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ARTICLE

Inquiring into Disaster: The Efficacy of Inquiries as Opposed to Alternative Mechanisms in Learning from Disaster Events

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As one of the most significant disaster responses in recent history, it has been announced that there will be an inquiry into the response of the New Zealand government to the COVID-19 pandemic. Public calls for an inquiry were framed on the idea that, while present generations have learned from COVID-19, "it's vital those lessons are passed on to future generations" for future pandemics. The idea of learning from past disasters to improve conditions for and prevent or prepare for future disasters is a common theme in disaster response, inquiries into disaster events, and administrative law more generally. This article investigates four key inquiries which sought to learn from disaster events, in order to better prepare for future similar disasters. I examine whether these inquiries actually achieve purposes such as punitive accountability and public catharsis rather than the learning they claim to achieve. While these alternative purposes are equally valid and fulfil important societal functions, my analysis will show that they overshadow the learning function of inquiries, which our disaster response framework suggests should be their primary function. Ultimately, through analysis of three case studies, I will conclude that alternative mechanisms like independent reviews are better for achieving a pure learning purpose. Although, inquiries still have a place in public law in relation to punitive accountability and public catharsis. Both inquiries and reviews have a place in our recovery from the COVID-19 pandemic, and we can play to the strength of each to truly improve our response frameworks.

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I Introduction

In 2022, the New Zealand Government announced the Royal Commission of Inquiry into Lessons Learned from Aotearoa New Zealand's Response to COVID-19 That Should Be Applied in Preparation for a Future Pandemic.[1] While we have already seen smaller agency reviews by the Disability Rights Commissioner, the Finance and Expenditure Select Committee and the Auditor-General,[2] throughout the pandemic, there had been calls for an inquiry into the overall government response.[3]

Public calls for an inquiry were framed on the idea that, while present generations have learned from COVID-19, "it's vital those lessons are passed on to future generations" for future pandemics.[4] As we returned to a "new normal", calls for an inquiry grew more prevalent: "The end is in sight, but the pandemic has left an indelible imprint on the nation's soul. And to heal we need to understand it better."[5] As epidemiologists Michael Baker and Nick Wilson stated, it was important to build on our successful pandemic response "with a strong, science-informed strategy" to get us through the rest of the pandemic and be ready to respond to future health disasters.[6]

The Royal Commission of Inquiry, chaired by epidemiologist Professor Tony Blakely, announced on 5 December 2022 that it will inquire into the government's overall response to the COVID-19 pandemic to learn from it and help New Zealand better prepare for future pandemics.[7] The Inquiry is expected to report back in mid-2024 and will examine a wide range of subjects, including the legislative and regulatory measures used to support public health and immediate economic responses, to the consideration of the interests of Māori during the pandemic.[8] The Inquiry's website states:[9]

> The Royal Commission is focused on identifying lessons that can be learned from the COVID-19 experience to strengthen our overall pandemic preparedness. It's important we learn from the past, so we are better prepared for the future.

1 Radio New Zealand "Royal Commission of Inquiry into Covid-19 pandemic response: What you need to know" (5 December 2022) <www.rnz.co.nz>.

2 Gabrielle Baker and Paula Toko King *Inquiry into the Support of Disabled People and Whānau During Omicron: Final Report* (Human Rights Commission, 20 April 2022); Finance and Expenditure Committee *Inquiry into the operation of the COVID-19 Public Health Response Act 2020* (July 2020); and John Ryan *Co-ordination of the all-of-government response to the Covid-19 pandemic in 2020* (Office of the Auditor-General, B.29[22j], December 2022).

3 Alexander Gillespie and Claire Breen "NZ needs a royal commission into its Covid-19 response" (10 December 2021) Radio New Zealand <www.rnz.co.nz>.

4 Gillespie and Breen, above n 3.

5 Andrea Vance "Covid-19: the death of more than 1000 New Zealanders merits an inquiry" (29 May 2022) Stuff <www.stuff.co.nz>.

6 Michael Baker and Nick Wilson "New Zealand's new cut-down Covid response is a missed opportunity – here are 5 ways to improve it" (16 September 2022) Radio New Zealand <www.rnz.co.nz>.

7 Radio New Zealand, above n 1.

8 Gillespie and Breen, above n 3; and Jamie Ensor "Royal Commission of Inquiry into New Zealand's Covid-19 response announced" (5 December 2022) Newshub <www.newshub.co.nz>.

9 NZ Royal Commission Covid-19 Lessons Learned "About Us: Mo mātou" <www.covid19lessons.royalcommission.nz>.

Continual improvement is a central facet of disaster response, as is reflected in the third edition of the *Coordinated Incident Management Systems* (*CIMS*).[10] This is the framework used by emergency management agencies to coordinate and cooperate effectively, and was used by most government agencies to respond to the COVID-19 pandemic.[11] *CIMS* uses doctrine to inform training and development, which informs incidents, which cyclically informs doctrine.[12] Similarly, response to events is seen as a cycle to recovery, with recovery now included as an express role in the third edition.[13] Continual improvement is seen as a counterpart to prevention, which is a key element of Civil Defence Emergency Management.[14] This supports the idea that it is always ideal to prevent an incident rather than prepare for one. Equally, the nature of disaster events often means that preventing them is impossible. For example, the inquiries into events surrounding the Canterbury earthquakes will not prevent another earthquake from happening, though they may improve conditions for future earthquakes and help us prepare for them.

The idea of learning from past disasters to improve conditions for and prevent or prepare for future disasters is a common theme in inquiries into disaster events and administrative law more generally. Mark Bovens identifies "The Learning Perspective" as one of the effects of accountability processes in general.[15] Alongside this, Boven identifies "Popular Control" of those in power by the public and "Prevention of Corruption and Abuse of Power" as primary effects, and reinforcing the legitimacy of governments and allowing for public catharsis as secondary effects.[16] While inquiries often aim to have learning at their centre, this article will examine whether they actually seek punitive accountability, such as popular control or prevention of corruption and abuse of power, as described by Bovens. This will largely be seen when inquiries seek to find fault in public actors or when they recommend policy reform. This article will also examine whether inquiries allow the "secondary effect" of public catharsis to take over, as inquiries will always be performative accountability due to their highly visible nature. Catharsis often has an important place in disaster events, as it "can help to bring a tragic period to an end", because it gives a voice to victims and makes public actors account for their conduct.[17] However, sometimes this secondary purpose can overshadow the learning function of inquiries, which *CIMS* suggests should be their primary purpose.

This article looks into various inquiries into disaster that have aimed to assist in preparing for future disasters. It is incredibly common to see calls for an inquiry after a significant societal event, and I will examine whether inquiries actually achieve purposes such as punitive accountability and public catharsis rather than the learning they claim to achieve. While these alternative purposes are equally valid and fulfil important societal functions, the analysis will show that they overshadow the learning function of inquiries, which *CIMS* suggests should be their primary function. Ultimately, I will conclude that alternative mechanisms like independent reviews are better for achieving a pure learning

10 New Zealand Government *Coordinated Incident Management System (CIMS): Third Edition* (Officials' Committee for Domestic and External Security Coordination, August 2019).
11 At 5.
12 At 13.
13 At 8–14.
14 At 107.
15 Mark Bovens "Analysing and Assessing Accountability: A Conceptual Framework" (2007) 13 ELJ 447 at 463–464.
16 At 463.
17 At 464.

outcome, though inquiries still have a place in public law in relation to punitive accountability and public catharsis.

This article will use Professor W John Hopkins' definitions of "disasters" or "disaster events".[18] While "disaster" and "emergency" are often used interchangeably in legislation, they may be distinguished by their scale, consequences and duration.[19] An emergency is something that requires an immediate response, though it may not have significant lasting consequences.[20] While not every emergency is a disaster, emergencies may become disasters if they have lasting impacts on wider society, requiring ongoing public intervention.[21] Hopkins illustrates this by using the example of a house fire, which is an emergency that only impacts those directly involved, as opposed to the Canterbury earthquakes or Indian Ocean tsunami, which are "obvious examples of such emergencies leading to disasters".[22] Each of the examples used within this article are clearly disasters, and often if an event calls for an inquiry, it will be a disaster by default, as the need for an inquiry reflects the event's ongoing societal impact.

It is undoubtedly true that COVID-19 has had a far greater ongoing impact than comparable disasters examined in this article. However, on a practical level, the New Zealand Government has responded to the pandemic using the exact same framework as other disasters. Therefore, the pandemic differs only in the scale of its impact and response. For this reason, I have no hesitancy in using previous disasters as a mechanism to evaluate how we may best learn from the COVID-19 pandemic. Every disaster is, to some extent, unique, and it is inevitable that any comparison will be imperfect. However, these comparisons are important if we are to continue learning from disasters.

In examining the forward-looking impact of inquiries, I will first describe our statutory regime for inquiries and the powers available to them. Next, I will analyse four inquiries which each claimed to achieve improvement purposes following significant disaster events:

(1) the Commission of Inquiry into the Collapse of a Viewing Platform at Cave Creek Near Punakaiki on the West Coast;
(2) the Royal Commission on the Pike River Coal Mine Tragedy;
(3) the Royal Commission of Inquiry into Building Failure caused by Canterbury Earthquakes; and
(4) the Royal Commission of Inquiry into the Terrorist Attack on Christchurch Mosques on 15 March 2019.

I will ultimately find that these inquiries tended to emphasise other purposes, such as punitive accountability and public catharsis, which overshadowed and minimised the effectiveness of their learning function.

In light of this conclusion, I will compare these inquiries against smaller-scale reviews which also achieved improvement purposes. I will examine the following:

(1) the Independent Review of Maritime New Zealand's Response to the MV Rena Incident on 5 October 2011;

18 W John Hopkins "The First Victim—Administrative Law and Natural Disasters" [2016] NZ L Rev 189 at 192.
19 At 192.
20 At 192.
21 At 192.
22 At 192.

(2) the post-implementation review of Hurunui/Kaikōura Earthquakes Recovery (Unreinforced Masonry Buildings) Order 2017 and Securing Fund; and
(3) the Review of WorkSafe New Zealand's Performance of its Regulatory Functions in Relation to Activities on Whakaari White Island.

Analysis of these reviews will show that reviews are generally better mechanisms for achieving real learning following a disaster due to their focused and more internal nature.

Finally, in light of this comparison between inquiries and reviews, I will analyse whether a review or the impending Inquiry would be more appropriate to learn from the COVID-19 pandemic, since it is by learning from past disaster events that we may revise how we respond to current and future ones. In this analysis, I will look at reviews that already exist in relation to COVID-19 and the potential alternative purposes that could overshadow the learning purpose of the COVID-19 Inquiry. I will ultimately conclude that reviews are more appropriate for learning from the COVID-19 pandemic and its response. However, there is still a role for an inquiry in relation to fact-finding, punitive accountability and public catharsis since we are able to implement a dual approach and play to the strengths of each mechanism.

II Inquiries in New Zealand

In order to best understand how we can learn from the COVID-19 pandemic, we must first understand how inquiries function in the New Zealand context, particularly in relation to their purposes. This section will outline the statutory framework for inquiries and the functions and purposes they fulfil. Following this, I will build on this context and analyse different case studies of inquiries.

Inquiries are, to an extent, part of our national culture, and their place in our public consciousness is represented by the public outcries for inquiries often heard in the media.[23] This was particularly seen prior to the announcement of the COVID-19 Inquiry. New Zealand has had a culture of inquiries since its inception, as our first formal inquiry recommended that our seat of government should sit in Wellington, where it now remains.[24] The Law Commission suggested that this culture of inquiries highlights how "independent review is perceived as an important way of seeking answers and allaying public concerns".[25] The inquiries examined in this article will show how disasters loom particularly large in the public consciousness, heightening the need for independent examination. Many of our significant policy changes have emerged from inquiries, including our accident compensation regime, electoral system and court structure.[26] We also commonly have inquiries into conduct, including how disasters occur, as is the subject of this article.[27]

Inquiries are transient, without permanent structure or status, reflecting the often-unanticipated events which provoke them.[28] This gives inquiries a unique opportunity to solve problems flexibly, aided by their adaptable structure and procedure.[29] In the

23 Law Commission *A New Inquiries Act* (NZLC R102, 2008) at 40.
24 At 4.
25 At 40.
26 At 4.
27 At 4; and Ivor Richardson "Commissions of Inquiry" (1989) 7 Otago LR 1 at 13.
28 Law Commission, above n 23, at 37.
29 At 39.

discussion of the previous law, the Law Commission described that the potential reasons why an inquiry may be set up are:[30]

(1) establishing the facts;
(2) learning from events;
(3) catharsis or therapeutic exposure;
(4) reassurance;
(5) accountability, blame and retribution;
(6) political considerations; and
(7) policy development.

The inquiries in this article all attempt to undertake a "learning from events" approach, and this article will analyse whether they actually undertake "catharsis or therapeutic exposure" and "accountability, blame and retribution" purposes. As put by the Law Commission, one of the key problems which hinder the progress and value of public inquiries arises where different purposes conflict.[31] Not all purposes can be pursued conjointly; the more purposes pursued by one inquiry, the less cohesive the inquiry will be.[32]

For this article, inquiries will be defined as in s 6 of the Inquiries Act 2013 (the 2013 Act), including all three kinds of inquiry available to us, the first of which is the "heavy artillery" of a Royal Commission of Inquiry, which stands above the others in terms of prestige.[33] Below this sits public inquiries established by the Governor-General and government inquiries established by Ministers. These "differ only in status, method of appointment, and the way they report back".[34] Additionally, this range of options enhances flexibility.[35] All of these kinds of inquiries may be established for matters of public importance, including disaster events.[36]

The modern regime for inquiries comes under the 2013 Act, which provides for public inquiries, government inquiries and Royal Commissions into matters of public importance.[37] Terms of reference govern each inquiry, and, under s 12(1), each inquiry must prepare a final report for presentation in line with these terms of reference.[38] These terms of reference generally provide the purpose of the inquiry and what an inquiry should and should not inquire into.

Inquiries must act independently, impartially and fairly and may not determine any civil, criminal or disciplinary liability of any person.[39] However, an inquiry can make findings of fault or recommend further steps to determine liability.[40] An inquiry generally has control over its procedure, though it is governed by the principles of natural justice and the need to avoid unnecessary delay or cost.[41]

30 At 37.
31 Law Commission *The Role of Public Inquiries* (NZLC IP1, 2007) at 18.
32 At 18.
33 Law Commission, above n 23, at 4.
34 Inquiries Act 2013, s 4; and Cabinet Office *Cabinet Manual 2017* at [4.79].
35 At [4.79].
36 Inquiries Act, s 3(1)(a).
37 Nadja Tollemache *Laws of New Zealand Information* (online ed) at [102A].
38 At [102B]–[102C].
39 At [102C]; Inquiries Act, ss 10 and 11(1); and Cabinet Office, above n 34, at [4.87].
40 Tollemache, above n 37, at [102C]; and s 11(2).
41 Tollemache, above n 37, at [102D]; s 14; and Cabinet Office, above n 34, at [4.88].

The old regime for inquiries came under the Commissions of Inquiry Act 1908 (the 1908 Act).[42] Interestingly, the 1908 Act provides explicitly for inquiries into:[43]

> ... any disaster or accident (whether due to natural causes or otherwise) in which members of the public were killed or injured or were or might have been exposed to risk of death or injury.

This means that inquiring into disaster was seen as a purpose in and of itself, which perhaps relates to the need for public catharsis following significant events.

The 2013 Act emerged out of the Law Commission report discussed above, which identified issues of expense, delays, formality and adversarial methods with the existing regime, which created a preference for ministerial inquiries, which were less useful because of the limited powers they had available.[44] The 1908 Act had been amended too many times, becoming confusing and constraining the powers available to inquiries.[45] The Law Commission recommended a new regime, which eventuated in the 2013 Act.[46]

Ivor Richardson outlined that it is important when assessing the performance of any particular inquiry to identify its nature, context, the conduct of the inquiry and its conclusions.[47] This aids in understanding the diverse conditions in which inquiries are established, and where possible, this article will identify relevant context as it relates to the analysis of purpose.[48]

For the purpose of this article, the majority of the inquiries examined are under the 2013 Act. For each inquiry, I will discuss the report's context, terms of reference and conclusions. While the nature of the inquiries is not the subject of this article, it is an element of context essential for analysing the inquiry's effect.

With this basic understanding of the framework in which inquiries exist, we may now begin by analysing case studies of inquiries into disaster events, which hoped to achieve improvement and learning purposes, to assess the efficacy of inquiries for this purpose. These case studies will generally show that the learning purposes of inquiries tend to be overshadowed by alternative purposes, and therefore a COVID-19 inquiry might not be the best mechanism for learning from the pandemic.

III Inquiry Case Studies

Inquiries are not only a part of our national culture, but they are a part of our incident response culture. When we have a disaster, particularly one which results in fatalities, we will nearly always have an inquiry to inform our recovery and preparedness for future events. However, analysis will demonstrate that these inquiries also tend to allow public mourning through public catharsis, fault-finding and policy reform through punitive accountability. Analysis of the following case studies will show that these overshadowing purposes minimise the effectiveness of the learning function of inquiries, and therefore

42 Tollemache, above n 37, at [102L].
43 Law Commission, above n 23, at 48; and Richardson, above n 27, at 3.
44 Law Commission, above n 23, at 4 and 13.
45 At 13.
46 At 5.
47 Richardson, above n 27, at 7–8.
48 At 7–8.

an inquiry may not be the best mechanism to learn from the COVID-19 pandemic. This will first be shown through an analysis of the Cave Creek Inquiry.

A *Commission of Inquiry into the Collapse of a Viewing Platform at Cave Creek Near Punakaiki on the West Coast (1995)*

The Commission of Inquiry into the Collapse of a Viewing Platform at Cave Creek Near Punakaiki on the West Coast was established in 1995 following the collapse of a viewing platform where 14 young people lost their lives.[49] The young people belonged to a group of 17 students from an outdoor recreation course, who crowded onto the viewing platform above Cave Creek when the platform collapsed and fell about 30 metres.[50]

In a similar way to the COVID-19 pandemic, though on a smaller scale, the incident loomed large in the public consciousness, "because this is such a small country, many people know of someone who was involved".[51] This led to the establishment of the Commission of Inquiry on 8 May 1995 under Judge GS Noble to inquire into the cause or causes of the collapse and the lessons to be learned so that such a tragedy might never recur.[52] This means that the Inquiry explicitly hoped to achieve fact-finding and learning functions. This section will analyse whether these purposes were fulfilled and whether the learning function of the Inquiry was, in fact, overshadowed by other purposes.

On the above matters, the report concluded that system failures caused the catastrophe:[53]

> Standing back and viewing the evidence objectively … I am left with the overwhelming impression that the many people affected … were all let down by faults in the process of government departmental reforms.

These systemic failures meant that the primary cause of the collapse was that the platform was not constructed correctly, contributed to by inadequate engineering input, mismanagement of the construction, non-compliance with statutory requirements, lack of loading restriction signs, inadequate inspections of the platform and an insufficient project management system for employees.[54] The Inquiry, therefore, concluded that the department acted unlawfully, and that Crown immunity from prosecution under the Building Act 1991 and Health and Safety in Employment Act 1992 should be removed.[55] This finding of fault contributes to the purpose of punitive accountability, even though it was outside the scope of the Inquiry. The report also concluded that the lessons that may be learned from the incident are that governmental departments must have adequate

49 GS Noble *Commission of Inquiry into the Collapse of a Viewing Platform at Cave Creek Near Punakaiki on the West Coast*: *Preliminary information and contents* (Department of Internal Affairs, 10 November 1995) at 11.

50 At 11.

51 At 11.

52 At 11.

53 GS Noble *Commission of Inquiry into the Collapse of a Viewing Platform at Cave Creek Near Punakaiki on the West Coast: Part Two* (Department of Internal Affairs, 10 November 1995) at 93.

54 GS Noble *Commission of Inquiry into the Collapse of a Viewing Platform at Cave Creek Near Punakaiki on the West Coast: Part One* (Department of Internal Affairs, 10 November 1995) at 117–118.

55 Noble, above n 53, at 130; and for immunity under the two Acts: at 138 and 140 respectively.

resources before they are charged with carrying out statutory functions that benefit the community.[56]

From these conclusions, we may see that the fact-finding function of the Inquiry took primacy and that this tangentially became a finding of punitive accountability, even though this was not within the scope of the Commission. The learning function of the commission seems to have taken a back seat, though arguments may be made that finding causes and fault will assist in preventing future similar incidents. While this is true, the explicit statement of a learning function in the purpose of the Inquiry should have received more explicit consideration within the report. Inevitably, public pressure morphed the focus of the Inquiry into one of catharsis and punitive accountability.

One important development to note is the action the Department of Conservation has taken since the Inquiry to ensure that similar incidents do not happen.[57] This is noteworthy because it demonstrates that learning has happened on a practical level. The Department has implemented a Visitor Asset Management System to ensure inspections of all structures within the Department every two years, with high-risk structures inspected by engineers every six years.[58] Furthermore, the Crown's exemptions under the Building Act and Health and Safety in Employment Act were removed, and an additional $127 million was given to the Department to ensure improvements were made.[59] As a result of the measures, the Department of Conservation website reads, "we are confident that the same set of circumstances that led to Cave Creek will never happen again".[60] These changes show that, while learning from the disaster may not have been addressed adequately within the Inquiry, it appears to have happened within the Department.

In summary, while the Inquiry aimed to fulfil the purposes of fact-finding and learning, it instead fulfilled the purposes of fact-finding, punitive accountability and public catharsis. While learning was present in the Inquiry, it was overshadowed by other purposes and was instead fulfilled through an internal review. This raises the question of whether inquiries are the appropriate function to learn from events, as real learning appears to have only happened within the Department of Conservation's internal review. While the Inquiry helped to determine cause and fault, it may not have been the appropriate forum to enact the actual learning from the event. This will be reflected later in this article as inquiries are contrasted against internal reviews, which may be more appropriate forums for learning from disaster events.

The Cave Creek Inquiry successfully achieved the learning function set out in its purpose, despite not addressing it adequately within the Inquiry. This means that the Inquiry was successful in learning from the disaster event, though this may not have been a consequence of its own merits. This suggests that internal reviews may be the best mechanism to learn from the COVID-19 pandemic rather than inquiries, and this same trend can be seen in the Pike River Inquiry.

B *Royal Commission on the Pike River Coal Mine Tragedy (2010)*

The Royal Commission on the Pike River Coal Mine Tragedy was established in December 2010 following a major explosion on 19 November at the Pike River mine near Greymouth,

56 At 93.
57 Hugh Logan "Ten years on" Department of Conservation <www.doc.govt.nz>.
58 Logan, above n 57.
59 Logan, above n 57.
60 Logan, above n 57.

where 29 employees or contractors of Pike River Coal Ltd were trapped underground, though two escaped.[61] On 24 November, a second explosion occurred, which was not survivable, and the mine exploded two further times before it was sealed.[62]

Analogous to the COVID-19 Inquiry, the significance of the disaster meant that an Inquiry was established. The Commission was to look into the cause of the explosions and loss of lives, the mine practices, the search, rescue and recovery operations and the current law.[63] The terms of reference for the Inquiry asked for recommendations on the prevention of similar disasters, alongside recommendations for the ongoing safety of the mine, practices for search, rescue and recovery in similar disasters and any changes needed to relevant laws and practices.[64] This shows an explicit learning aim alongside fact-finding and policy reform purposes. These policy reform perspectives can relate to popular control, which comes under the bracket of punitive accountability. The findings of the Inquiry itself reinforce this:[65]

> The lessons from the Pike River tragedy must not be forgotten. New Zealand needs to make urgent legislative, structural and attitudinal changes if future tragedies are to be avoided. Government, industry and workers need to work together.

The Inquiry therefore aimed to fulfil the purposes of learning and punitive accountability, and this section will analyse whether learning was fulfilled or whether the pursuit of alternative purposes, such as punitive accountability and public catharsis, overshadowed it.

In reference to its learning purpose, the Inquiry made a total of sixteen recommendations to avoid future similar tragedies from occurring.[66] These recommendations included that there should be a new regulator with a sole focus on health and safety, updates to mining regulations, more worker participation in health and safety and improvements to emergency management.[67] These suggested reforms appear to largely focus on the learning purpose specified in terms of reference, as administrative and regulatory reforms such as those suggested reduce the likelihood of further tragedies.[68] This shows implied findings of fault under punitive accountability despite not being provided for in the terms of reference.

This analysis demonstrates that, while the Inquiry was asked to achieve the purposes of learning and punitive accountability, it instead placed emphasis on public catharsis, which overshadowed the prescribed purposes of learning and punitive accountability. While the learning scope was achieved, when an inquiry is spread thin across multiple purposes it cannot be expected to achieve all of them to its fullest ability.

Interestingly, the Commission coincided with the establishment of an inspectorate for mining and petroleum and an independent task force to review New Zealand's health and safety system.[69] This indicates that perhaps an internal review would have been, and

61 Graham Panckhurst, Stewart Bell and David Henry *Royal Commission on the Pike River Coal Mine Tragedy: Volume 1 + Overview* (October 2012) at 6.
62 At 12.
63 At 3.
64 At 7.
65 At 3.
66 At 13.
67 At 36–40.
68 At 29.
69 At 31.

indeed was, a more appropriate mechanism to learn from the event. There is a question here of what the government really intended when establishing the Inquiry if it also established a coinciding review on the same subject.

We may imply that this means the Inquiry's true purposes were fault-finding and public catharsis, despite what was stated in its terms of reference. The Inquiry was a useful way to display to the public that the Government intended to learn from the disaster, though the actual learning appears to have occurred through internal mechanisms.

Alongside the above analysis of the Cave Creek Inquiry, discussion of this Inquiry demonstrates that, while inquiries can achieve learning purposes, they tend to be overshadowed by other purposes. The actual learning in both inquiries analysed so far has been achieved through internal reviews, and as such, we must question whether internal reviews may be a more appropriate mechanism for us to learn from the COVID-19 pandemic. However, an exception to this trend may be seen in the success of the Canterbury Earthquakes Inquiry.

C *Royal Commission of Inquiry into Building Failure Caused by Canterbury Earthquakes (2011)*

On 22 February 2011, the Canterbury region, including Christchurch City, suffered a significant aftershock following a series of earthquakes beginning on 4 September 2010.[70] The 22 February earthquake prompted one of the most significant disaster responses in New Zealand's living memory, with 185 people dying of injuries suffered in the aftershock.[71] Such a significant disaster triggered the Royal Commission of Inquiry into Building Failure Caused by Canterbury Earthquakes.

This Commission was established on 14 March 2011 under Chairperson Cooper J and engineers Sir Ron Carter and Richard Fenwick as Commissioners, with the purpose of examining issues around the built environment in the Christchurch central business district and inquiring into future adequacy of the relevant building codes and standards.[72] The need for this Inquiry arose from the fact that most of the deaths that occurred during the earthquake resulted from building failure, including the multi-fatality failures of the Canterbury Television (CTV) Building and the Pyne Gould Corporation (PGC) Building.

The purpose of the Commission was to inquire into the cause of building failures and the adequacy of the current legal framework for buildings, and to provide recommendations on measures necessary or desirable to prevent or minimise future building failures due to earthquakes.[73] This purpose provides for fact-finding purposes and learning purposes, excludes fault-finding and does not mention public catharsis. This section will analyse whether this learning purpose was, in fact, achieved, or if it was overshadowed by other purposes, as happened in the case studies analysed above.

The majority of the recommendations made by the Inquiry were of a technical nature on how to improve buildings for future earthquakes, though some more general recommendations were made relating to building management in disasters.[74] Looking

70 Mark Cooper, Ron Carter and Richard Fenwick *Final Report: Volume 1* (Canterbury Earthquakes Royal Commission, 29 June 2012) at 3.

71 At 3.

72 Canterbury Earthquakes Royal Commission "About the Royal Commission" <https://canterbury.royalcommission.govt.nz>.

73 Cooper, Carter and Fenwick, above n 70, at 15.

74 Mark Cooper, Ron Carter and Richard Fenwick *Final Report: Volume 5* (Canterbury Earthquakes Royal Commission, 29 November 2012).

forward, the Commission also made various recommendations for legislative, policy and best practice changes to prevent and minimise the failure of buildings in future earthquakes.[75]

Overall, the recommendations from the Commission and the changes they influenced have significantly impacted the development of better learning and preparedness for the next earthquake disaster. Following the Inquiry, the government accepted most of the recommendations the Commission made.[76] The government has introduced new laws for managing earthquake-prone buildings, implemented immediate changes to processes and created cross-agency actions, improved occupational regulations for building and construction sector professions, revised standards and created or updated guidance for designing new buildings.[77] These were part of a multi-year work programme within Ministry of Business, Innovation & Employment (MBIE).[78]

Since this Commission specifically addressed building collapses and aimed to improve our systems going forward, it seems that it has achieved its purpose of helping us to learn from the earthquakes. However, new design methods are constantly being invented and can only be tested in significant events such as major earthquakes.[79] While inquiries like this reduce the likelihood of future building collapses, they do not guarantee that such events will not happen.[80]

From this brief analysis, inquiries seem to have been an effective tool in helping us to learn from the Canterbury earthquakes and assisting in the continual improvement of our public systems as they relate to emergency management in disaster events. Due to the more technical nature of the Inquiry, there appears to have been less overshadowing by other purposes, though elements of catharsis and punitive accountability are seen in the Inquiry's final report, which relates to the failure of the CTV building.[81] This is unsurprising due to the high public interest in the CTV building failure, though it does detract from the improvement function of the Inquiry to some extent and is not necessarily reflected in the terms of reference for the Inquiry.[82]

This Inquiry is one of the few analysed in this article that fully achieved the learning purpose it set out to achieve. However, it also achieved some aspects of punitive accountability and public catharsis, even though they were not prescribed in the terms of reference. This demonstrates that even highly technical inquiries can be distracted by other purposes, though in this Inquiry, the alternative purposes did not entirely overshadow the learning purpose.

Interestingly, an independent review may not have been better at learning from the disaster in this case, though it may have been more focused and allowed more expert contribution. There is no doubt that the public catharsis element of this Inquiry was important after such a significant disaster, though this detracted from the central learning purpose of the Inquiry, even if only to a small extent.

In summary, this inquiry has been more successful than others at achieving a learning purpose, due to its technical nature, though even this inquiry has been subject to the

75 At 5.
76 Ministry of Business, Innovation & Employment *Responses to the Canterbury Earthquakes Royal Commission recommendations: Final Report* (February 2017) at 4.
77 At 4.
78 At 1.
79 At 2.
80 At 4.
81 Cooper, Carter and Fenwick, above n 70, at 1–2.
82 See Appendix 1: Terms of Reference.

secondary purposes of public catharsis and punitive accountability. This limits the efficacy of the inquiry's learning purpose, albeit minimally in this case.

If we attribute the more focused nature of this Inquiry to its highly technical nature, then we can infer that such success would not be replicated in a COVID-19 inquiry. While epidemiology is a specialist field, there is a good general understanding of public health and high public interest in COVID-19. It is much more likely that the purposes of the COVID-19 Inquiry will follow the pattern shown in the Cave Creek and Pike River Inquiries, and learning would be overshadowed by punitive accountability and public catharsis. For these reasons, an internal review may be more appropriate for learning from disasters as set out in *CIMS*. This same pattern is shown in the Christchurch Attack Inquiry.

D *Royal Commission of Inquiry into the Terrorist Attack on Christchurch Mosques on 15 March 2019 (2019)*

On 15 March 2019, an individual carried out a terrorist attack on Al-Noor Mosque and the Linwood Islamic Centre in Christchurch, murdering 51 people and attempting to murder a further 40 people.[83] The individual is now serving a sentence of life imprisonment without parole.[84] The Commission was announced just ten days after the event, reflecting the grave impact of the attack.[85] William Young J and Jacqui Caine were appointed as commissioners.[86]

The Inquiry was directed to examine what State sector agencies knew about the individual's activities, what action the agencies took, whether there were any additional measures the agencies could have taken and "what additional measures should be taken by relevant State sector agencies to prevent such terrorist attacks in the future".[87] This focus on public actions and response can be analogised to the terms of reference for the COVID-19 Inquiry, which direct the Inquiry to examine legislative, regulatory and operational settings.[88] The Christchurch Mosque terms of reference similarly sought recommendations on improvements to information gathering, sharing and analysis practices and any changes that could improve relevant State sector agency systems or operation practices to prevent future attacks.[89] This required "expansive thinking about the systems and institutions set up to protect and connect New Zealanders".[90]

These terms of reference show that the Inquiry had an explicit learning purpose, alongside fact-finding and policy aims. The terms of reference further imply a purpose of punitive accountability in examining whether state actors could have taken further measures. The Inquiry interpreted these terms as in the course of making "recommendations for the future".[91] This section will discuss whether these learning and punitive accountability functions were achieved or whether they were overshadowed by public catharsis.

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83 William Young and Jacqui Caine *Report of the Royal Commission of Inquiry into the terrorist attack on Christchurch masjidain on 15 March 2019* (26 November 2020) vol 1 at 7.

84 At 10.

85 At 10.

86 At 48.

87 Royal Commission of Inquiry into the Terrorist Attack on Christchurch Mosques on 15 March 2019 Order 2019, cl 5(d).

88 Royal Commission of Inquiry (COVID-19 Lessons) Order 2022, sch cl 4(1).

89 Royal Commission of Inquiry into the Terrorist Attack on Christchurch Mosques on 15 March 2019 Order, sch cl 5(1)(a).

90 Young and Caine, above n 83, at 10.

91 At 10.

The Inquiry found that there were insufficiencies in the firearms licence application process,[92] though the planned attack "could not have been detected except by chance".[93] However, the Inquiry recommended systemic change in creating a national intelligence and security agency to provide a more comprehensive approach.[94] Importantly, the Inquiry concluded that:[95]

> New Zealand will never be immune from violent extremism and terrorism. Even with the best systems in the world, a determined would-be terrorist could carry out an attack in New Zealand in the future.

Terrorist attacks are a kind of disaster that can never be fully prevented, though we may still learn from them and improve our systems in response. Because of this, the Inquiry identified that the government should establish a greater commitment to transparency with New Zealanders, and that we all have a part to play in setting values in our communities.[96]

The Inquiry appears on first glance to have fulfilled its learning purpose, alongside its fact-finding and policy purposes, which contribute to popular control and punitive accountability. However, it also acknowledged the importance of public catharsis: "The most important of these [themes and issues] is the need to confront and engage openly with hard issues."[97] This shows that, while the Inquiry was asked to achieve learning and punitive accountability purposes, it also achieved the purpose of public catharsis, which minimised the efficacy of the learning purpose. Once again, we must question to what extent multiple purposes can be realised by one inquiry without being spread too thin.

The Inquiry has initiated systemic change, which should improve conditions for future disasters. This should be applauded, though it reveals more than anything that multiple purposes are inevitably pursued in inquiries. When a public mechanism is intended to placate the public need for catharsis, it will always be subject to the whim of the public and the overlapping and contradictory desires of the people impacted. It is, therefore, the role of the government to ensure that the correct mechanism is used to fulfil the intended purpose, and for a learning purpose, this may not be an inquiry. From the analysis of all four case studies in this article, we must therefore ask whether internal reviews are the best mechanism to learn from the COVID-19 pandemic rather than inquiries. The next section of this article will continue this analysis by looking at the benefits of inquiries more broadly and whether there are any benefits of inquiries in relation to learning from disasters that internal reviews cannot also meet.

E *Benefits of inquiries*

The above analysis demonstrates that while public inquiries are often appropriate mechanisms to respond to disasters, they tend not to entirely fulfil the learning purposes that they set out to achieve. This raises the question of whether alternative mechanisms, such as internal reviews, could be more appropriate for fulfilling this learning purpose and for helping us to learn from the COVID-19 pandemic. This section will analyse the benefits

92 At 12.
93 At 15.
94 At 15.
95 At 17.
96 At 17.
97 At 17.

of inquiries when compared against internal reviews and whether these benefits mean that inquiries have any advantages over reviews when helping us to learn from disasters.

The Law Commission noted in its discussion (in the context of the 1908 Act) that inquiries are required "where public confidence demands a greater impression of independence".[98] Interestingly, the Cave Creek Inquiry was provided as an explicit example of an inquiry which could have been a departmental, state services or ministerial inquiry.[99] However, none of these would have met the public demand for the Department of Conservation to be held accountable by an independent body.[100] This demonstrates that often it is not what the inquiry *actually* achieves which is important, but rather what it is seen to achieve and what it symbolises to the public as a "highly visible" tool for government.[101] This can provide a political benefit as it demonstrates an impartial view of divisive events to the public.[102] Bovens' framework contributes to the secondary purpose of reinforcing the legitimacy of governments, as they are seen to be accountable to the public.[103]

The Law Commission also identified that inquiries could shed light on the workings of government and public administration in a way that other mechanisms cannot due to the powers available to it in terms of eliciting information.[104] Equally, they allow participation from the public in a way that other mechanisms do not due to their relative rarity, high profile and distance from the government.[105] This may have the effect of "mollifying" the public—"the real benefit of inquiries lies not so much in their findings, but in the fact that they take place and follow an open, participatory process".[106] Again, this relates to Bovens' idea of popular control and the prevention of corruption and abuse of power, which have arisen as overshadowing purposes in the above inquiries.[107]

If the only reason for holding an inquiry is for the government to be shown to hold an inquiry, then it is clear why the purposes of inquiries often morph and sometimes conflict. The Law Commission described conflict of purposes as a key problem for inquiries, and often this need for public catharsis conflicts with a "politically expedient outcome of an inquiry" such as learning from events.[108] Similarly, punitive accountability often conflicts with making useful recommendations about policy and procedures to prevent future disasters.[109] This is especially so in the case of disasters, where policy decisions are not necessarily the most rational.[110] Many of these factors can be seen in the context of COVID-19, as it is a divisive and emotional topic which is very likely to attract the need for public catharsis.

When inquiries are held for the primary purpose of placating the public or for political jockeying, they are unlikely to make useful policy recommendations to help us learn from disaster events. For this reason, it is worth considering whether alternative mechanisms may be better for learning from disaster events.

98 Law Commission, above n 31, at [28].
99 At [28].
100 At [28].
101 At [41].
102 At [41].
103 Bovens, above n 15, at 447–468.
104 Law Commission, above n 31, at [40].
105 At [42].
106 At [44].
107 Bovens, above n 15, at 447–468.
108 Law Commission, above n 31, at [49].
109 At [49].
110 At [49].

Equally, there will always be a need for public catharsis and sometimes punitive accountability following a disaster event such as COVID-19, and this article does not contest that inquiries are a useful means for achieving this. Nevertheless, inquiries may not be the best mechanism to learn from an event, and it may not be accurate for inquiries to claim that they do or for those establishing an inquiry to ask them to assist in learning from an event.

Therefore, it is unsurprising that the government held both an internal review and an Inquiry following the Pike River mining disaster. This may perhaps be the best solution going forwards, as it allows for learning opportunities, public catharsis and punitive accountability. All public and systemic desires and requirements would be met if this were to be standard procedure going forward.

In the case of the COVID-19 Inquiry, both an inquiry and a review would be appropriate, though there could be an issue in deciding an appropriate forum for review due to the wide-ranging impact of the pandemic. This will be discussed further in-depth later in this article.

Next, this article will analyse cases in which alternative mechanisms, such as internal and independent reviews, were used following a disaster and whether they were more appropriate for learning from the disaster and preparing for future disasters. Analysis of these reviews will later be used to assess whether the Inquiry or a review would be more appropriate when learning from the COVID-19 pandemic.

IV Alternative Mechanisms

To better understand whether inquiries are the best way to achieve improvement aims is by comparison to alternative mechanisms, such as internal reviews. Inquiries can be distracted by other purposes when attempting to fulfil learning aims. Therefore, we must assess whether alternative mechanisms, such as internal reviews, are better at adhering to their prescribed purposes. This section will assess three different reviews of Maritime New Zealand, MBIE and WorkSafe. Ultimately, I will conclude that reviews are better than inquiries at adhering to their given purposes and, therefore, better at helping us to learn from disaster events.

A *Independent Review of Maritime New Zealand's response to the MV Rena incident on 5 October 2011*[111]

An example of an independent review that helped us learn from a disaster is the independent report commissioned to review the response of Maritime New Zealand (MNZ) into the Rena oil spill, which is similar to the two reports that will be discussed. Simon Murdoch was commissioned as an independent reviewer to examine the factors which contributed to or limited the effective response of MNZ to the Rena incident. This is very similar to what the COVID-19 Inquiry is being asked to examine, though the responses have differed in their scope as this review examined only a single agency. This section will examine how well this review achieved the learning purpose it set out to achieve and whether any other purposes overshadowed this learning.

111 While I have previously worked for Maritime New Zealand, all information contained in this article is from within the public domain.

Unlike the other disasters discussed in this article, the Rena disaster did not contribute to the loss of human life, but it had a significant impact on the surrounding environment and wildlife and required a significant response from MNZ. As described in the review, "[a] major maritime casualty is both an industrial accident and a natural disaster".[112] On 5 October 2011, the cargo vessel Rena struck the Astrolabe Reef, 12 nautical miles off Tauranga and grounded while carrying 1368 containers and 1733 tonnes of heavy fuel oil.[113] An oil leak was detected that night, and a salvage team removed approximately 1350 tonnes of oil in hazardous conditions.[114] On 11 October, an overnight storm resulted in the loss of approximately 350 tonnes of oil and 86 containers, triggering a significant oil spill response to clean beaches and recover debris.[115] The Rena continued to break down, with all accessible oil removed by 15 November and a total of 341 containers removed.[116] On 8 January 2012, the Rena split into two pieces, with the stern section completely sinking by April.[117]

As the response wrapped up in 2012, the independent review was commissioned. This review was incredibly efficient, as Murdoch was appointed on 5 October 2012, conducted more than 80 meetings between 25 September and 30 December, and released his independent review in March 2013. The review focused on MNZ as a whole rather than on individuals who participated in the response.[118] The review focused on learning from the incident and what MNZ needs to do in future major incident responses to succeed.[119]

The review was deemed necessary because the Rena response initially caused MNZ to buckle across its systems and response machinery.[120] This was to some extent only natural due to MNZ's small size and the large scale of the disaster, but MNZ's funding mechanism added to it through industry "tax". As put by Murdoch:[121]

> A casualty of the dimensions and complexity of the Rena grounding with a broad spectrum of risks at national, regional and local levels would inevitably find points of vulnerability in the standing response plans and available systemic capability for which MNZ has statutory responsibilities.

The review concluded that MNZ should consolidate their incident planning, develop a national strategy to cover a variety of serious maritime incidents properly, develop a new response management structure and clarify salvor roles in future responses, along with various other recommendations.[122] These recommendations were largely focused on strengthening MNZ's response infrastructure and policies to enhance durability for future responses, which clearly achieves the learning function of the review. Therefore, it adhered specifically to its given purpose, which is a pattern not seen in any of the inquiries above. This suggests that reviews may be better than inquiries at achieving sole learning functions, which *CIMS* suggests should be prioritised over other purposes.

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112 Simon Murdoch *Independent Review of Maritime New Zealand's Response to the MV* Rena *Incident on 5 October 2011* (March 2013) at 3.
113 Maritime New Zealand "MV Rena" <www.maritimenz.govt.nz>.
114 Maritime New Zealand, above n 113.
115 Maritime New Zealand, above n 113.
116 Maritime New Zealand, above n 113.
117 Maritime New Zealand, above n 113.
118 Murdoch, above n 112, at [3.3].
119 At 4.
120 At 3.
121 At 3 (emphasis omitted).
122 At 103–104.

Similar to the other reviews that this article will examine, this review examined a single agency rather than a system or a general topic, though, like the Whakaari review, it had a fairly broad scope. This demonstrates how reviews can be appropriate in disasters where the lead agency requires feedback on their performance for learning purposes.

This review also raised an interesting topic. Due to the internal nature of the review, Murdoch did not have any formal powers of inquiry, which meant that all participation in the review was voluntary.[123] While this did not necessarily hamper the process of the inquiry due to the willingness of participants, it is easy to see that this could be a downfall in similar events. For example, if a review was finding fault within an organisation, rather than hoping to learn from an incident, the willingness of participants would not be able to be relied upon.

In summary, an independent review was the appropriate way to learn from the Rena incident, and it helped MNZ to strengthen its response infrastructure. The review kept its purpose clear, and the lack of public engagement meant no catharsis or fault purposes were pursued. This follows the pattern of the following reviews, where reviews were sufficient for the intended scope and clearly helped to achieve learning and improvement aims. This question of scope will be interesting when discussed in the context of the COVID-19 response, which was a uniquely extensive event. Though first, it is useful to build on this analysis by examining further reviews.

B *Post-implementation review of Hurunui/Kaikōura Earthquakes Recovery (Unreinforced Masonry Buildings) Order 2017 and Securing Fund*

Another similar review was that of the Hurunui/Kaikōura Earthquakes, which resulted in changes to regulations and funding for unreinforced masonry buildings.[124] This review followed a 7.8 magnitude earthquake near Culverden on 14 November 2016, which impacted Kaikōura, Hurunui, Blenheim and the Wellington CBD, causing damage to land, infrastructure and buildings.[125] This resulted in an increased risk of a significant earthquake in the affected areas by eight times the usual risk level for the following month and two times the usual risk for the following eight months.[126] This increased risk was especially so for unreinforced masonry, which previous events had demonstrated posed an increased risk to life in an earthquake event.[127] To respond to this increased risk, the government issued the Hurunui/Kaikōura Earthquakes Recovery (Unreinforced Masonry Buildings) Order 2017 (the Order) on 27 February 2017 under the Hurunui/Kaikōura Earthquakes Recovery Act 2016, which provided for securing of unreinforced masonry.[128]

MBIE commissioned a post-implementation review to inform them of the effectiveness of the regulatory design and implementation of the Order and its related Fund to inform future regulatory design.[129] Interestingly, the examination of legislation and regulatory design could also be a function of a COVID-19 Inquiry. This review of MBIE was conducted

123 At [3.2].

124 Dave Brunsdon, Trang Ly and Olga Filippova *Post-implementation review of the Hurunui/Kaikōura Earthquakes Recovery (Unreinforced Masonry Buildings) Order 2017 and Securing Fund: Independent Review Report* (MBIE, September 2020).

125 MBIE *Hurunui/Kaikōura Earthquakes Recovery (Unreinforced Masonry Buildings) Amendment Order 2018: Engagement document* (January 2018) at 2.

126 At 2.

127 At 2–3.

128 At 3.

129 Brunsdon, Ly and Filippova, above n 124, at 1.

by Dave Brunsdon, Trang Ly and Olga Filippova, who were all independent of MBIE.[130] This section will analyse how effective these reviewers were at helping us to learn from the earthquakes and whether any alternative purposes were pursued.

Ultimately, the review concluded that the Order was effective because it was clear about its aim and how to achieve it.[131] This effectiveness was due to clear time frames, consideration of interaction with other legislation, including lessons from the Canterbury earthquakes, utilising advice from stakeholders and removing the need for building consent for improvement work to enhance affordability.[132] Additionally, the Order and Fund needed a people-focused approach, which was eventually adopted by MBIE, to ensure their implementation.[133] Due to this intervention, 118 buildings were made safer, 114 through securing and strengthening of unreinforced masonry, and four through demolition.[134]

The review identified the intention of the Order as managing life-safety risks by requiring the securing of parts of buildings most likely to kill or injure people during a future earthquake.[135] Furthermore, it found that this aim was achieved.[136]

MBIE used the review itself to inform how it developed and implemented regulatory interventions.[137] The review recommended that MBIE adopt a people-focused approach in future interventions, develop further information on potential secondary order effects, build flexibility to enable policy and legislative instruments and follow its own monitoring and evaluation plan to identify and resolve issues early.[138]

The findings of this review may be uniquely compared against an article from the same year by Stannard, which argued that a balance is needed within building regulation because:[139]

> MBIE is the steward of the system responsible for promoting a sector culture that will facilitate engagement and true listening at all levels, not just at a business leader level.

This reflects the report's recommendations to take a more people-focused approach to regulatory interventions in the future and suggests that the report was an effective mechanism for making these recommendations.

From this analysis, we can see that the review succeeded in achieving its learning purpose and was not distracted by alternative purposes, unlike the inquiries discussed above. This suggests that reviews may be more successful than inquiries at adhering to their given purposes, and in general, this review appears to have been an effective mechanism for checking the response of MBIE to the Hurunui and Kaikōura earthquakes. It may be noted that this review had a fairly narrow scope, limited only to MBIE and its response to unreinforced masonry. This limited scope, to some extent, limits the effectiveness of reviews such as this, but equally, the narrow scope encourages better

130 Brunsdon, Ly and Filippova, above n 124.
131 At 1.
132 At 1.
133 At 2.
134 At 2.
135 At 1.
136 At 1.
137 At 31.
138 At 31–32.
139 MC Stannard "The New Zealand Building Code – a rethink?" (paper presented to the New Zealand Society for Earthquake Engineering 2020 Annual Conference, 2020) at 4.

examination of the subjects of the reviewer. Smaller-scale reviews are also more cost-effective, though they allow less public input into decisions.

From this review, we may conclude that internal reviews can be effective for learning from matters which are generally uncontroversial and limited in scope to a specific agency or entity. They are an effective vehicle for examining response to a disaster event and for helping the relevant agency or entity to improve response in the future. From this review, it also seems that alternative mechanisms to inquiries are less likely to consider other purposes and more likely to focus on improvement aims. Next, the WorkSafe review following Whakaari White Island will be examined to see if this trend continues and if a review would indeed be a more effective mechanism to learn from the COVID-19 pandemic.

C *Review of WorkSafe New Zealand's Performance of its Regulatory Functions in Relation to Activities on Whakaari White Island*

The independent review of WorkSafe is similar in nature to the reviews previously discussed, as an internal review of an entity's response to a disaster. The review was commissioned to review WorkSafe's handling of Whakaari/White Island leading up to the eruption in December 2019, in which 22 people died.[140] The review was commissioned by the Minister of Workplace Relations and Safety and led by David Laurenson KC.[141] Interestingly, it coincided with WorkSafe's biggest prosecution, which related to the eruption, against the owners of the island, the National Emergency Management Agency and GNS Science.[142]

WorkSafe is New Zealand's primary health and safety regulator, and it operates under the WorkSafe New Zealand Act 2013, with responsibilities under the Health and Safety at Work Act 2015 and the Health and Safety at Work (Adventure Activities) Regulations 2016.[143] Given these responsibilities, the review, conducted through MBIE, was asked to advise on whether WorkSafe has carried out its obligations as a regulator of the activities on Whakaari appropriately.[144] The COVID-19 Inquiry could fulfil a similar function in relation to how different government agencies have carried out their obligations during the pandemic.

The review's terms of reference allowed it to examine WorkSafe records relating to Whakaari and conduct interviews, if necessary, with WorkSafe staff and representatives from Business New Zealand, the Council of Trade Unions, the Tourism Industry Association and Recreation Aotearoa.[145] The review covered a five-year period, from November 2014, when the adventure activity regulations were enacted, to 9 December 2019, when the eruption occurred.[146]

The purpose of the review was to assess WorkSafe's performance concerning the eruption and identify any changes to its regulatory approach that may be necessary or

140 Sam Olley "Whakaari eruption: Review of Worksafe months overdue" (16 September 2021) Radio New Zealand <www.rnz.co.nz>.

141 Olley, above n 140.

142 Olley, above n 140.

143 MBIE *Review of WorkSafe New Zealand's performance of its regulatory functions in relation to activities on Whakaari White Island: Terms of Reference* at 1.

144 At 1.

145 At 2.

146 MBIE "Independent reviews of WorkSafe" (16 August 2022) <www.mbie.govt.nz>.

desirable.[147] This can be considered a learning aim, as a change in regulatory approach would enhance WorkSafe's performance during a future similar disaster. This section will assess whether this aim was met and whether other purposes were pursued.

The review found that WorkSafe "fell short of good practice in its regulation of activities on Whakaari White Island over the 2014-19 period".[148] The review, therefore, recommended that activities on Whakaari should be their own adventure activity, current operators should be audited for appropriate experience and qualifications, technical expertise can be engaged when required and WorkSafe should consider developing safety guidelines for activities on Whakaari.[149] These recommendations aimed to ensure that "[i]f we strengthen the adventure activities regulations and improve WorkSafe processes, we can reduce the risk of terrible events like the Whakaari White Island eruption happening again".[150]

Following the disaster, WorkSafe has implemented several improvements around the strengthening of the adventure activities regime, including increasing the number of inspections carried out, improving capability and introducing extra training. Following the independent review, WorkSafe responded with an intention to implement the suggested improvements, review the NZ Adventure Activities Certification Scheme and the Safety Audit Standard and improve activity safety guidelines in partnership with industry technical experts.[151]

It is clear from WorkSafe's response that the review has had its intended effect of initiating an improvement of WorkSafe's response systems so that it may better respond to future similar incidents, and that no other purposes were pursued. Unlike the earlier unreinforced masonry review, this review had quite a wide scope in terms of subject matter, though it was still limited to a single entity. This shows that reviews can be appropriate for more complex events, though their scope must still be narrowed.

However, we must note that this review stuck to its intended purpose. While also pursuing the purpose of fault-finding, as within its terms of reference, the review successfully achieved an improvement purpose and produced focused recommendations to that effect. The carry through of purpose may have been contributed to by the lack of public involvement in the review, as consultation with the public was outside its scope. This meant that public catharsis could not have been pursued, despite the fact that this was an incident which had a significant impact on the public.

From the reviews analysed so far, it may be seen that reviews are better able to adhere to their initial purposes than inquiries, allowing them to improve response systems and, therefore, prevent and prepare for future disasters. Next, I will assess the general benefits of reviews compared to inquiries and the situations in which it would be more appropriate to hold a review over an inquiry, with specific reference to COVID-19.

147 David Laurenson *Review of WorkSafe New Zealand's Performance of Its Regulatory Functions in Relation to Activities on Whakaari White Island* (MBIE, 8 September 2021) at [1].

148 MBIE, above n 146.

149 MBIE, above n 146.

150 New Zealand Government "Govt responds to independent review into WorkSafe" (press release, 22 October 2021).

151 WorkSafe "Response to Review of WorkSafe's Performance of its Regulatory Functions in Relation to Activities on Whakaari White Island" (22 October 2021) <www.worksafe.govt.nz>.

D *Benefits of alternative mechanisms*

The above analysis has shown that reviews are generally better at adhering to their given purposes than inquiries, in particular in relation to learning, which *CIMS* suggests should be a priority when recovering from a disaster event. This demonstrates that, when recovering from the COVID-19 pandemic, it may be more appropriate to respond with internal reviews than with the Inquiry. However, this section will confirm this analysis by comparing inquiries and reviews on a more general level.

When comparing inquiries and reviews, it is important to acknowledge the common thread of the need for independent review. As put by Mark Saunders and James Ortiz:[152]

> ... [t]he smartest people can miss things ... . Having a fresh set of eyes look at our work can help us see what our own blinders and mental filters may hide ... . As former NASA Administrator Mike Griffin said, "You cannot grade your own homework."

While discussing independent reviews in a different context, these words nonetheless ring true, especially after a disaster event. If a disaster could have been prevented or improved, it is important that we have someone come in with fresh eyes. It is also apparent that both reviews and inquiries may fulfil this function as independent bodies, so we are left with the question of which is more appropriate. I will answer with the favourite phrase of lawyers: "It depends".

Inevitably, both reviews and inquiries have strengths and weaknesses, and they will be appropriate in different circumstances. In this section, I hope to demonstrate these differences and recommend which is more appropriate for achieving a sole learning function in relation to COVID-19.

I assume for the purpose of this section that inquiries are more appropriate for achieving the purpose of public catharsis due to their participatory nature and apparent independence from the government.[153] Many of the proposed benefits of inquiries direct only towards this purpose, but does this help us to learn from a disaster? Public input may help us to learn, as it may show public bodies how they appeared to have failed and succeeded during an incident, though there is scope for public input into an independent review, as seen in how stakeholders in the response were consulted during the Rena review.[154] Therefore, most of the proposed benefits of inquiries point only to the purpose of public catharsis and not to the purpose of learning or improving after an incident, and the benefit of public input in learning is equally met by independent reviews.

However, I must acknowledge that inquiries have greater investigatory powers than independent reviews due to the legislative schemes they come under. I would argue, though, that this again points to a different purpose of fault-finding. If a review's sole aim is to learn from an event, then there is no reason for people not to contribute willingly. We all have a general instinct to learn from an event, and this would draw most people into a review of this kind. Again, this strength of inquiries points towards another purpose.

Generally, reviews tend to be less expensive and quicker since they have limited scope and are restricted to one agency or entity. Reviews are also, as this article has shown, generally better at adhering to their given purposes without being overshadowed by

152 Mark Saunders and James Ortiz "Nobody's Perfect: The Benefits of Independent Review" *ASK Magazine* (online ed, United States, 1 September 2009) at 55.

153 Law Commission, above n 31, at [42] and [44].

154 Murdoch, above n 112, at [1.7]–[1.8].

punitive accountability or public catharsis findings. This means that reviews are better mechanisms for learning from an incident if the scope of the incident is limited.

This brings me to the final strength of inquiries which are not seen in reviews—the way that inquiries can consider a wide scope of subjects. This kind of power could be useful in incidents which require whole government responses, like COVID-19, and which do not have a prominent lead agency.

Inquiries are one of our only public mechanisms which are uniquely able to take a step back and look at the big picture. This is largely due to their independence and separation from central government. This power could be particularly useful in the context of COVID-19, as every government agency has had at least some role in responding to the pandemic over the last three years. Having a mechanism which is able to view the response in its entirety would have a unique contribution to our learning from the pandemic, particularly if it were to examine the interaction between different public actors as governed by the *CIMS* framework.

This creates a unique challenge for reviews because this wider view is generally something not available to them. As the reviews analysed in this article have shown, reviews are generally confined to a single agency or entity. This means that if we were to respond to COVID-19 solely with reviews, we would be missing an important part of the bigger picture.

This does not necessarily exclude reviews of events which have a wider scope, and we could have a review of the Ministry of Health's response to COVID-19, which considers partner agencies, but it would be logistically trickier than setting up the Inquiry, which is purpose-built for wider topics. I cannot point to any examples of previous inquiries where a review could not have replaced the learning function, but COVID-19 may be an exception to this.

This analysis demonstrates that a review will generally be more appropriate to learn from a disaster unless the scope of the disaster is too wide to be limited to a review of one agency or entity. An inquiry may be a more appropriate mechanism where other purposes like punitive accountability or public catharsis are sought. I conclude that the only disadvantage of reviews compared to inquiries regarding learning and improvement purposes is their generally limited scope. This limitation of scope becomes uniquely relevant when assessing whether an inquiry or review would be more appropriate to learn from the COVID-19 response.

V COVID-19 Inquiry

With a good base understanding of the benefits of alternative mechanisms when contrasted against inquiries, we may begin to assess specifically which mechanism would be most appropriate to learn from the COVID-19 pandemic. This section will begin the analysis by discussing internal reviews which already exist in relation to COVID-19 and the alternative purposes which the COVID-19 Inquiry could pursue. I will ultimately conclude that internal reviews are the best mechanism for achieving a pure learning function, which *CIMS* suggests should be our priority when recovering from a disaster. However, there is also a place for the COVID-19 Inquiry in meeting demands for public catharsis and punitive accountability and looking at the broader interaction between different public bodies.

A *Existing reviews*

This section will examine three existing independent reviews in relation to COVID-19, the Waitangi Tribunal's *Haumaru: The COVID-19 Priority Report*, the Disability Convention Independent Monitoring Mechanism's *Making Disability Rights Real in the Covid-19 Pandemic* and the Finance and Expenditure Select Committee's *Inquiry into the operation of the COVID-19 Public Health Response Act 2020.*[155] Each of these is different in nature and examined different aspects of the COVID-19 response. These reviews will show whether it is possible for independent reviews to help us improve our pandemic response and prepare for future pandemics without having a full inquiry into COVID-19.

(1) The Waitangi Tribunal COVID-19 Priority Report

Interestingly, the Waitangi Tribunal is a permanent Commission of Inquiry under the Treaty of Waitangi Act 1975.[156] This means that its report on the COVID-19 pandemic response was, to some extent, an inquiry, though in reality it took the form of an independent review. The Tribunal review was held in response to a claim from the New Zealand Māori Council in November 2021 to examine:[157]

> (1) Having regard to the disproportionate numbers of Maaori vaccination rates and COVID-19 cases:
> (a) Is the Crown's vaccination strategy and plan consistent with te Tiriti o Waitangi and its principles?
> (b) Is the Crown's November 2021 COVID-19 Protection Framework consistent with te Tiriti o Waitangi and its principles?
> (2) What changes are required to ensure the Crown's vaccination strategy and November 2021 COVID-19 Protection Framework are Tiriti compliant?

This forward-looking function examines the necessary changes to ensure the response is Tiriti compliant and explicitly fulfils an improvement function. However, what is interesting is that it relates to the rest of the present pandemic rather than to preparing for future pandemics.

In summary, the Crown's breaches of te Tiriti have resulted in immediate, profound and lasting prejudice, with Māori more likely to be infected with COVID-19, more likely to be hospitalised and more likely to die as a result.[158] The Tribunal concluded that the Crown would remain in active Treaty breach until it ensured an equitable vaccine rollout, and recommended for the Crown to provide:

(1) further funding, resourcing, data, and other support to Māori service providers and communities to support their pandemic response;[159]
(2) collection of and reporting on data relating to ethnicity and people with disabilities;[160]

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155 Waitangi Tribunal *Haumaru: The COVID-19 Priority Report* (Wai 2575, 2021); Independent Monitoring Mechanism *Making Disability Rights Real in a Pandemic: The Independent Monitoring Mechanism's report on the New Zealand Government's response to the COVID-19 emergency* (January 2021); and Finance and Expenditure Committee, above n 2.

156 Waitangi Tribunal "Waitangi Tribunal" (5 May 2022) <www.waitangitribunal.govt.nz>.

157 Waitangi Tribunal, above n 155, at 5.

158 At 106.

159 At 109–110.

160 At 110–111.

(3) monitoring of the pandemic response to ensure accountability to Māori;[161]
(4) assurance that the paediatric vaccine and booster vaccine rollout is equitable;[162] and
(5) empowerment of Māori to coordinate the Māori pandemic response.[163]

These recommendations from the Tribunal ought to have been incredibly useful for the Crown in implementing the pandemic response going forward, as the Tribunal usefully outlined specific actions which the Crown should take. If the Crown is to achieve true "partnership" and "collaboration" with Māori, as outlined in its own *CIMS* framework, then it should have taken note of these recommendations and implemented them into the response.[164] The Crown should also have considered whether these recommendations can be implemented into future incident responses. It is clear from this report that the Crown's framework for engaging Māori during a response was insufficient and did not uphold the Crown's te Tiriti obligations.

This review clearly achieves an improvement function, though due to the Tribunal's nature, the review is confined only to breaches of te Tiriti and how it could be better upheld in the rest of the COVID-19 response. Though interestingly, the impact on Māori is one of the functions that the Inquiry may examine, and the Tribunal's analysis clearly fulfils this function in terms of both fact-finding and learning.[165]

(2) Report by the Independent Monitoring Mechanism of the Disability Convention

The next independent review that I will analyse is the report from the Disability Convention Independent Monitoring Mechanism (IMM), which is made up of the Human Rights Commission, the Disabled People's Organisations Coalition and the Ombudsman under the Disability Convention.[166] The IMM released a report on how the COVID-19 pandemic impacted disabled people, as the Disability Convention "says that the Government must make sure disabled people are protected during emergency situations".[167]

The review was released on the issue of making improvements for disabled people in the next emergency situation, and in particular, tāngata whaikaha Māori.[168] The review recommended that the government improve the following:[169]

- services for disabled people
- involving disabled people in making decisions
- accessible information
- education
- health
- work
- access to justice for disabled people in places of detention.

161 At 111–112.
162 At 112.
163 At 112–114.
164 New Zealand Government, above n 10, at [2.4].
165 Royal Commission of Inquiry (COVID-19 Lessons) Order, sch cl 4(1).
166 Independent Monitoring Mechanism *Making Disability Rights Real in the Covid-19 Pandemic: Easy Read summary* (January 2021) at 12–13 and 19.
167 At 21 (emphasis omitted).
168 At 23.
169 At 27 (emphasis omitted).

This review clearly fulfilled an improvement function, and again the impact of the pandemic on disabled people is another subject that an inquiry has been asked to address.[170] The Inquiry may consider this when looking at the impact on, and differential support for, communitites disproportionately impacted by the pandemic.[171] The IMM, a body with expertise relating to disability, was a very suitable body to conduct this review. In the same way that the Waitangi Tribunal was the best body to review the upholding of te Tiriti. It is unlikely that this same expertise will be found in the Inquiry due to the range of subjects it is asked to address, and during the Inquiry expert bodies will likely only be consulted.

(3) Finance and Expenditure Select Committee

Finally, the Finance and Expenditure Select Committee conducted an Inquiry into the operation of the COVID-19 Public Health Response Act 2020.[172] Similarly to the Tribunal, this review is technically an inquiry, though it is more similar in nature to a review due to its restricted scope.

The Select Committee recommended that the Government pass legislation to provide a new framework to respond to future health emergencies, which would allow greater clarity and integration of te Tiriti and tikanga Māori.[173] The COVID-19 legal framework was passed under urgency, which did not allow for Select Committee examination of the Bill, which would be enabled if enduring legislation were passed.[174]

In summary, the Inquiry found that "[t]he COVID-19 Act was necessary and appropriate … but enduring health emergency response legislation should be developed".[175] This has a clear, forward-looking improvement function, though greater specificity for the recommended legislation would have been of greater help. Again, the legal framework is an aspect of the COVID-19 response which the Royal Commission of Inquiry has been called to address, and while I do not consider that this function has been achieved by the Select Committee's Inquiry, I consider that it could have been.

It perhaps may have been more appropriate for a review of legislation to have been conducted by another body, such as the Ministry of Health, which has greater familiarity and interaction with the COVID-19 legislative framework and health legislation in general. It would be possible for a review of legislation to have been conducted in place of an inquiry to achieve an improvement function, though this has not been done in this situation.

(4) Efficacy of reviews

In summary, these reviews in relation to the COVID-19 response have generally been effective, aside from the Select Committee Inquiry, and have fulfilled improvement functions in place of an inquiry. For the Tribunal and IMM reviews, the bodies were more appropriate forums to undertake the review of their aspect of the COVID-19 response due to their position as subject matter experts. Arguably, these reviews have done a better job

170 Gillespie and Breen, above n 3.
171 Royal Commission of Inquiry (COVID-19 Lessons) Order, sch cl 4(1).
172 Finance and Expenditure Committee, above n 2.
173 At 3.
174 At 3.
175 At 4.

than an inquiry could have in their place, demonstrating how reviews have a definite place in helping us improve following the COVID-19 response.

B *Alternative purposes*

Next, I will consider whether the COVID-19 Inquiry is appropriate or whether it is likely to fulfil alternative purposes to the exclusion of its learning purpose. I have already concluded that inquiries tend to have less focused outcomes than reviews, which leads to limited achievement of improvement and learning purposes. Generally, reviews tend to be more focused and better at achieving legitimate improvement and learning from disaster events. However, in a COVID-19 context, reviews have a more limited scope and generally focus within the jurisdiction of a single agency or entity. Equally, this narrow focus may be better for learning from an event as a review will provide specific feedback on a single topic or area and may also utilise the specialist knowledge of bodies.

The analysis in this article shows that an inquiry can be successful at helping us to learn from a disaster event, but the public nature of inquiries means that they can be led astray and end up following alternative purposes, which overshadows the learning function. The question then becomes: would the learning function of the COVID-19 Inquiry end up being overshadowed by alternative purposes?

Many different reasons have been given when calling for the COVID-19 Inquiry. Some of these reasons ask for improvement and learning from the pandemic:

- "The starting point … should be New Zealand's preparedness for a pandemic. This requires an assessment of our health system's resilience, the extent of pre-pandemic planning, and the institutional framework for directing the pandemic response."[176]
- In 2022, the government must show it is willing to listen and learn, and it can do that by committing to a Royal Commission of Inquiry.[177]
- If any good comes from this pandemic, it will be the future Royal Commission of Inquiry helping us better manage the next one.[178]
- Given the possibility of future pandemics, it's vital those lessons are passed on to future generations.[179]

Though equally, some calls for an inquiry are motivated by the need for public catharsis:

- There can be no doubt New Zealand's handling of the pandemic justifies the same attention. It has overshadowed everything in the past two years, and no New Zealander has been untouched by it in some way.[180]
- What divides democracy and dictatorship? Public accountability.[181]

It seems inevitable that public catharsis will have a role in the Inquiry due to the wide-reaching societal impact of the pandemic. Equally, a punitive accountability purpose is likely to be present due to its connection to catharsis. Having an inquiry for the purpose of catharsis is not a bad thing, but we cannot have an inquiry for catharsis and say that we are learning from it. This does not do our system justice, and it does not help us to actually

176 Roger Partridge "Questions for the Covid-19 Royal Commission of Inquiry" *The New Zealand Herald* (online ed, Auckland, 15 March 2022).

177 Rachel Smalley: "Learning from COVID : Why there must be a Royal Commission of Inquiry into our response" (18 March 2022) Today FM accessed via <https://web.archive.org>.

178 Partridge, above n 176.

179 Gillespie and Breen, above n 3.

180 Gillespie and Breen, above n 3.

181 Smalley, above n 177.

improve for the future. Interestingly, the announced Inquiry clearly has learning as its primary purpose in its Terms of Reference, though public catharsis and punitive accountability are not excluded.[182]

Based on the analysis of this article, I would suggest that the Inquiry into COVID-19 may be useful, but if we actually want to learn from the pandemic, we need independent reviews focused on specific aspects of the response. The Inquiry will touch on legislative, regulatory and operational settings relating to public health, the supply of goods and services, the immediate economic response, public health communication and decision-making structures. This includes consideration of Māori interests and the impact on essential workers, including disproportionately impacted populations and communities.[183]

As foreshadowed earlier, inquiries also have the unique ability to take a wider perspective on a disaster response, which is not available to reviews. In recommending a dual approach, I suggest that the examination of broader inter-agency cooperation during the COVID-19 response is best left to an inquiry, as is the fulfilment of the purposes of public catharsis and punitive accountability.

Reviews do not preclude an inquiry, and vice versa. The Inquiry will absolutely have a role in our recovery from the pandemic, but if we really want to learn from the pandemic, then we need focused and targeted reviews. An inquiry may present the appearance of improvement to the public, but true reform comes from within our public systems themselves and the independent reviews which provide feedback to them.

VI Conclusions

The Inquiry into the COVID-19 pandemic aims to look into how we can learn from the response. However, I propose that it is not appropriate to claim that such an Inquiry would help us to achieve improvement and preparedness for future disasters through learning, as analysis has demonstrated that public inquiries are often derailed by public pressure to achieve catharsis and find fault. Therefore, I conclude that independent reviews are a much better mechanism to actually achieve learning, as they are more targeted and focused.

This is not to say that the Inquiry would not contribute to our recovery from the pandemic and help us to move forward as a society. Inquiries achieve an important role, but the analysis in this article has demonstrated that they are not the most effective public mechanism to help us to learn from and improve after a disaster. Inquiries are better suited instead to fact-finding, punitive accountability and public catharsis after a disaster.

There may be some utility in simply saying that inquiries will help us learn, even if they do not, as the idea of having an independent body assisting in an improvement function may provide some catharsis to the public in and of itself. However, this same catharsis can be provided through fact-finding with the goal of helping us to move on from a disaster. It is dishonest to the public to claim that inquiries achieve a purpose which they do not.

The analysis in this article suggests that a dual approach could be appropriate when aiming to learn from a disaster by having concurrent inquiries and reviews. An inquiry can provide a public perception of independence and allow catharsis, while reviews can provide actual learning for public bodies. This concept can be analogised to the relationship between a minister and the public servants within a ministry—an inquiry is a

182 Royal Commission of Inquiry (COVID-19 Lessons) Order, sch cl 4(1).
183 Schedule cl 4(1).

public-facing figurehead which is seen to provide a purpose. At the same time, reviews are the internal machinery of government which actually achieve the purpose. If we want to learn from a disaster, this purpose should be achieved by reviews rather than inquiries.

Both inquiries and reviews have a place in our recovery from a disaster, and we can play to the strength of each to truly improve for the next disaster. It is apparent to all of us that there are many lessons to be learned from the COVID-19 pandemic, which we must integrate into our health response systems to ensure that we are better prepared for the next pandemic. This learning will best be achieved through internal reviews.