Written evidence from Professor Lucy Easthope (STI0018)

I am a specialist in disaster response and recovery, with a particular interest in the aftermath of disaster and the legal process.

My work brings me into regular contact with the inquiries process after tragedy.

I have highlighted below a number of areas of concern. These are:

1. Inquiry "machinery" inc cost – teams including data analysis and researchers moving from one inquiry to the next.
2. Inevitable timescale delays – people dying during process, families feeling justice is delayed, other similar incidents happening before the inquiry reports.
3. Failure to consider interaction with other legal processes after disaster particularly criminal and civil processes.
4. Unsatisfactory 'folding in' of inquest process into unsuitable inquiry process.
5. Hard to reconcile candour with reputational and legal advice.
6. Choice of Experts and misuse of bias/ conflict.
7. Expertise of Secretariat and use of time cut offs, other country examples, bodies of research - when understanding subject that they are inquiring into.
8. Final editorial process and material selection.
9. Terms of Reference.
10. Overselling of what an inquiry delivers.
11. Disclosure behaviour – "data dumps" by government departments and failing to comply with the spirit of duty of candour.
12. Rules of disclosure unclear and unsanctioned compared to other areas of English and Welsh Law.
13. Failure to consider other methods - e.g. fast action reports and urgency grants for disaster studies on the ground. [Positive examples include The Kerslake Review and the ESRC Urgency Grant fund, now discontinued].

14. Consistent sense of non-delivery/ injustice for families when inquiry report is received.
15. Mixed messages as to purpose – judicial v memorialisation v restorative v blame.
16. Exclusion of other types of post-disaster learning methodologies.
17. No central oversight for recommendations or comparative analysis of multiple inquiries finding similar issue [e.g. Covid inquiry, Grenfell inquiry and Manchester Arena attacks inquiry all cover similar ground on Civil Contingencies Planning].
18. Traumatic process for all participants including respondents despite measures to improve experience.
19. No central and protected library for material relating to UK disaster including hard copy of reports. Repetition of key learning. My own research has found that all inquiry findings can be broadly categorised into approximately 10 themes.
20. Removal of training on public inquiries process and the 2005 Act from the UK Emergency Planning College portfolio

However it is important to note:
Inquiries serve an important purpose and many participants have reiterated that both the process and the final report are meaningful.

Sample Resources

Cortvriend, A. et al, 2023. When This Is Over: Reflections on an Unequal Pandemic. Bristol University Press.

Disaster Action website. www.disasteraction.org.uk as at 1.3.2024.

Easthope, L. 2008. Public inquiries: A thematic review of the research. Cabinet Office Emergency Planning College.

Easthope, L. 2018. The Recovery Myth. Palgrave.

Easthope, L. 2022. When The Dust Settles. Hodder and Stoughton.

Kerslake Arena Review. 2018. https://www.kerslakearenareview.co.uk as at 1.3.2024.

Toft, B. 2005. Learning From Disasters: A Management approach. Palgrave.

Wells, C. 1995. Negotiating Tragedy: Law and Disasters. Sweet and Maxwell.

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