



# Risk and responsibility : A Lawyer's view

**>> MARK SCOGGINS**

Solicitor Advocate, Fisher Scoggins LLP





**Fisher Scoggins** LLP

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# **Risk and Responsibility**

## **The Legal Aftermath**

### **A Lawyer's View**

#### **Barbican**

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**Mark Scoggins**  
Fisher Scoggins LLP  
Hamilton House  
One Temple Avenue  
London EC4Y 0HA

Tel: 020 7489 2035  
Fax: 020 7489 2113  
Mobile: 07711 086177

Email: [scoggins@fisherscoggins.com](mailto:scoggins@fisherscoggins.com)

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## Aims and objectives

- Legal and liability issues
- Prove you do and did a good job
- Defend your process and decisions
- Deter enforcement action
- Deter civil compensation claims
- Defend your actions in court and elsewhere
- Put forward the strongest mitigation
- Keep your reputations

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## Expectations and assumptions

“Public perceptions of acceptable risk and expectations of what will be done in an emergency are ... changing. The speed with which the media reaches the scene and communicates its impressions has intensified public scrutiny of disasters. Increasingly, expectations are for causes to be identified and addressed quickly – and that *response arrangements will be thought out well in advance and effectively coordinated.*”

**Cabinet Office Emergency Planning Review  
Discussion Document August 2001  
§4.6**

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## Apart from being sued what to worry about?

- Internal debrief/inquiry
- HSE/EA/HPA/other regulatory report
- Public inquiry
- Inquest
- Criminal prosecution
- Trial by media and public opinion
- Central government
- Council meetings public and private
- Employees and other stakeholders
- Disciplinary proceedings

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## Who are your real judges?

“There is an overarching, fundamental lesson to be learnt from the response to the 7 July attacks .... there is a lack of consideration of the individuals caught up in major or catastrophic incidents. Procedures tend to focus too much on incidents ... and ... processes rather than people. Emergency plans tend to cater for the needs of the emergency and other responding services, rather than explicitly addressing the needs and priorities of the people involved.”

**London Assembly  
Report of the 7 July Review Committee  
6 June 2006  
§ 1.15 page 9**

## Why are you a potential target?

- Where is the aggravation going to come from?
- What constituency will have the motive and the means?
- Three main groups:
  - *Involved* (survivors)
  - *Affected* (relatives/friends)
  - *Everybody else*
- Action groups form overnight: *FaceBook, Youtube, Bebo*
- Governments set up public inquiries only under pressure
- Prosecutions are an easy way of deflecting the blame
  - ... and smothering public debate
- Compensation claimants look for deep pockets
- Surely someone (in authority) must be to blame

## The scrutiny

- What you decided/ordered/did
- Why
- When
- How [*inc. depth & breadth of consultation*]
- Implemented/achieved?
- Effective?
- Reviewed/revised?
- Logged or otherwise credibly provable?
- Easily locatable long after the event?

## The principle in practice

“I believe that the ability to retrieve and view documents which record *key decisions* is not just important, but *essential* – and equally important is the *rationale* behind them.”

**David Masters**  
**HM Coroner for Wiltshire**  
**Inquest into Hercules crash of January 2005**  
**22 October 2008**

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## **Ideal approval ... ministerial praise**

“I would like especially to praise the work of the Thames Valley emergency services, and also the agencies who worked closely together to respond to the accident with well-prepared contingency plans.”

**Alistair Darling**

**Sec of State for Transport**

**10 November 2004**

**[Ufton Nervet level crossing crash of 6 November]**

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## CLAIM ... AND BE ABLE TO PROVE

- “We did a good and professional job”
- “We could cope: service as (almost) usual”
- “We were as ready as we could reasonably be”
- “Safety of people came first by a very long way”
- “The top took and takes a vigorous interest”
- “Saving money was not a consideration in safety”

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## CLAIM ... AND BE ABLE TO PROVE

- “We had a robust plan and it worked well”
- “We acted quickly, decisively and sensibly”
- “Decision-making was informed and swift”
- “Everybody knew their role and did it well”
- “We had the best information available to the right people”



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**Everything going badly wrong  
will likely have the same root cause**

**COMMUNICATION  
FAILURES**

## **Not just theory ...**

“The key to an effective response to a major or catastrophic incident is communication. This includes communication within and between the emergency, health, transport other services. It also includes effective communication with the individuals caught up in the incident, and the public at large.”

**London Assembly  
Report of the 7 July Review Committee  
6 June 2006  
§1.9 page 8**

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## Communications failures in their main forms

- The hardware won't work properly (or at all)
- People will be poorly trained/equipped/led
- Information will be:
  - Sparse/unavailable/contradictory
  - Not shared (or quickly enough) with the right people
  - Redacted/edited/suppressed (in good faith)
  - Distorted/inaccurate/incomplete (but not treated so)
  - Not acted upon (or quickly enough)
  - Not recorded accurately or at all



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## **Public judgment**

“I accept that Severn Trent’s response to the emergency was impeccable ... appropriate in every way.”

**H.H. Judge Geddes QC  
Dept. of Environment v Severn Trent Water  
Hereford Crown Court**

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## **Praise in execution**

“The fire-fighting tactics employed by the combined forces of the French and UK teams were competent and effective. The two Commanders worked together and they amended their strategies to cope with developments. The fire-fighting operation was characterised by resoluteness and high personal commitment of the fire-fighters ... The fact that no fire-fighters suffered serious injury ... is a credit to them and to the tactics employed. The Commanding Officers of both nations deserve commendation for their performance of duty at this difficult fire.”

**Channel Tunnel Safety Authority  
Report of the Inquiry into the fire of 18 November 1996  
Chapter IX para 23**

## **Working together ... too late to do anything**

“As of September 11, the Port Authority lacked any standard operating procedures to govern how officers from multiple commands would respond to and then be staged and utilized at a major incident at the WTC.”

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## **Preparation and planning again ...**

“The lack of training or experience of Eurotunnel staff in the management of emergencies was apparent. ...[T]he overriding requirement for sound communications collapsed at an early stage. ... The public emergency services’ principal officers in the two Incident Control Rooms were not immediately aware of this and for an hour unsuccessful attempts were made to establish the important link between the two command posts. ... System failures, coupled with reliance on manually kept records, have made detailed analysis of aspects of the command and control function very difficult.”

**Channel Tunnel Safety Authority  
Report of the Inquiry into the fire of 18 November 1996  
Chapter VIII paras 19 & 20**

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## Weaknesses in planning despite years of experience

“All Posts have been required to prepare emergency plans for many years, but ... the plans we reviewed revealed differences in the detail, content and level of staff involvement in preparing the plan. Two common weaknesses were a lack of detailed planning of *individual roles and responsibilities* ... and failure to consider what *assistance* may be available from *other* ... Posts .”

**National Audit Office Report  
Consular Services to British Nationals  
24 November 2005  
Para 4.10**

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## Speed and readiness: a lack of both

“The EHOs of North Lanarkshire Council were extremely slow in obtaining even such information as Mr Barr was prepared to give them about his outlets and when given information they did not react competently. My impression is that they were not sufficiently well briefed to have been an efficient force. They did not know what the overall plan was, *if any*, of which their work was part.”

**Graham Cox QC, Sheriff Principal**  
**Fatal Accident Inquiry into the E. coli 157 outbreak**  
**Ruling: page 122**  
**14 August 1998**

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## Exercise and improve

“Posts are also encouraged to test their emergency plans at least once a year using both table-top exercises ... and “live” exercises. The FCO ... survey indicated that so far only *one third* of the Posts we consulted had tested their plans. *Common* problems revealed by tests include *faulty communications, absences of key staff* and *difficulty in gaining access* to affected areas .”

**UK National Audit Office Report  
Consular Services to British Nationals  
24 November 2005  
Para 4.12**

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## The most recent ... and sadly typical ... example

“Inter-agency cooperation ... is inadequate. Agencies are generally working in isolation from one another and there is ... a lack of effective co-ordination. The relationships, accountabilities and lines of communication between [agencies] are not sufficiently clearly defined. Not all of the agencies are clear about their remit or how their work links with the work of others. ... The standard of record-keeping ... across all agencies is poor. The capture and dissemination of organisational learning is not systematic and relies on individual leaders taking responsibility for circulating good practice.”

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**Joint Area Review  
Into the death of Baby P  
1<sup>st</sup> December 2008  
Para 4.12**

## **Do you know ... ?**

- Your own job and responsibilities
- Your staff's jobs and their knowledge of them
- The actual state of readiness around the region
- Arrangements between occupiers of shared sites
- Arrangements between public and private bodies
- The true capacity of the emergency services to assist
- Where the buck stops ...

## Key questions for those in charge (on the ground or higher)

- What was *your* job in the incident?
- Were you *relevantly trained* to do it?
- Did you have a *clear plan and procedures*?
- Did you get all the *support and resources* you needed?
- Did you do your job *properly*?
- Did other people do *theirs*?
- Can you *prove* it?
- Could you all have done a *better* job – if so, how?
- Why did you not do that better job on *this* occasion?

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## Poor communication after the event ...

“it is ... disappointing that the tone of the report [*of the London Assembly*] is largely negative. There is... little acknowledgement of the openness of responding agencies about the lessons learnt ... The report was not shown to responders in advance of publication (despite an earlier undertaking to allow the LRT to check it for accuracy), and the Committee does not seem to have the benefit of informed ‘technical’ advisers. As a result there are a number of misunderstandings and inaccuracies that could have been eliminated, reducing responders’ concerns.”

**London Regional Resilience Forum  
Multi-Agency Debrief into the 7/7 Response  
22 September 2006  
§ 4.6-4.7**

## **No record, no proof, you lose the argument**

“Unfortunately, it is not possible to examine in detail the London Ambulance Service’s response to the Edgware Road explosion ... because records of the response were not maintained. The timeline provided to us by the London Ambulance Service contains no entries beyond 9.21 am... This failure to maintain records is not unique to the Ambulance Service; the London Fire Brigade has also commented ... on the failure to record information about its response and the need to do so in future.”

**London Assembly  
Report of the 7 July Review Committee  
6 June 2006  
§3.37 page 52**

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## **The Case for the Defence**

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**Rational**

**Professional**

**Informed**

**Flexible**

**Calm**

**Concerned**

**Co-operative**

**Accountable**

**Prepared**

**Recorded**

# The End

**... and may the blame be found to lie  
with someone else ...**

**(provided the evidence proves it)**