THE IMPACT OF LEARNING ON POLICY DEVELOPMENT IN RESPONSE TO CRISIS

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Abstract: In this paper, we review two significant events that were held up to the scrutiny of public inquiry in the UK. We suggest that outcomes of such reviews results in policy learning that is captured in new rules and regulations that may be more to do with learning lessons rather than creating the capacity to develop more effective practices. If policy learning is to become more effective, it has to grapple with the inherent difficulties associated with the idea that emergence and the capacity to take innovative, creative and effective action are at the heart of implementation, rather than the more simple objectification and institutionalization of norms.

Keywords: Policy Learning, Learning from Crisis, Emergence, Practice

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1. INTRODUCTION

A fundamental challenge for future organizational learning research is to develop better understanding of the impact of learning, especially during conditions of uncertainty and unpredictability (Antonacopoulou, 2009). Whether we describe these changing contexts as 'turbulent times' (Drucker, 1993), 'crisis' (Pearson et al. 2007), 'failures' (Mellahi and Wilkinson, 2004), 'disasters' (Turner and Pidgeon, 1997) or 'extreme events' (Buchanan and Dawson, 2007), what they all hold in common is that they highlight *emergence* and *emergency* as endemic in everyday practices (Antonacopoulou and Sheaffer, 2010). While a growing body of research examines the relationship between learning and crisis (Smith & Elliott, 2007; Weick & Sutcliffe, 2007; Baumard and Starbuck, 2005), this literature reflects the difficulties and range of conditions affecting whether or not learning actually takes place. These studies also acknowledge that we cannot assume 'lessons learned' from such experiences will suffice in developing a rigorous and relevant strategy to respond to future crises. Mindful of such concerns, we consider that an orientation towards '*learning in context'* demands that we consider the way in which a learning perspective potentially foregrounds unfolding practices and unexpected outcomes that are hidden from policy development processes. Thus, in this paper, we examine strategic learning and policy development in response to crisis by examining the enactment of policy in real cases.

A common response to organizational failure is to conduct an inquiry, internal or public. Where there are significant political or social implications, the public inquiry has become an institution. Drawing from Turner's (1976) notion of cultural readjustment it has been argued that the processes by which organizations learn from crisis may be seen through knowledge acquisition, knowledge transfer through to knowledge creation (Elliott, 2009). Central to this study is a critique of the frequent confusion between identifying lessons (policy learning) and organizational learning, which might be described as lessons flowing through into new practices. Simply put, we are interested to examine how policies tend to emerge in response to failures and crises and propose ways in which learning can become embedded in such policies. Our analysis will draw on recent cases where policies have been developed in relation to improving child care and in response to major environmental incidents. The specific child protection policy under review failed to prevent the deaths of two children as a result of physical abuse from their carers, despite these children being placed under the care of London's Borough of Haringey's Children Services. Laming's progress Report (2009) following the second neglect incident acknowledged praise for an 'outstanding policy document' developed in response to the Laming (2003) inquiry from the first neglect incident. In the second policy case, a major flooding incident is presented and the Public Inquiry Report (Pitt, 2008) is considered. In this case, the analysis of the detail of the report and its recommendations highlights a preoccupation with assigning responsibility and creating regulations, consideration of the landscape and technologies that create the backdrop to such a crisis, but less attention to the way that will need to be translated into social action in a future event. Thus, in both cases we can see how policy development and attention to detailing procedures do not necessarily prevent the specific events they were designed to address. A disconnection, between policy and practice, whereby new policies are formulated with only a limited appreciation of how the lessons identified may be disseminated and shape

future practice only goes to reinforce Elliott's (2009) assertions that the policy development processes through which organizations may learn from crisis are partial at best.

Given that even similar scenarios will differ in some regard, perhaps the experience of key staff, or the range of tools available, or the structural context in which an event occurs may be additional forces that will need to be orchestrated as part of a strategic organizational learning approach to deal with crises. If we are to account for the difference learning has the potential to make to policy development, we need to explore how the shifting contexts in which learning takes place 'in practise' provides a foundation for developing innovative responses, such as unlearning through experimentation (Antonacopoulou, 2006). We organize the ideas in the paper in three main sections. We begin with an overview of the current body of knowledge in relation to the role of learning in relation to failure and crisis. In the second section we present our cases and the lessons identified with in them. Thereafter, we illustrate a practice-based, strategic organizational learning view (Antonacopoulou, 2009) with reference to how policy development largely ignores the importance of emergent learning in context when implementing recommendations though analysis of two policy development examples. In doing so, we highlight the persistent difficulty in capturing learning from failure. In the last section we account for the potential impact of learning in response to contextual conditions. We conclude by outlining the implications for policy development and future organizational learning research and practice.

2. LEARNING AND CRISIS

2.1 Learning Lessons from Failure and Public Inquiries

A public inquiry is a typical official response to what have been described as focusing events (Birkland, 1998, for example). Such events share key characteristics with accepted notions of organizational crisis in combining material harm and/or threat, in exceeding an organization's capabilities to manage and in posing a symbolic challenge to the appropriateness of an organization's current operating norms and core beliefs (Turner, 1976; Pauchant and Mitroff, 1992; Pearson and Clair, 1998**).** Such events present a challenge to previously accepted norms and beliefs and may provide the motivation for identifying lessons to be learned.

Typically organizational learning from crisis has been conceptualized as a linear process, proceeding through the stages of knowledge acquisition and transfer to assimilation into the norms and practices of organizational actors (Elliott, 2009). Acquisition, through an inquiry, results in a collection of codified outputs in the form of recommendations for regulations, reporting structures, best practices, tools and technologies, for example. The limitations of public inquiry processes as a source of knowledge have been explored in a number of studies. For example, weaknesses include their vulnerability to pressure from established and well resourced advocacy coalitions who may push a particular line of interest (May, 1992; Birkland, 1998); or to the vicissitudes of the skill sets of an inquiry panel, political interference or limiting effect of the terms of reference (Elliott and McGuinness, 2002). A key limitation of the policy learning literature is the confusion of lessons identified with learning, a weakness also implicit in Turner's (1976) seminal work.

In one of a limited number of studies of 'knowledge transfer' after a crisis Elliott and Smith (2006) examined the influence of different patterns of regulation upon practice. Central to their analysis was a contested and fragmented institutional field in which regulations, a key

policy tool for implementing lessons identified, was one of many forces shaping practice. As Laming's (2008) observations after the second neglect incident indicate, that it was a failure to implement the sound recommendations he had made five years earlier, we contend that there has been a lack of attention to how new policy changes the social fabric and the capacity to enact change. If anything, we would argue that mindful of the cognitive and emotional challenges policies related to crisis entail, it is more likely that a sense of inertia may creep in as key actors struggle to come terms with the crisis in their learning. What this means is that lessons may well not be learned and changes in behavior may fail to materialize given the threatening implications that policy changes may have to current practices and key actors' identities. Following Elliott (2009) it can be argued that the persistent separation of policy from practice, (in the minds of policy makers and academics alike) may be one of the key reasons for why lesson are hard to learn. If policy is developed void of an understanding of the complexities of performing the key practices which it seeks to improve it is no surprise why the impact of learning may be limited. Clearly, if learning from the lessons that failures reveal is to be supported, then there is a need to better understand the process of learning in the midst of crisis and in relation to the context that crisis creates. Such a processual view of learning and of crisis management provides scope to appreciate beyond the basic knowledge processes (knowledge acquisition, creation etc.) the tensions that lessons from failure create that by implication will affect both the process of learning and the process of bringing about the desirable change. If we shift our attention from lessons learned to the impact of learning lessons then perhaps we can usefully also focus on the ways learning is implicated as part of everyday practice and not only in relation to critical incidents such as failures and crises. This processual perspective could also usefully form the foundation for understanding pragmatically the interplay between policy and practice in delivering (social) change. We explore this processual view next by focusing on the contextual specificity of learning and in relation to emerging organizational practices.

2.2 Learning in Practise and Emergent Practice

It has long been argued in organizational learning research that learning does not take place in a vacuum. Learning is purposeful and contextually specific at least as far as what is learnt, how learning takes place and, if it takes place, why it takes place (Carlile, 2002; Bechky, 2003). However, much of our analysis of context specificity has maintained a rather broad view of what context is ranging from such things as the industry characteristics and trends, the organizational culture on a macro level and individuals' predispositions and group psychological safety on the micro level (see for example, Spender, 1989; Knorr-Cetina, 1999; Tucker and Edmondson, 2003). The dominant view appears to be that when we do refer to context it is as if it were a container where learning takes place. We would question such a limited view of context and instead would be inclined to introduce here a view of context as a set of forces (visible and invisible, tangible and intangible) that participate in shaping and not just monitoring the learning process. We therefore, make the case for learning in context to account for the ways in which contextual forces participate in the learning process. We illustrate this perspective by drawing attention to two important aspects of context: artefacts and practices. We feel that both of these aspects of context reflect both the landscape and infrastructure that harbour the tensions embedded in learning.

The role of artefacts in the learning process has been receiving increasing attention in organizational learning research as our understanding of objects has also been enriched beyond the limited scope of these as just tools in the learning process (Engeström, 1987;

Engeström and Blackler, 2005; Macpherson et al, 2010). Objects and artefacts in particular carry a series of symbolic undertones that in some cases frame the way future emergent practice, or learning, is expected to take place (Knorr-Cetina, 1999). For example a public enquiry report, particularly if long and detailed in the recommendations it puts forward, signals implicitly the range of issues that need to drive future conduct. Such reports as a tangible object emanating from the otherwise intangible inquiry, provides credibility to the claim for the need to learn. However, recognising the need to learn and highlighting it through reports is no guarantee that learning will take place. Hence, inquiry reports and in particular the recommendations they tend to be organized around become the basis for outlining the specific learning that is expected to take place. The report as an artefact operates both as a retrospective account of past learning and a prospective account of further learning that is deemed necessary. In essence, such an artefact maps both the landscape for learning and provides the infrastructure (or so it is assumed) for pursuing such learning. Fundamentally therefore, artefacts embody the unheard voices of past learning (Engestrom, 1987; Spender, 1996). And it is here that we can note the tension that artefacts such as inquiry reports and their recommendations tend to generate. We would argue that one of the obvious tensions experienced is when attempting to put the recommendations into practice.

Implementing the recommendations from an inquiry report is akin to an invitation to embark on a reflexive critique that deconstructs aspects of the current practice and the ways in which such practices are performed. At the most basic level such an implication emanating from the process of implementation is a direct call for rethinking one's actions, one's accountability and responsibility in relation to such actions, and not least one's identity and self-esteem. However, while such challenges potentially upset personal and collective identities developed through these past accomplishments, and also settled institutional accounts of how to do things competently, they propose a preformed prescriptive account of how things should be in the future and do not acknowledge the uncertainty of predicting future 'best practice' when practice is applied in ambiguous and unpredictable circumstances. So we want to draw attention to a view of practices as emergent, a view that has in recent years extended the dominant institutionalization perspective that has formed the basis on which we have sought to understand organizational and social practices (see Antonacopoulou, 2008; Schatzki, 2005). By emergent practice we draw attention to the ongoing unfolding of action in the way social actors interact and transact as they negotiate different priorities. This means that practices are both reflections of the past and present landscape and infrastructure supporting what is already known and has been learned. At the same time, however, practices have the quality to unfold not only because of what is known, but what is not known and cannot be known in advance. This is where the emergent practice reflects future possibilities that may not have been thought possible ex-ante. Emergent practices are just that, possibilities that emanate from the creative scope to try things out, to experiment, to be in a practising mode in the midst of action. What this means is that when past learning fails to be relevant it is in the practising that learning replenishes the scope for action and the prospect for such action to lead to the desirable improvements. Fundamentally, this emergent practice cannot be predetermined, it cannot be controlled and it cannot fit into a list of recommendations either. It is by definition implicated in the everyday practice of *learning in practise*. This means that emergent practice is founded on the learning that unknown situations will call for not retrospectively and not prospectively, but in the midst of action.

We illustrate these modes of learning in relation to crisis in two case examples that we analyse exposing their approach to dealing with the crisis and the learning that the inquiry reports generated outlines in the list of recommendations it presents.

3. CASE ANLYSIS PROCESS

From the discussion above we can see that the learning from previous events in public policy development has been codified, generally in a number of recommendations following a public inquiry. Therefore, in analyzing reports, as well as considering the discourse and evidence, on which recommendations were based, specific attention was focused on how those recommendations were presented in terms of their intended influence on future activity, and the context in which that activity would take place. Guided by the literature on learning from failure and learning in context, discussed in the previous two sub-sections, when analyzing this data we paid attention particularly to the way in which such recommendations might be institutionalized within the specific arenas of our two cases: Child Social Care and Flood and Emergency Planning. Public Inquiry reports from both cases were loaded into Nvivo 8, and the recommendations were coded in terms of the type of action that was suggested, who was involved, whether this was a new technology, institutional structure or artefact that embodied the learning from the incidents. In addition, where appropriate, we noted whether new expectations were accompanied with measures that might help build the capability to implement such measures, in practice by those involved. In other words, attention was given to how lessons were identified, what those lessons might be, how they were intended to be implemented and put into practice. Initial codes were then grouped in similar categories and compared between cases. Following this second stage, four categories emerged*: institutional norms; tangible technologies; landscape; and capacity for action*. Each of these categories included several sub categories, but with some differences between cases to reflect each of the idiosyncratic problems and contents reviewed in the inquiry report. These categories were then used to construct an explanation of each case and the learning that emerged from the inquiry. These cases are presented below.

4. ANALYSIS OF TWO PUBLIC INQUIRIES

4.1 Victoria Climbié and Baby Peter: Failure of Care in the London Borough of Haringey

Since 1948 there have been around 70 public inquiries concerned with child abuse and protection in the UK. Since the 1970's Hinchcliffe (2003) reports a consistent eighty or so children die per annum as a result of abuse and neglect (although UNICEF (2003) suggest a figure of almost twice this in a survey of child maltreatment deaths in rich countries). Child maltreatment deaths are international phenomena, frequently linked to poverty and stress although influenced by other national contextual factors. Each child death is tragic, but some trigger particular concerns, especially when agencies charged with ensuring the care of children at risk are held to have acted inadequately. Despite their individual nature Hinchcliffe, (2003) identifies the emergence of a common pattern of failings; in communications between individual staff and between agencies involved in child care; in not following established procedures; in the inexperience and lack of skill of individual social workers; and the poverty of available resources. The death of Victoria Climbié in 2000 was one such case which attracted much attention. Social Services were first aware of threats to Victoria in May 1999. Two months later Victoria was admitted to hospital where a paediatric registrar informed the police about a number of injuries believed to be non-accidental. One week later Victoria was admitted to another hospital suffering from a scald to her face, where she stayed for 13 days, during which time a referral was made to Haringey Social Services.

Discharged from hospital Victoria was returned to the care of her carer, her great-aunt Marie-Therese Kouao. This was approved by a social worker and police officer, despite strong suspicions. For the remaining seven months of her life Victoria was seen only four times by professionals. Two visits were undertaken by the social worker allocated to Victoria, but she paid little attention to the young girl believing the main issue was poor housing. The other two times that Victoria saw a professional were when Kouao took her to Tottenham Social Services accusing her partner of abusing Victoria. Victoria died in February 2000 having been kept tied in a black sack, in a cold, unlit bathroom, beaten regularly and starved of food.

With high public interest in the case, not least because of the authorities' tardy response, an inquiry was commissioned (Laming, 2003b) which stated that:

> "Had this tragedy of Victoria Climbié been because one doctor, one social worker, one police officer, had failed to see one telling sign indicating deliberate harm, frankly there is no system in the world that can prevent that; any one of us can make mistakes ... However, when you get the whole system engaged ... [t]he very day that she died the case was being closed as no further action was needed, that was the day she was in the third hospital ... Never once was an assessment of need made; never once, whether by the hospital, social services or the police service. What happened to this little girl was shocking in the extreme." [quoted in evidence to Hinchcliffe, 2003:9-10]

Concluding that the legislative framework around child protection, established following previous inquiries was adequate, Laming (2003) asserted his intention to bridge policy with practice and to overcome the difficulties of implementation.

In 2007 seventeen month old Peter Connelly died at the hands of his carers in a house little more than one hundred metres from where Victoria had lived. Peter suffered ongoing brutal, maltreatment and his case was well known to a range of authorities; more so even than Victoria. Peter's death occurred four years after Laming's Report (2003) was published and new legislation, policy and guidance had been created and disseminated; his death seemed to point towards a failure to learn from the first incident – Victoria's case.

Among the lessons identified with regard to the practice of safeguarding children and young people in Haringey included:

- Poor strategic leadership and management from elected members and senior officers
- Failure to ensure full compliance with some requirements of Laming (2003) (for example, the lack of written feedback to those making referrals).
- Insufficient challenge from the local management boards to its member agencies.
- Lack of an independent chairperson for the Management Board.
- Poor communications between Social care, health and police authorities with regard to the assessment planning and review of cases of vulnerable children.
- Failure of assessments, across all agencies, to identify those at immediate risk of harm
- Inconsistent quality of practice across all agencies which is inadequately monitored by line managers.
- Poor quality child protection plans.
- Inadequate performance monitoring leading to inadequate support and/or challenge to managers and practitioners.

- Poor and inconsistent record keeping on case files across agencies.
- Over reliance on quantitative data to measure agencies' performance.

Many of these criticisms had been identified following the death of Victoria and had been the subject of recommendations from Laming's (2003) inquiry. Indeed Laming was subsequently asked to review progress being made to implement effective arrangements for safeguarding children (Laming, 2009); his frustrations are evident as he urges in his introduction that with the utility of policy and legislation the various agencies should "NOW JUST DO IT!" [7].

A number of recommendations were made with a view to translating the lessons learned from investigating the circumstances of Victoria's death into better child protection practice. These can be grouped into four main categories: *institutional norms; tangible technologies; landscape; and capacity for action*. The first category, *institutional norms*, included recommendations for the allocation of responsibility and levels of authority. Laming (2003) had observed:

> "This Inquiry heard too much evidence of organisational confusion and 'buck passing' for me to believe that the safety of a child can be achieved simply through issuing more guidance." [360-1]

To ensure proper lines of accountability Laming recommended the appointment of a cabinet minister to chair a National Children and Families Board (NCFB) which through its regional offices, would form a national infrastructure advising the minister on legislation, policy and guidance relating to families and children as well as monitoring and ensuring implementation by local authorities with social services responsibilities. At local authority level a 'Management Board for Services to Children and Families', was to be established and chaired by the Chief Executive; this board would possess strong links to community based organisations. The Board would appoint a director to oversee inter-agency arrangements. Government inspectorates would inspect both service delivery quality as well as the effectiveness of inter-agency arrangements. These recommendations identified clear lines of responsibility for senior officers and elected members and linked children and family services to the highest levels of national and local government. Thus, **Recommendation 7** states that:

> "The local authority chief executive should chair a Management Board for Services to Children and Families which will report to the Member Committee referred to above."[Laming, 2003: 372]

Another set of Laming's (2003) recommendations were focused around establishing best practice and process including detailed prescriptions on how cases should be allocated, managed, monitored and reviewed So **Recommendation 19** proposed that managers of duty teams must devise and operate a system which enables them immediately to establish how many children have been referred to their team, what action is required to be taken for each child, who is responsible for taking that action, and when that action must be completed. **Recommendation 21** proposed a new standard of process such that when a professional made a referral to social services concerning the well-being of a child, that referral had to be confirmed in writing by the referrer within 48 hours. Finally, **Recommendation 30 included instructions for** Directors of social services to ensure that senior managers inspect, at least once every three months, a random selection of case files and supervision notes. In other words, these types of recommendations stipulated levels of authority and outlined 'best practiced' procedures for tracking and monitoring standards of case referrals.

Our second category identifies *tangible technologies and tools*, including those intended to support a common language, acknowledging the performative nature of discourse (Wetherell (2001). Laming identified difficulties in working across disciplines and made recommendations around communication protocols around the referral of cases and information, the creation of a common language, and a shared electronic information system. Complementing Laming's (2003) recommendations establishing a national infrastructure, he advocated written documents confirming verbal referrals and information sharing, and the physical signing off by managers of action plans and of a random sample of case files and supervision notes undertaken every three months. This also provided an obvious audit trail for managers monitoring practice. Additionally he reports evidence of duplicate data systems being developed to capture quantitative, or easily codified knowledge, alongside others focused upon recording qualitative assessments or case notes. Another common weakness was that systems were rigid and might require double entry of some data, a problem compounded where individual agencies maintained their own systems alongside shared systems. The integration of systems within an organisation is difficult and near impossible between agencies. Fears about breaching patient or client confidentiality or the data protection legislation were all put forward as constraining information sharing between agencies. Laming (2009) noted the general poor understanding of data protection by frontline team members. In short, IS, databases, and other technologies did not support an integrated information and compounded the complex social and institutional infrastructure set up to manage such networks necessary for child protection.

The third of these categories, *landscape or context*, encompasses those recommendations that acknowledge the physical and social infrastructure that inevitably sets the scene on which such an event is played out. The influence of the social landscape is reflected in the persistent difficulties in communications between the various agencies engaged in safeguarding children, reflecting differing cultures and problems with feedback and communication. A key weakness was that some agencies had a strong view of role allocation whereby they viewed their roles as helping social services rather than themselves sharing responsibility for safeguarding children. Here then the networks of institutions and their institutional norms provide a social infrastructure that is an important aspect of the landscape of social care and child protection. More broadly, we might also consider the urban landscape as well, and the lack of oversight by close communities or families that might prevent or at least mitigate against early identification of the potential level of risk within particular households.

Finally, the fourth category, notes the building of *capacity and capability* to translate recommendations into action. It is worth reflecting on the fact that Laming (2009) does address some capacity and capability building measures in relation to low morale amongst staff working in child protection services with high levels of staff turnover and vacancy rates approaching 10% compared to 0.7% for teachers. Within some of the authorities visited, Laming estimates that more than 50% are new qualified with less than a year's experience. Numbers of health visitors is at an all time low and finally child protection work is perceived of as low status police work. Reflecting on the success of implementing his earlier report he advocates that any call relating to child protection should be quickly transferred to a trained person with access to a social worker with experience of complex or high risk referrals. He also recognises that the actual quality, education and experience of those involved in such cases may be inadequate and suggest that such expertise may need a concerted effort to raise the value of health and social workers and to develop human capital of its practitioners. So as

an example in **Recommendation 85,** the Department of Health is tasked with inviting the Royal College of Paediatrics and Child Health to develop models of continuing education in the diagnosis and treatment of the deliberate harm of children, and in the multi-disciplinary aspects of a child protection investigation, to support the revalidation of doctors described in the preceding recommendation. This should develop the capacities and capabilities of doctors in identifying and managing such cases. **Recommendation 102** suggests that The Home Office, through Centrex and the Association of Chief Police Officers, must devise and implement a national training curriculum for child protection officers as recommended in 1999 by Her Majesty's Inspectorate of Constabulary in its thematic inspection report, *Child Protection*. Here again the intention is to develop the human capital available to improve the capacity for action in the future.

Also, responding to criticisms of an over emphasis upon process and targets, Laming (2009) identifies the declining time for reflection, peer based learning and apt, supportive supervision. Indeed, many of the systems discussed above did not support reflective thinking, or the exercise of judgement which lies at the heart of risk analysis. All of these are suggested to require attention if the implementation of policy recommendations are likely to be successful through creative, reflective and emergent practice.

4.2 Gloucester Floods: The Pitt Report

In June and July of 2007, there were a number of 'extreme weather events' that resulted in two major floods within the United Kingdom. The floods were considered to be 'the country's largest peacetime crisis since World War II' (Pitt, 2008: vii). The first flood occurred during the week of 20th June and affected significant areas in Yorkshire and Humberside; the second, during the week of 18th July, mainly affected Gloucestershire, Warwickshire, Shropshire, Herefordshire and Oxfordshire. The Meteorological Office (Met Office) provides weather forecasts for the Environment Agency, whose responsibility it is to provide appropriate extreme weather warnings to the general public. During these extreme events, four of the Environment Agencies regions experienced problems with the flood forecasting systems, ether due to technical failures or to inadequate equipment. Due to the volumes of water involved, flood defences were overwhelmed in 50% of cases due to overtopping, although the actual flood defences only failed physically in 0.2% of cases. Flooding was caused either by: 'fluvial flooding', due to the volume of rain and the lack of capacity to absorb that rain in the ground or to transport it in the rivers; and 'pluvial flooding', due to the volume, intensity and locality (in urban areas where drainage is limited) of rainfall (Pitt, 2008).

As well as thirteen deaths, there was widespread damage to households, businesses and infrastructure (such as roads, power supplies, water supply and telecommunications). In the June event infrastructure failures included the shutdown of the Neepsend electricity substation and the closing of the M1 for 40 hours for safety reasons, and the near collapse of the Ulley reservoir dam. In the July event, the Mythe water treatment works flooded, leaving 350,000 without mains water for two weeks. In addition, 10,000 people were left stranded on the M5 and surrounding roads, and 500 people were left stranded at Gloucester railway station. In both cases, power was lost to approximately 40,000 homes; a near catastrophic failure was averted by flood defences at Walham substation, which would have meant the loss of power to 500,000 people. The human effects included coping with the aftermath of the flood damage to homes and businesses (8,600 homes flooded in Hull (20,000 people) in the

June event), and coping with the devastation and stress caused during the event with impacts on the elderly, fear of opportunistic theft when housed in emergency shelters, loss of communications, lack of clean water, health problems and managing claims and clean up. Businesses had to cope with loss of power, communications and premises as well as recovering lost paperwork, missed orders and dealing with insurance claims. In the agriculture sector, widespread loss of crops was the most significant factor, but there was also a significant loss of animals that affected dairy and livestock farming. Heritage sites were also damaged. The economic impact is impossible to estimate, but was considered to be billions of pounds, both in damage recovery and lost revenues.

Against this backdrop, a major public inquiry was launched, the findings of which are known as the Pitt Review, since it was led by Lord Pitt. This report, published on 25th June 2008, ran to 505 pages, and included 92 recommendations. The report itself was constructed from extensive written and verbal submissions, visits to affected areas and consideration of other countries' experiences. The most notable criticisms of the events focused on the poor quality of flood warnings, the lack of technical ability to manage flood risk, critical infrastructure failures that lead to the loss of essential services, the difficulties in coordinating and managing the response to the crisis, and the lack of education and advice on how to protect homes and to recover from such a crisis. In other words there were failures in the preparation, management and recovery from the crisis. Through close examination of the recommendations it is possible to categorise them into a number of areas, which will be described below.

The first category, *institutional norms*, included recommendations for the allocation of responsibility and levels of authority, expected standards, procedures, routines, or regulations that should be followed in the preparation for, management of, and recovery from, a flooding event. Particularly stark was the number of recommendations that allocated a specific responsibility to an institution. So, for example, **Recommendation 1** suggests that:

> Given the predicted increase in the range of future extremes of weather, the Government should give priority to both adaptation and mitigation in its programme to help society cope with climate change'

This recommendation assigns overall responsibility to government for the development of a response to future likely flood scenarios, and as such would suggest that the performance in preparation, management and recovery of any future event would be, partially at least, a judgement about Government competence. In other words, by assigning responsibility to Government for enabling society to cope with the effects of climate change, this provides a norm and institutionalized expectations against which future conduct will be assessed. Another example in this category would be **Recommendation 2 and 3** that the Environment Agency (EA) is responsible for a national overview of all flood risk. This provides a template against which the EAs future conduct can be judged as legitimate, or not, but also this recommendation provides the EA the authority to engage in activities that can be justified with reference to the outcomes of the Pitt Review. The majority of recommendations include a specific allocation of responsibility to institutions to develop procedures, policy or regulations and are indications of how they might be held accountable for future actions. Institutions that are included in such 'standards' or 'norms' driven recommendations include the police, rescue services, the met office, local authorities, specific government departments (such as Defra, Department of Health and the MOD), Heritage Trust, the insurance industry and local businesses.

The second category, *tangible technologies*, encompasses those recommendations that indicate a need to invest in specific, or future technological development, that might enable better flood warning, or to provide records for preparation and management of floods. They also suggest recommendations about how technologies can be embedded in institutions, and which can be incorporated into operations to allow the management of preparation, coping and recovery. So for example, **Recommendation 62** suggests an urgent need to invest in telecommunications technologies to allow access to flood warnings on an 'opt out' basis. **Recommendation 37** includes discussion about the development of flood visualisation tools. **Recommendation 44** suggests that the facilities (accommodation, IT and communications) of category 1 & 2 responders should be assessed and improved if necessary to incorporate technologies that provide redundancy and resilience. Finally, as an example at least, **Recommendation 6** provides for the investment in the technical capability to forecast, model and warn against all sources of flooding. Overall, such recommendations encompass issues such as flood prediction technologies, IT, and communications. Mainly the technologies discussed are in the areas of flood prediction and mapping.

The third of these categories, *landscape or infrastructure*, encompasses those recommendations that acknowledge the geographic, physical and social infrastructure that inevitably sets the scene on which such an event is played out. Here then we are concerned with recommendations that acknowledge that floods that involve property, for example, will be inevitable within a country that has houses built on flood plains, and that transport, communication, power, sewerage and water grids, are part of the landscape of any future event. Recommendations in relation to landscape issues consider ways to limit potential damage by containing development and/or ensuring that existing and future infrastructure and building development incorporates safeguards to alleviate the impact of floods. So, **Recommendation 7** advises that future developments in high flood risk areas should include consideration of such risk in developing and maintaining defences. **Recommendation 9** argues for a control on the laying of impermeable surfaces in gardens and in businesses. **Recommendation 10** suggests that connection to sewerage infrastructure should not be a right, but must depend on capacity. Other specific recommendations include the acknowledgement that resilience needs to be built into critical infrastructure assets, such as power station redundancy, in order to mitigate or understand the risks associated with such assets. Finally, there are 23 recommendations that suggest the creation of networks of institutions in order to prepare for, manage and recover from flood events. For example **Recommendation 14** tasks local authorities with developing networks with local institutions to manage local flood risk. **Recommendation 27** proposes and alliance between Defra, the Environment Agency, Natural England and other parties to develop natural protection measures within shorelines and flood catchment areas. Recommendation 39 tasks the environment agency with making timely information on floods available to the disaster management commands. Therefore, while there cannot be a removal of risk from flooding given the historical development of the nations' infrastructure, recommendations in this category argue for attention to the continued development of a landscape (social and physical) to be cognisant of flood risk and to 'build in' safeguards and networks where possible and/or appropriate.

Finally, there are recommendations that attempt to *build capacity and capability* to take actions. Since any future response to flood will inevitably depend on how emergency services, government, and citizens are able to cope with emerging situations, these recommendations suggest ways of practicing, and developing human and social capital to

cope with an emergency. In other words, these are the sort of activities that enable resilience by creating the capacity of social action through developing networks of actors to cope with management and recovery. Such recommendations include those targeted at how resilience can be built into the capacity of individuals, local neighbourhoods and voluntary organizations to be prepared and self reliant during crisis. **Recommendation 70** for example acknowledges that, in such a scenario, official emergency agencies are likely to be stretched beyond capacity and that much of the management and recovery to a flooding event will depend on the creativity, ingenuity and capability of individuals and communities to take action. It is their human and social capital—their experience and local networks—that will enable the mitigation of extreme events. Such local 'Resilience Forums' are considered to have a crucial role in any crisis. Another type of recommendation in this category focuses on practicing by, and creating networks between, agencies directly involved in flood management. This is intended to be done by implementing 'flooding exercises' to prepare and test new coordination arrangements, **Recommendation 49**.

5. DISCUSSION AND CONCLUSIONS

In both cases there is a stark bias towards the review of procedures, responsibilities, authority, standards and regulations that set the context and expectations of future conduct. In that sense, lessons learned are predominantly defined with reference to institutional instruments of control and norms of expected behaviour. They provide a set of 'best practice' understandings about institutional and individual responsibilities. In addition, other findings shape the particularly material and symbolic context and landscape on which future practice will be conducted. Such tools and changes embody the current state of knowledge about how we might have coped better with the event that has just taken place. While this is not to suggest that such learning is not valuable, nevertheless such tools and physical and social landscape will essentially be part of the context of any such future event (Elliott and Macpherson, 2009). So, since most recommendations tend to be framed as prescriptions for *how to do things differently* so that current practices are improved, or a more suitable material and symbolic context is shaped, it is not hard to see the difficulties brewing in the midst of any effort to make the lessons learned from past experience relevant to experiences that are yet to be had. For we must not forget that the whole purpose surrounding learning that is implicated in the implementation of recommendations, is learning that would be expected to generate change on a whole range of levels. If we consider how organizational practices are to be transformed as a result of the learning that recommendations outline, it is not hard to see why there may be resistance by individual actors to change how they do what they do. It is not hard to see why the very infrastructure for performing existing practices may be hard to change given all the networks of actors and their collective approaches will need to be redesigned. It is not hard to see, why the organizational culture will be put to scrutiny and the way things are done around here will no longer be considered valid. All in all, these challenges may not appear hard to see, but perhaps most of the time we tend to miss seeing them not least because we also ignore that organizational practices, however fixed we might consider them to be, they do have an emergent quality.

Ofsted (2009), in a review of baby Peter's case observed that a key challenge was:

> "to ensure that leaders of local services effectively to translate policy, legislation and guidance into *day-to-day practice on the frontline of every service*."[4, italics added]

Laming's (2003) advocacy of best practice and establishing audit trails reflects a strengthening trend in public service accountability. Auditors collect and analyse evidence from which they can form a judgement of adequacy. Indeed an Ofsted (2006) inspection undertaken as Peter suffered abuse and neglect found Haringey's arrangements for the social care of children to be adequate with good prospects for further improvements. A year later Haringey's services were rated as good (Elliott, 2009), a view dramatically revised in 2008 after Peter's death when a number of serious concerns were identified including, inadequate line management and leadership including poor oversight by elected members and senior officers; a managerial failure to ensure full compliance with Laming's Report; poor inter agency communications; poor child protection plans; poor record keeping on case files; and an over reliance upon quantitative data to monitor performance (Ofsted, 2008b). It appears that Ofsted too could be duped by an over reliance on quantitative measures to the detriment of narrative accounts (Butler, 2008). Indeed, commenting on the fact that an earlier audit had found Harringey's social care of children to be compliant with expected standards, the Ofsted's chief inspector initially explained this turnaround by claiming that standards had declined steeply; a view revised days later with the admission that officials had been able to "hide behind" false data to achieve a rating of good (Curtis, 2008; Elliott, 2009).

Yet amidst the audit culture there are voices that recognise it is not compliance with quantitative evidence that identifies good practice:

> "I have no time for a 'tick box' approach. Statistics are no substitute for inspections. As inspectors, we are far more interested in outcomes and how they are achieved than whether people are dotting the Is and crossing the Ts in their self-evaluation forms. ... we want our inspectors to see more of what is happening on the ground, whether through more lesson observation or talking to social workers. But data matter too. And given recent concerns, I have asked council chief executives to assure me of the accuracy of any data provided by their authorities." [Gilbert, 2008]

In the actual application of the procedures defined in Laming (2003) it is evident that there was much leeway in applying proper procedure. For example, contemplating Peter's death Haringey's Director of Children Services stated that that they operated rule of optimism in which their starting premise was that parents were working with them (see Badham, 2008). It was suggested that social workers proved too willing to believe the accounts of Peter's mother, who was described as a dominating and forceful individual (Badham, 2008). Here, then, the actual failure is perhaps not one of procedures, but the ability to deal with a complex evolving case and to be able to influence others and to use the human capital and social capital to manage a difficult situation which was constantly emerging in, and through the practice of a number of institutions and individuals. It is stark though, that only a few of the recommendations of Lamming address the capacity of individuals to conceptualize problems and take action. Even then the recommendation only addresses raising the quality of social workers by through better *standards* of education within the profession.

In the second policy case, Elliott and Macpherson (2009) have discussed how the major flooding incident resulted in a significant breakdown and failure in business continuity management, despite a local government agency winning awards for its business continuity management processes. The problem is that such awards are presented based on paper plans, procedures and records. They take no account of how those plans are actually put into action. Elliott & Macpherson concluded that learning in, and from, experience prepares us only to repeat the lessons learned to make meaning of, and act out, practice in a similar situation.

While the plans may have been appropriate for some extreme or unforeseen events, they did not prepared local government for the unforeseen exceptional flooding. Also, it is not clear from the report how effective the actual actions taken were to implement the prepared plans. Only when things breakdown do we become aware of the inadequacy of our recognised practices (Chia & Holt, 2009; Turner, 1976). In this case the awards are meaningless unless they are plans on which they are based are actually tested. Also, while those involved may have learned valuable lessons, and made valuable contacts when enacting (unsuccessfully) the business continuity plans, they will never get the chance to put this learning into practice again since they were moved roles as part of a restructuring in response to this perceived failure. Moreover, within the case discussion leading to recommendations there was recognition that further disaster was avoided by the ingenuity, creativity and tenacity of people dealing with the situation as it unfolded. This resulted in a recommendation to practice for future events through multi-agency exercises. This shows some recognition that the institutional norms, tools and landscape are only the backcloth against which emergency or emergent actions take place.

We have tried to capture the focus of policy learning in the figure below. Here we represent the focus of policy learning on such outcomes that define the context of future activity, and only a few such actions are likely to be directly targeted at the capacity to take innovative or creative action in dealing with a future difficult or extreme event. Yet it is such *emergence* that is possibly more important when trying to cope with ambiguity and uncertainty. It is not that identifying lessons is not important, but we must also be cognizant that such lessons are put into practice, but rarely in circumstances that replicate the events in which they were formed.

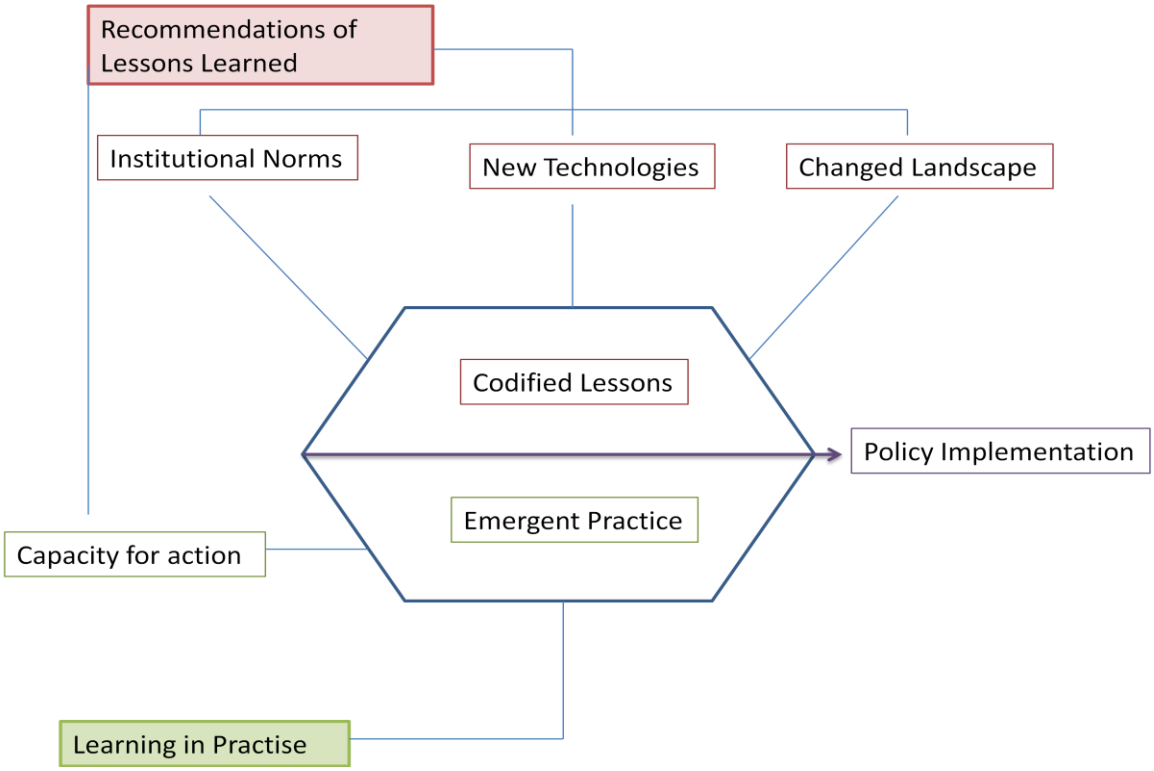

Figure 1: Recommendations for Learning Lessons

Indeed lessons learned become embedded in the context that shapes and defines accepted practice, but dealing with unforeseen or difficult cases requires that such understanding of 'best practice' evolves continually. In the floods we can see emergent practice evident in the immediacy of having to cope with extreme events. Even in more day-to-day environments, such as social care, it is possible to identify how tools, procedures and social structures hampered effective implementation of intended outcomes. Indeed, in the Baby Peter case, compliance through audit hid the inability to effectively apply learning in real events. If policy learning is to become more effective, it has to grapple with the inherent difficulties associated with the idea that emergence and the capacity to take innovative, creative and effective action are at the heart of implementation, rather than the more simple objectification and institutionalization of norms.

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