-government.org.uk/

The importance of people's voices – Flora Cornish

One of the key themes to emerge from the workshop was the need to ensure cognitive diversity. In particular that a valuable source of detailed information goes to waste if decision/policymakers ignore users/ people (for example, residents in the case of Grenfell).

In this piece, Dr Flora Cornish answers a series of questions on her work with residents of North Kensington and provides some personal reflections on the workshop.

1. What is your background and why do you have an interest in learning from catastrophic events?

I have been researching, collaborating with, and teaching about community leadership in public health crises since the early 2000s, when I began research in the field of HIV/AIDS. I'm an Associate Professor in the Department of Methodology at the London School of Economics, and my passion is for knowledge exchange and dialogue within and beyond the university, with the intellectuals, activists and practitioners for whom knowledge has material stakes.

In her book A Paradise Built in Hell[90], Rebecca Solnit celebrates the deep creativity and solidarity of communities ravaged by catastrophe, and the fleeting instantiation of possible societies based on alternative relations of care. Arundhati Roy has written about the COVID-19 pandemic as a 'portal'.[91] There will be a before and an after, and we can choose, she says, to go through the portal with all our heavy baggage or lightly, "*ready to imagine another world . . . and fight for it*".

We won't learn lessons by interpreting the emergency with the same old frameworks and same established voices that created the situation we need to learn from. Voices are attached to their positions, and denialism after disaster, as people protect their positions, is rife, and antithetical to learning. Learning from one-off events is a methodological challenge. With the idea of 'communicative generalisation',[92] I have suggested that the lessons we could learn need a plurality of voices and a plurality of audiences.

I am interested in routes to responsible social change. In the case of Grenfell, I have tried to understand the mechanisms through which change happens. After almost three years, however, my view is that the crucial issue is more about how social change or learning is resisted by those in power, who cling to the status quo, rather than how change comes about. To make learning possible, we have to get a handle on how people and systems actively or unconsciously protect themselves from the threat of learning and change.

[90] https://www.penguinrandomhouse.com/books/301070/a-paradise-built-in-hell-by-rebecca-solnit/
[91] https://www.ft.com/content/10d8f5e8-74eb-11ea-95fe-fcd274e920ca
[92] https://journals.sagepub.com/doi/full/10.1177/1354067X19894930#articlePermissionsContainer

2. **What stood out for you from the workshop? Did anything surprise you? What interested you the most?**

One surprise stood out. On the train journey to Cambridge I had mused over whether my emphasis on resistance to change was going to be too negative or pessimistic for this meeting. But as we started to frame a discussion about learning, colleagues at my table seemed to be uncannily speaking my words. We all shared intense frustration at the apparently senseless lack of urgency or action to make buildings safer, given what was already evident after the 2009 Lakanal House fire, and again, so devastatingly, in the nearly three years since Grenfell. "*Why don't they care?"* we asked.

Lawyers on our table emphasised that the call to 'learn' lacks any bite in the absence of legal or financial sanctions to enforce the recommendations of inquests or inquiries[93], and given the murkiness of responsibility for the safety of flats in blocks with complex ownership/management arrangements.[94] Others queried, at a more psychological level, how to get 'under the skin' of those with authority to make changes, suspecting that it matters that they do not themselves – or maybe they don't know anyone who does - live in flats in dangerously-clad buildings. In the aftermath of the fire, Joe Delaney, resident of a block neighbouring Grenfell Tower, used the term '*institutional indifference*' to characterise the dysfunctional relationship between authorities and residents of North Kensington. This idea resonated and led us to ask about *individual indifference*. How can demands for safety measures be made to bite? How can '*they*' be made to care?

At a more general level, the composition of the group of workshop participants struck me as very important. Here were people across very diverse fields of expertise, with decades of experience, and informed analyses, willing to spend a day with people they didn't know, in an open-ended and uncertain process. People who might otherwise be found on opposing sides of a table, or competing over professional perspectives, engaged substantively and critically together, discovered commonalities, and articulated differences. 'We' seemed to care. And we also have positions of authority. If 'we' all care, what do we do differently that shows it?

3. **You have been directly involved with the Grenfell community in the aftermath of the fire.**

a. **Can you share what you've done?**

Frustrated by what I saw as a very disconnected official response which repeatedly missed the mark, and seemed unable to hear and respond to what community representatives were saying, and together with community leader colleagues, we have

[93] https://www.instituteforgovernment.org.uk/publications/how-public-inquiries-can-lead-change

[94] https://www.law.ox.ac.uk/housing-after-grenfell/blog/2020/01/reflecting-systemic-failures-illustrated-fire-safety-crisis

worked on a knowledge exchange project documenting the community response after the fire. We do so partly as learning for future emergency responses, so they can coordinate better with local responses, but also to support local sense-making.

To visualise this recent social history, we are constructing 'timelines' of the aftermath. One of these is a digital timeline[95] documenting the long and still unresolved back-and-forth controversy over the potential contamination of local air and soil by the fire. We are also working on using timelines as the basis for participatory workshops where people can create their own timelines of the aftermath.

At the same time, we are working on academic publications about 'community resilience', community responses, and how change is cultivated and resisted.

b. **What did you personally learn from the work with the Grenfell community?**

That the big questions, the possible answers, the insightful analyses are all alive and flourishing, in discussions and debates being had among those affected, and others whose lives are interdependent with those most affected. The love and care for their community that was so evident among neighbours after the disaster is a foundation for wisdom about how to respond and recover.

Beginning three weeks after the fire, a series of public meetings brought together representatives of the official response and local people, for updates and questions. I started recording the issues raised at these meetings, with no knowledge or judgement of how significant they would prove to be. What were the issues? The struggle for truth and justice, housing the survivors, the safety and respectful treatment of the Tower, physical and mental health impacts, and questions over authority and governance – all of which became crucial aspects in the response and recovery. I started gathering information about the issue of contamination of air and soil simply because it was raised by residents as an issue. Little did I know that it would become a long-drawn out and complex controversy involving the frontiers of scientific knowledge, citizen science, investigative journalism, numerous senior scientists and many community meetings.

But, from spending time in the community, I knew that the issue was of concern to local residents, and that they were knowledgeable about it. I knew that standard advice being given by health authorities about wiping down surfaces with a damp cloth or peeling home-grown vegetables, was completely incongruent with residents' experience of breathing problems and out-of-the-ordinary dust, and the strength of their concerns. I found it puzzling how they could not seem to hear what residents had been saying loud and clear for months. Listening from a distance is hard.

---

95 https://cdn.knightlab.com/libs/timeline3/latest/embed/index.html?source=11cvlcX885PLew8yZiRACyKPEcgbvuY3iL76xbqrA1Ug&font=Default&lang=en&initial_zoom=2&height=650

c. **What three things do you think policy and decision makers could learn from the Grenfell community?**

- Don't be scared of people. Trust them, listen to their leadership, get out of the way.
- Leadership involves taking a risk and taking responsibility at a time of crisis.
- The experiential lives and accountabilities of decision-makers are often too distant from the lives of people affected by their decisions. Boundaries need to be massively crossed and distances shortened.

d. **In the context of learning from catastrophic events, is there anything else you'd like to say about cognitive diversity and the importance of diverse voices being heard?**

I have some uneasiness that the words 'learning' and 'cognitive diversity' are too innocent, or depoliticised. I see voices as embodied, experiential, situated, social, and structural (all things beyond the 'cognitive'). People have materially different experiences and that is what is most important, and what gives them 'cognitive diversity'.

And wise and articulate, situated voices are flourishing, so the question is not so much about allowing voices to be expressed, but about ensuring their legitimacy and power. I keep saying that participation is nothing without power.

Dr Flora Cornish is a community psychologist working on the role of grassroots mobilisation in responding to public health crises, with a particular interest in collaborative knowledge exchange and dialogue. For the last two years, in the aftermath of the Grenfell Tower fire, she has been working closely with residents of North Kensington, documenting and interpreting their role in providing support to their neighbours and in bringing about wider change. She is Associate Professor in Qualitative Research Methodology at the London School of Economics.

Saving Lives Is Not Enough[96] – David Wales

*This piece is an excerpt from a report produced by David Wales and Kristina Stiles – Saving Lives is Not Enough (*https://tinyurl.com/SLINE2019*). The report sets out 10 proposals for how the Fire and Rescue Service (FRS), the Ambulance Service and the burns sector could develop a more strategic and holistic view of the entire burn survivor journey to improve the level of support that burns victims receive.*

Introduction

The research undertaken for [Saving Lives Is Not Enough] was characterised by revealing a sense of differences, gaps and fragmentations, between the emergency and healthcare services and their customers. This appears to be due to:

i. the absence of a collective multi-agency knowledge of the importance and implications of understanding the event from a casualty perspective.
ii. single service/sector approaches to service design and planning which do not provide an end-to-end and full agency view of the casualty experience. This leaves the casualty vulnerable to the impact of individual and cumulative assumptions, variations in knowledge and different aims.
iii. an academic and policy focus on understanding the customer experience of mass casualty or serious emergency events with less attention given to the importance of higher frequency but lower impact incidents.

From a casualty perspective, the experience is often a sum of the parts rather than a cohesive and comprehensive pre-hospital care model. This section considers why that is the case and how this understanding could be relevant to the emergency services more generally.

Research methodology

This project was purposefully atypical in the way it was developed. It began conceptually in response to the limited strategic dialogue between the burns and FRS communities despite their obvious common involvement in the casualty pathway and care. Methodologically, it adopted the technique of plotting the end-to-end casualty journey and allowing the evidence (where available) to identify their requirements (clinical and

[96] From https://edition.pagesuite-professional.co.uk/html5/reader/production/default.aspx?pubname=&pubid=80309ccf-1774-42c8-905a-c9cc7badc97b

non-clinical) along this continuum.[97] [98] [99] It was surprising how often this simple change in mindset and methodology revealed insights missed by existing practice and traditional approaches to designing and delivering services.

The current situation of limited cross-service knowledge and dialogue between all stakeholders creates, at worst, the potential to cause harm as well as potentially missing opportunities for achieving a better outcome. Additionally, it can make the experience of a distressing event even worse and more challenging for all involved.

The need for a customer focus

In targeted areas, the government has articulated an expectation that emergency services are better at working together, expressing this through legislation and national improvement schemes.[100] [101] [102] The focus of these is on improving inter-agency collaboration including the efficiency and effectiveness of emergency response capability. It achieves this through greater alignment of areas such as operational command, procedures and equipment. Whilst improving the ability to resolve incidents from an operational perspective clearly benefits these initiatives alone are insufficient to optimise their experience and outcome.

Academic literature conveys how emergencies and other events are experienced by those involved, most often in relation to mass casualty or large-scale events.[103] [104]These identify a set of needs and expectations, which are quite different to the necessary, but often functional and task-oriented activities, that response organisations tend to focus on. Without awareness of these issues and appropriate support measures, a range of very real and often long-lasting physical, psychological and social effects can result.[105]

---

[97] Lemon K, Verhoef P. 2016. Understanding customer experience throughout the customer journey. Journal of Marketing 80(6):69-96

[98] Clark M, Harrington T, Myers A. 2016. Promoting excellence in customer management: emerging trends in business. Journal of Emerging Trends in Marketing and Management 1:119-129

[99] Nutley S, Powell A, Davies H. 2013. What counts as good evidence? Alliance for Useful Evidence: London.

[100] Her Majesty's Government. 2017. Policing and Crime Act 2017: Chapter 3. [Online] https://www.legislation.gov.uk/ukpga/2017/3/pdfs/ukpga_20170003_en.pdf [Last accessed 18 May 2019

[101] Her Majesty's Government. 2004. Civil contingencies act 2004: Chapter 26. [Online] https://www.legislation.gov.uk/ukpga/2004/36/pdfs/ukpga_20040036_en.pdf [Last accessed 18 May 2019

[102] JESIP. 2016. Joint Doctrine: interoperability framework. [Online] https://www.jesip.org.uk/uploads/media/pdf/JESIP_Joint_Doctrine-The_Interoperability_Framework_%5Bedition_2-July2016%5D.pdf [Last accessed 18 May 2019].

[103] Lindahl C. 2012. Legends of Hurricane Katrina: the right to be wrong, survivor-to-survivor storytelling, and healing. Journal of American Folklore 125(496):139-176

[104] Lindell M. 2013 Disaster Studies. Current Sociology Review 61(5-6):797-825

[105] Fothergill A, Peek L. 2015. Children of Katrina. University of Texas Press: Austin

However, within the current collaborative initiatives there is not a corresponding multi-agency agenda to stimulate service improvements based on the public perspective and experience. Isolated guidance documents, typically for mass casualty events, acknowledge the human aspects to consider.[106] [107] This has some commonality with customer experience but is not the same. Government has begun to recognise the concept and practice of customer experience although to date this has primarily been in administrative and finance functions.[108] [109] This follows the path of many commercial (and increasingly public sector) organisations who recognise the value to the organisation, employees and customers of understanding and managing the experience as well as their product or services.[110]

The current picture

Encouragingly, most of the emergency services have, to different degrees, already recognised the importance of what can be referred to generically as a customer experience strategy, initiating their own in-sector vision and programmes. However, these are developing individually and not as part of a cross-service co-ordinated approach. Ironically, this means different priorities, standards and terminology will continue to be experienced by the customer as they traverse the care of each agency, and a significant improvement opportunity will be lost. Local adaptations of national policies will see further variation, not always justified by customer needs. Below is an indicative assessment of the position, as identified by national publications, of each of the four primary emergency services in relation to customer experience.

- The NHS has for many years advocated the need to put the patient at the centre of its services. Customer experience methodologies and tools have been adapted for the healthcare environment and the principle of public representation in

[106] Cabinet Office. 2016. Human aspects in emergency management: guidance on supporting individuals affected by emergencies. [Online] https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/564306/human_aspects_gui dance_2016_final.pdf [Last accessed 18 May 2019].

[107] Eyre A. 2006. Literature and best practice review and assessment: identifying people's needs in major emergencies and best practice in humanitarian response. Department for culture, media and sport: London

[108] Department for Business Innovation & Skills. 2013. BIS Research paper no 155: customer journeys in business support services. [Online] https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/260891/Customer_journeys_ in_business_support_services.pdf [Last accessed 18 May 2019].

[109] Department for Works and Pensions. 2017. Pension Wise service evaluation: full year findings on customer experiences and outcomes of using the Pension Wise service. [Online] https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/653621/pension-wiseservice-evaluation-full-year-findings.pdf [Last accessed 18 May 2019].

[110] The Institute of Customer Service. 2019. UKCSI: the state of customer satisfaction in the UK. The Institute of Customer Service: London.

decision-making bodies is well established.[111] [112] [113]There is a strong drive to enable people to take responsibility for their health through technology and initiatives for improving access to information and services.[114][115][116]

- The Ambulance Service, as part of the NHS, promote a similar vision. It has leadership and strategy committed to delivering patient centred care and involving the public in the service. However, the Ambulance Service does not appear to be as advanced as the wider NHS in the implementation of these aspirations.[117] [118] [119]
- The FRS do not appear to have a customer experience strategy, or any plans to promote public representation on decision making forums.[120] [121] [122]
- The police have a unique and potentially more challenging position within the community. Despite this, recognition of the importance of the customer perspective and experience is acknowledged alongside other priorities and seen

[111] National Institute for Health Research. 2016. Care at the Scene: research for ambulance services. [Online] https://www.dc.nihr.ac.uk/themed-reviews/Care%20at%20the%20scene%20final%20for%20web.pdf [Last accessed 18 May 2019]

[112] Coulter A, Collins A. 2011. Making shared decision-making a reality. King's Fund: London.

[113] NHS England. 2017. NHS England patient and public voice partners policy. [Online] https://www.england.nhs.uk/wpcontent/uploads/2017/08/patient-and-public-voice-partners-policy-july-2017.pdf [Last accessed 18 May 2019].

[114] NHS England. 2019. NHS Long Term Plan. [Online] https://www.longtermplan.nhs.uk/wp-content/uploads/2019/01/nhs-long-termplan.pdf [Last accessed 18 May 2019]

[115] NHS England. 2019. Universal personalised care: implementing the comprehensive model. [Online] https://www.england.nhs.uk/wpcontent/uploads/2019/01/universal-personalised-care.pdf [Last accessed 18 May 2019].

[116] Nesta. 2013. The business case for people powered health. [Online] https://media.nesta.org.uk/documents/the_business_case_for_people_powered_health.pdf [Last accessed 18 May 2019].

[117]NHS England. 2015. Transforming urgent and emergency care services in England. [Online] https://www.england.nhs.uk/wpcontent/uploads/2015/06/trans-uec.pdf [Last accessed 18 May 2019

[118] Allied Health Solutions. 2013. Paramedic evidence based education project (PEEP) end of study report. [Online] https://www.collegeofparamedics.co.uk/downloads/PEEP-Report.pdf [Last accessed 18 May 2019].

[119] Association of Ambulance Chief Executives. 2011. Taking Healthcare to the Patient 2. [Online] http://aace.org.uk/wpcontent/uploads/2011/11/Taking-Healthcare-to-the-Patient-2-REPORT.pdf [Last accessed 18 May 2019].

[120] National Fire Chiefs Council. 2018. NFCC strategy 2017-2020. [Online] https://www.nationalfirechiefs.org.uk/write/MediaUploads/committee%20documents/NFCC_Strategy_Final_july_2018.pdf [Last accessed 18 May 2019].

[121] Local Government Association. 2018. Fire Vision 2024. [Online] https://www.local.gov.uk/sites/default/files/documents/10.20%20%20Fire%20Vision%202024_4.pdf [Last accessed 18 May 2019].

[122] Home Office. 2018. Fire and Rescue National Framework for England. [Online] https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/705060/National_Framework _-_final_for_web.pdf [Last accessed 18 May 2019].

in initiatives such as those relating to victims of crime and giving communities a voice in setting policing priorities.[123] [124] [125] [126]

The above suggests that the current situation will see the individual services develop in different ways at different speeds (or not at all). Emergency service customers will continue to experience fragmented and disconnected services and the potential for avoidable harm will also remain present. A lesson from the private sector is a requirement to have the organisational ability to meet the rapid pace of change in terms of customer expectations. What is innovative and desirable today quickly becomes the norm, and failure to deliver it then causes dissatisfaction and complaints. Customer expectations are rapidly changing and increasing in response to the standards set by the best organisations in any sector and there is less acceptance of agencies which do not measure up. This would suggest the need to put in place mechanisms and structures capable of working across the emergency services in order to support delivery of a consistent and effective customer experience programme.

Better by design

A silo approach to designing, delivering and evaluating services creates an experience and outcome that can only be as good as its weakest part.[127] As a result, unintended consequences, harm or opportunities for improvement can be left unrecognised.[128] [129] The experience of conceiving and developing this report identified areas where this was

[123] Association of Police and Crime Commissioners, National Police Chiefs' Council. 2016. Policing Vision 2025. [Online] https://www.npcc.police.uk/documents/Policing%20Vision.pdf [Last accessed 18 May 2019]

[124] Her Majesty's Government. 2011. Police Reform and Social Responsibility Act 2011. [Online] http://www.legislation.gov.uk/ukpga/2011/13/pdfs/ukpga_20110013_en.pdf [Last accessed 30 June 2019].

[125] National Police Chiefs' Council. 2018. Delivery Plan 2018-19. [Online] https://www.npcc.police.uk/Delivery%20Plan/Delivery%20Plan%2018_19/FINAL%20NPCC%20Delivery%20plan%202018_19 _.pdf [Last accessed 30 June 2019].

[126] Her Majesty's Government. 2018. Victims Strategy. [Online] https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/746930/victim-strategy.pdf [Last accessed 18 May 2019].

[127] Mock C, Peck M, Peden M et al, eds. 2008. A WHO plan for burn prevention and care. World Health Organization: Geneva. [Online] https://apps.who.int/iris/bitstream/handle/10665/97852/9789241596299_eng.pdf;jsessionid=1C46A5E8D60605A23AE0B598F 5EAEA05?sequence=1 [Last accessed 18 May 2019].

[128] World Health Organization. 2011. Burn prevention: success stories and lessons learned. [Online] https://apps.who.int/iris/bitstream/handle/10665/97938/9789241501187_eng.pdf?sequence=1&isAllowed=y [Last accessed 18 May 2019].

[129] Humanity & Inclusion (Operations Division), F3E. 2018. Incorporating the principle of "Do No Harm": how to take action without causing harm. Reflections on a review of Humanity & Inclusion's Practices. [Online] https://www.alnap.org/system/files/content/resource/files/main/donoharm_pe07_synthesis.pdf [Last accessed 18 May 2019].

the case. Similar conditions may also exist in other emergency service activity or indeed for any activity or event where multiple agencies or organisations are involved.[130]

One way to mitigate this is by using a transparent and evidence-based approach. There are likely to be variations in the levels of maturity regarding use of evidence and research across the emergency services at national, local and even departmental levels. It is important that an approach is agreed to ensure a common or minimum standard of evidence and to understand where the knowledge gaps are. Alongside this, an appropriate decision-making process should be established. Human factors will also be present and effect partnerships, for example, a range of biases, the influence of hierarchies or power structures and how challenge and different views are managed. Openly discussing and managing the options to address these are beneficial in creating the right environment. This is particularly valuable when working with other organisations where the people, data and ways of working may not be familiar to all parties. Tools such as customer journey maps provide a useful means by which to visibly plot a range of factors all the way through the customer journey across each agency, avoiding the potential for many issues raised in this report.[131] [132]

The current fragmented and single service approach to the nascent customer experience agenda risks missing the opportunity to collaboratively create a consistent emergency service customer culture and architecture. The cost of doing so retrospectively when each service has made research, personnel, technology and operational investments and developed its own ways of working will be far greater. Developing a standardised set of customer experience measures would underpin cross sector improvement allowing comparison and meaningful sharing of good practice based on how the service is received throughout the full span of an event by the customer, and not just how efficiently and effectively it is delivered as assessed by the service provider. In that respect the measures would provide a personal assessment by the end user of the relevance and impact of emergency services - something not currently fully known.

There is widespread recognition that the impact and acceptability of innovations such as this is enhanced when they are co-designed with meaningful stakeholder engagement involving all stakeholder groups that have a vested interest.

[130] Hitchcock A, Laycock K, Sundorph E. 2017. Work in progress. Towards a leaner, smarter public-sector workforce. [Online] https://reform.uk/sites/default/files/2018-10/Work%20in%20Progress%20Reform.pdf [Last accessed 18 May 2019].

[131] Institute for Government. 2015. Evidence transparency framework. [Online] https://www.alliance4usefulevidence.org/assets/IfGEvidence-Transparency-framework-v6.pdf [Last accessed 18 May 2019].

[132] McCarthy S, O'Raghallaigh P, Woodworth S et al. 2016. An integrated patient journey mapping tool for embedding quality in healthcare service reform. Journal of Decision Systems 25(sup1):354-368.

Summary

The theme of differences, gaps and fragmentations, noted during the production of Saving Lives is Not Enough, was seen again in the wider customer experience policies and strategies within the emergency services.

Academic and other evidence sources establish that the way in which public experience, and are impacted by, emergencies and other incidents is very contextual and personal. The requirement for emergency services to meet their statutory and functional roles is not in question. However, fulfilling these alone is insufficient to meet the different needs and vulnerabilities which arise for individuals and communities during and after traumatic events.

Partial recognition of this is provided by the inclusion of human aspects within legislation and guidance pertaining to large scale emergencies, which are fortunately infrequent. It is not clear why the same principles are not factored in to the more routine and small-scale events where they could also have a significant benefit.

Human aspects and customer experience have some areas of overlap but are distinct and serve different functions. Many organisations in the private sector, some government departments, and several public sector bodies have already adopted a customer experience strategy. Within the emergency services there is a mixed picture. The NHS and the Ambulance Service have made clear commitments to being patient centred across all their services and are making the leadership and organisational investment to meet this aspiration. The police use different language and provide a strategic commitment to customer experience within specific activities, but it is arguably less explicitly and distinctly articulated as an overarching priority. The FRS has no discernible plans to introduce a customer experience strategy or enhance public involvement.

Most emergencies and related activities will require a customer to have contact with multiple agencies over varying periods of time. Each service is currently on a different path and proceeding at different speeds in different directions. Against this landscape and direction of travel it will be impossible to design and maintain a co-ordinated, consistent and safe end-to-end journey or outcome for the customers. Individual services may achieve improvements but the opportunity to create an environment which aligns the aims and measures across the entire customer experience will be lost. At this early stage, there is a risk of duplicated investment or not realising the potential for collaborative procurement and development.

Alternatively, there is a timely opportunity to take a different course and create an integrated and coherent model of customer experience within the emergency services, and potentially beyond. In that respect there is a need to provide human services, humanely.

David Wales is the Founder of SharedAim, a company established to help organisations deliver excellent services and customer experience by design, through focussing on people and embracing uncertainty. He is also the International Research Lead for the National Fire Chiefs Council (voluntary role). During a distinguished career in the Fire and Rescue Service (FRS), he instigated and led an award-winning national study of human behaviour in fires. He is currently fascinated by leadership, the human side of the fourth industrial revolution, effective collaboration and productivity.

Why don't we learn from disasters? – David Slater

The Problem

After every disaster there comes a government minister to announce to the nation that a Public Inquiry will be held. This will examine all the circumstances and make recommendations so that we can 'learn the lessons' and ensure it can 'never happen again'. This mantra is followed by years of agreeing terms of reference, rules of procedure, consultations and quasi legal deliberations. Finally, when most of the nation, except the victims, survivors and those implicated have moved on, or lost interest, an 'Official' report is published. It is expected to make suitable and insightful recommendations, but for which there seems to be no mechanism for adoption or audit. They are usually a three-day wonder in the press and then seem to disappear for ever. Why? Because on balance of probabilities, this fortunately rare event is unlikely to reoccur anyway. (If in doubt do nowt?)

The classic case quoted is the spate of domestic gas explosions which occurred in London in the 1960s following an exceptionally long spell of drought conditions. The old gas mains were laid in the London clay bed, which ensured that even when corroded away, the clay tunnels still enabled a leak free supply. The unusually hot weather – for then – caused some of the clay layers to dry and crack, resulting in leakages of essentially hydrogen to build up in buildings. The Inquiry duly met and reported, by which time the weather had returned to 'normal', leaks and explosions settled down to their 'normal' frequency and everybody seemed happy that the problem was solved. In fact, very little had actually changed, but the process was deemed successful and further cemented the slow and ponderous (thorough?) public inquiry as the way to do it, in the governmental policy and 'how to' manuals.

But more recently as infrastructure and technology gets more complex and public opinion gets more risk averse, it is no longer acceptable to go through a perceived 'playing for time' process. Lessons are there to be learned and changes actually have to happen. Accountability and justice need to be seen to be done. There are two issues that we have to address, if we are to have a demonstrably appropriate way to learn (and implement) lessons from serious events. There are problems with the process itself, but there is also, increasingly a realisation that we have to follow up on dealing with the consequences, both human and systemic. Insurance is some form of compensation, but closure and peace of mind are priceless. More and more questions are being asked about whether public inquiries are in fact good value for money. For example, Nicholas Timmins of the Institute for Government sets out some of the presumed aspirations which are clearly not being delivered:

"Public inquiries have many purposes. They include exposing the truth after a scandal or major controversy. Sometimes they are there to decide who is culpable. Sometimes – perhaps too often – to make recommendations. Quite often to provide a moment of genuine catharsis – if

not "truth and reconciliation" then at least a healing of wounds, or a public acknowledgement of a real problem or injustice."[133]

The Process

There are two separate and conflicting drivers behind most investigations of accidents: the need for understanding what happened, and the need for justice. This inevitably presents us with what James Reason has described as "*the balance of blame*".[134] The first, the need to learn from what really occurred and why, may not focus so much on individual roles, and hence promotes a lack of accountability. The second driver, the need to assign blame, often leads to the investigations stopping, once a blameable ('root') cause has been agreed. Neither outcome is universally acceptable, which is why most inquiries to date seem to have fallen between these two stools. There is a further recognition these days that, not only does the blame game inhibit learning, there is a growing belief that we should treat people who have suffered in these disasters (victims and survivors) with compassion, not just focus on finding fault and culpability. [135]

But if we step back and ask what the objective of the process is, we may agree that it is primarily to reassure the public that all is under control and being dealt with. Now if we examine the process more closely, we can see that the current way we 'do inquiries', does not satisfy even this primary goal. The current system has difficulty coping with the balance of blame tussle between legal and scientific needs. It has not really addressed the real issue of how to reassure the public, which requires an appreciation of the realities in how the public think and form rapid and often unjustified opinions.

The Social Psychology

Humans have evolved to cope with dangerous environments where the emphasis was on survival and instinctive (fight or flight) responses. Consequently, rather than being the cool, rational, logical, reasoned and reasonable people we like to think we are, we:

- make judgements on situations very quickly (within a minute of meeting?)
- make most decisions instinctively, automatically, without consciously thinking.
- are very reluctant to change our minds (he who hesitates . . .)

Subsequently we are not very receptive to contrary arguments, open discussion, etc. (confirmatory bias). Our thinking is subject to a whole range of unconscious biases and prejudices. We automatically look for a 'story' that makes sense of the total perceived picture.

---

[133] https://www.instituteforgovernment.org.uk/blog/are-public-inquiries-worth-time-money-and-resources

[134] "Managing the Risks of Organizational Accidents" illustrated edition by James Reason (ISBN: 9781840141054)

[135] https://www.sciencedirect.com/science/article/pii/S0925753520300746

With these insights we can see that the inquiry process falls at the first hurdle. It takes too long. After the event there is a lack of authoritative response (waiting for the verdict – don't anticipate the party line). Within this vacuum, the media (social and mainstream) feel pressured to provide the 'stories', officially unchallenged, which become folk lore – everybody knows, rightly or wrongly. These stories can then instigate unjustified grievances and psychological damage, but most of all can make any objective and impartial inquiry process unachievable.

The case of the Costa Concordia[136] illustrates this process failure well.

On 13 January 2012, the cruise ship Costa Concordia attempted a sail-by salute past the island of Giglio. The captain, Francesco Schettino, had been in charge when the ship had performed this manoeuvre before. But this time, the ship struck an underwater rock off the island, partially capsized and listed on its starboard side, resulting in the deaths of 32 people. Schettino indicated in his defence that the underwater rocks the ship struck were uncharted, the helmsman did not speak English or Italian, and the ship's generators malfunctioned, impeding the rescue effort. Regarding his dry and early departure of the vessel, Schettino explained that he slipped off the ship when it turned over and he fell into a lifeboat. The Coast Guard ordered Schettino to leave the lifeboat and return to the stricken Costa Concordia. Schettino's recollection of his reason for not returning to his vessel was because it was "too dark" and the lifeboat had "stopped moving". Schettino was vilified in extensive media coverage that dubbed him "Captain Coward" and "Captain Calamity". He was subsequently convicted of multiple counts of manslaughter, causing a maritime accident, abandoning a ship with passengers still on board, and lack of cooperation with rescue operations. He is currently serving a 16-year jail sentence.

Many experienced maritime professionals are very unhappy with the findings and seminars are being held regularly to attempt to understand the implications. There has been speculation that Schettino was a convenient culprit to blame for the failure of the systems operated by Costa Cruises, which had disassociated itself from, but must have been aware of the practice of a sail-by salute, possibly even requesting it. There were clearly missed communications and failures by the whole bridge team. Some suspect that the same culture of not daring to speak up as a junior, to seem to correct a superior, was a major factor. Similar examples can be seen in aviation (Korean Airlines[137]) and healthcare. As Captain Schettino said in his own defence, "*I believe that for the Concordia, the bridge team failure was not limited to the failure in not executing the turning on the indicated wheel over point, or having planned the navigation at 0.5 miles from the shore*." Touching on training and human behaviour, he says "*any officer, part of a bridge team, is*

[136] https://www.bbc.co.uk/news/world-europe-16646686

[137] https://www.researchgate.net/publication/305883101_KOREAN_8509__A_CASE_OF_CULTURAL_VARIABILITY)

expected to be able to reckon and detect the peril in order to be in the position to offer his contribution to the whole team". There was no professional background available to the court lawyers and "*the relevant arguments have been neglected and misinterpreted*." There was, he states, nobody with "*nautical legacy and practical experience for understanding the various limitations aroused after the collision for handling the emergency on a mega-cruise ship*." He asks how, in the absence of such professional expertise, can the "*behaviour and conduct*" of a person be properly judged? "*How can they see their actions through the eyes of others without such knowledge?*"

It is a very valid point. It is worth asking whether it is right that this individual should have carried the whole responsibility for the accident and the subsequent developments, when his employers, their deficient procedures and his navigational team, were allowed to escape the severe punishment of his singular sentence. There were 33 lives lost that night. Should all the blame for this be heaped onto the head of one wretched man?

The Adversaries

The structure of the public inquiry follows this classic, two-sided, adversarial, advocate led, legal model. This requires entrenched and opposing positions: investigators (prosecution) and investigated (defence). This model has the advantage of historically being seen as a mechanism to assign liability (blame) so that justice eventually can be seen to be done and demonstrate that this particular lesson has been learned. But this seemingly ignores other interested parties.

These include the affected organisations, victims and survivors, popular villains, as well as the independent safety and scientific professionals who also urgently need to know and learn from what happened. Currently the inquiry process does not seem to provide for these needs, although many inspectors have tried to incorporate modifications, for example to more formally include victims.

Importantly as well, the independent, objective, 'scientific' investigations needed for establishing the facts, under the current inquiry model, become part and subservient to, the adversarial 'justice' process. This mind-set is a legacy from the 19th and 20th centuries, when first Victorian determinists, and later safety thinkers, were convinced that the universe obeyed simple laws and that effects can be mathematically and precisely related to causes in the simplified and assumption laden theories and models they proposed. There should therefore be no dispute as to the causes and effects.

Unfortunately, in today's ever more complex systems, these simplistic, linear thinking, predetermined models no longer hold. There needs to be a space to really probe the real-world effects and implications in a nonpartisan forum. This should allow a dialogue with experts, with the time and inclination to think more deeply and suggest explanations which recognise and allow for the realities and complexities of the systems involved.

The 'Injured' Parties

There is yet another set of parties, the victims, survivors and implicated, whose needs should be addressed and the lessons from their experiences taken notice of. There is a whole section that needs to be included here on how we could better treat the victims and survivors. Learning the lessons from healthcare that time spent just listening, talking and explaining the realities of situations, sympathetically and empathetically, is often much more helpful and cathartic than building up the expectation of retributive justice that often results from initial legally required defensive stonewalling.

The Alternatives

There have been suggestions about alternative approaches – for example Nicholas Timmins again:

"*In some cases, there may well be alternatives. The recent - highly revealing and highly cathartic - report on Hillsborough, was handled not by a public inquiry but by an independent panel. Lawyer free, much cheaper and quicker, and, in that case, chaired by a bishop*".[138]

But most do not address the inherent problems, the speed of response of the 'official' story and the trust and credibility of the source, which tend to form public opinion very early on in the process and if not addressed promptly, can cause the frustration and disillusionment with the entire process.

One of the more unsatisfactory aspects of this legalistically modelled process is then, the way that everything is put on hold until this 'public inquiry' has established facts, causes, and legal liabilities. Until then everything is *sub judice* and the corporate lawyers assume control. Cynical observers might refer to long grass and tin cans, but as outlined above, there are real consequences for delays in dealing with the human and technological implications of the lessons that need to be learned. People need closure and protection.

Rules and regulations need to be challenged if inappropriate. We cannot afford to wait years before definitive actions are taken on 'established' facts. What does the cost (millions) really buy us but time, important as that might be politically, or for compensation calculations?

The suggestion of a rapidly convenable independent panel (accident board) to identify the issues, the parties and the appropriate follow up is a model worth examining. This can be followed by more formal and legal processes in due course, but the wider lessons, appropriate immediate recommendations (but probably not the knee jerk blame), can be seen to be discussed and public opinion satisfied. Subsequent follow up can then be more measured and less pressured. Later the inevitable dissenting conspiracy theories

[138] https://www.instituteforgovernment.org.uk/blog/are-public-inquiries-worth-time-money-and-resources

and special pleadings will be able to make less impact on a public which already has a credible story to refer to.

Is there a way that this independent, trusted, non-conflicted group could create a 'safe space' for an inclusive examination of the incident? This could be a slim agile, independent accident board (similar to the aviation accident boards), with investigative powers and Chatham House rules, (with some overriding provision for national security or serious issues?). This could assist the government and reassure the public by tabling, as quickly as possible, a warts and all, working hypothesis? This would need to be extensively caveated with health warnings and not be used for legal actions (exceptions?), or liability evidence. Its findings may be over hasty, or overtaken by emerging evidence, but it will be able to rely on a safety net of a more formal and focussed legal inquiry / follow up report, to confirm and modify its first response. But some sort of legal exemption seems now to be in demand for the Grenfell Inquiry. What took them so long? Science and the law are essential pillars of society, but many people are thinking along the lines of, first, let's sort out, agree, or arbitrate a consensus on the science, before we have the legal battles.

We should be recognising that the real and immediate needs of the survivors are every bit as important as the need for the professionals and politicians to understand and really learn from these disasters. Many people feel that there needs to be some auditing of how actually the key findings from the various inquiries are followed up as they seem to have no formal standing in law or statute.

For most of these disasters, the main issues are not difficult to tease out. For example, an analysis of the Grenfell Tower fire[139] was produced in less than a week after the event.

It does not appear that in the intervening years the formal proceedings have thrown up anything which invalidates these initial findings. So why not get on with it and recognise and address promptly these humanitarian as well as the financial implications. Otherwise we will continue expensively, tragically and with real social consequences, not to learn from disasters.

[139] https://www.researchgate.net/publication/319183242_Gren

Postscript

Since this was written, we have become involved in a very different type of disaster (pandemic), to the 'accident' genre on which this report focusses. It is clear that here also, there will inevitably be calls for a "public inquiry" into how it has been handled. Nevertheless, much of the discussion on the tensions between blame and enlightenment will still hold. The major difference is the length of time that the disaster takes to unfold. This further strengthens the case for re-examining the wasted time and opportunities to learn, which are a consequence of deferring our learning opportunities until later. Such a timetable calls for thinking about a real time process of continuous learning and adaptation[140] to add a measure of resilience to our processes. The formal legal niceties can then follow in due course.

David Slater was educated at the University College of Wales and Ohio State University and initially taught chemical engineering at Imperial College, London. Through the 1970s and 1980s, as founder of Technica, he led the pioneering application of risk assessment techniques to the offshore and petrochemical industries. As Her Majesty's Chief Inspector of Pollution and Director of the Environment Agency, he had a leading role, through the 1990s, in developing and implementing risk-based pollution control legislation in the UK and Europe. He is currently a Director of the regulatory strategy organisation Cambrensis and holds a Royal Academy of Engineering Professorship at the University of Manchester.

[140] https://www.linkedin.com/pulse/coronavirus-learning-lessons-from-current-crises-david-slater/

www.bennettinstitute.cam.ac.uk

Department of Politics and International Studies
Alison Richard Building
7 West Road, Cambridge, CB3 9DT

office@bennettinstitute.cam.ac.uk

@BennettInst

UNIVERSITY OF CAMBRIDGE

Bennett Institute for Public Policy Cambridge