

Organisational challenges in the United Kingdom's post-disaster 'crisis support' work

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Local authorities in the United Kingdom are required to 'lead' multi-agency humanitarian responses to major disasters. Concerns mounted in the late twentieth century that responses to people bereaved in the immediate aftermath of such events at best failed to meet their needs and at worst compounded their distress. Subsequent reviews and reforms reframed some victim needs as 'rights' and established legal, administrative, and practice frameworks to improve matters. Local authority 'crisis support', provided in partnership with other actors, lies at the heart of the UK's contemporary emergency response to the bereaved. Drawing on primary research on the development and deployment of crisis support in a local authority, and while acknowledging incident- and context-related challenges, this paper considers the significance of challenges with their origins in organisational factors. Recent developments within and between responders may exacerbate these challenges. This paper argues, therefore, that further research into such developments is necessary.

Introduction

In the immediate aftermath of a disaster, officials recover and identify the dead, conduct post-mortems, gather, collate and disseminate casualty information, arrange body viewings, provide support, conduct investigations, and manage the media. Such actions can amount to a bewildering array of interventions for bereaved and survivors. Consequently, the sensitive provision of advocacy, guidance, and information, and the meeting of social needs, are essential elements of crisis support. Good practice is about orientating victims, helping them to 'get their bearings'.

This paper considers difficulties in providing 'crisis support' to disaster-bereaved people in the immediate aftermath of acute disasters in the UK. After briefly reprising victims' experiences in the late twentieth century, recent reforms are outlined. While acknowledging the issues raised respectively by incident characteristics on the one hand and wider social contexts, especially regarding social sense-making politics of blame, on the other, the study asserts that key difficulties can lie in organisational factors among and between responders

themselves. Drawing on primary research of crisis support in a UK local authority, principal organisational challenges are discussed with secondary references examples drawn from further afield. The paper suggests that appreciation of these factors is essential to understanding how responses are shaped. Notwithstanding recent reforms, changes within and between primary responders raise significant questions from for future responses.

Victim experience and emergency management reform

Psychosocial preparation was practically non-existent for the string of disasters that struck the UK from the mid-1980s (Hodgkinson and Stewart, 1991). After the bombing of Pan Am Flight 103 over Lockerbie, Scotland, on 21 December 1988 responses lacked coordination. Furthermore, while bereaved relatives were required to give distressing personal descriptions on multiple occasions, they were denied the information that *they* needed (Davis and Scraton, 1997). Families were prevented from viewing the deceased and visits to disaster sites were discouraged. The local authority filled indentations made by falling bodies only to discover that some families wished to see these sites in their original condition. The move to launder recovered clothing similarly failed to anticipate that some relatives would want belongings returned unsanitised.

Following the Hillsborough stadium disaster on 15 April 1989 the bereaved underwent ‘an inhumane and damaging process of identification’, queuing through the night before viewing displays of poor-quality photographs of the dead (Scraton, 2007). The deceased (96 supporters of Liverpool Football Club) were then presented in body bags for identification before being quickly reclaimed. Questioning took the form of hostile interrogation as police began, in parallel, a forceful campaign to blame the victims for the disaster (Scraton, 1999, 2007).

Support was similarly cursory four months later when the *Marchioness* pleasure cruiser sank on the River Thames in London after being hit by the *Bowbelle* dredger. Relatives were not permitted to view the dead or informed of post-mortems, and later it emerged that the hands of 25 of the 51 people who drowned on the night of 20 August 1989 had been secretly severed to facilitate fingerprinting (Clarke, 2001).

After the shootings at Dunblane Primary School in Scotland on 13 March 1996, relatives of the 16 children and 1 teacher who lost their lives suffered delays in obtaining information,

official misinformation, and were held in the same room as staff who had been prohibited from passing on what they knew, despite the fact that guidance and practice had been updated (Cullen, 1996; Scraton, 2007).

Across these disasters, misinformation was common, access to the dead was denied or managed oppressively, access to disaster sites was obstructed, and, after the *Marchioness* incident, the dead were secretly mutilated. Even in the light of the trying conditions associated with disasters, the victims were failed (Davis and Scraton, 1999).

Alongside these experiences, other factors added impetus towards change. First, political discourse increasingly reified the experiences of victims (Rock, 2004; Goodey, 2005). Second, the profile of disaster victimisation was heightened by almost instantaneous media representations. Traditional and new media platforms combined with the widespread availability of cameras and telephones to offer multiple windows on suffering. Third, trauma discourses differentiated traumatic loss from ‘ordinary’ bereavement, contributing to the establishment of specialist disaster services (Davis, 1999).

Early intervention was seen as necessary now to prevent distress becoming ‘disorder’. In response to the demands of disaster campaigners, the Labour Party government, elected in 1997, set up three inquiries into aspects of the *Marchioness* sinking and safety on the River Thames. One considered concerns about the response to the tragedy. Lord Justice Anthony Clarke (2001) found that denial of access to the deceased and the disfigurement of bodies probably violated Article 8 of the 1950 European Convention on Human Rights. He recommended four principles for response: (i) the provision of accurate and honest information; (ii) respect for the deceased and the bereaved; (iii) ‘a sympathetic and caring approach’; and (iv) ‘the avoidance of mistaken information’ (Clarke, 2001, p.114). Whilst confirming the central role of local authority social services, he commended the emergence of the police Family Liaison Officer (FLO), consolidating a direct role for the police in psychosocial response.

Meanwhile, other potential and actual crises, including fears about the Y2K ‘millennium bug’, fuel protests, and Foot and Mouth Disease, provided additional momentum towards reform. A review of emergency planning, set up in February 2001, was accelerated by the terrorist attacks in the United States on 11 September 2001 (O’Brien and Read, 2005). The

Civil Contingencies Act 2004 echoed Clarke's principles and established statutory duties for potential responders, with planning and training to be coordinated through local and regional resilience forums. Three features of the detailed guidance that have followed the Act are important here. First, there is a fundamental concern with coordination, with agencies 'combin[ing] and act[ing] as a single authoritative focus . . . consult[ing], agree[ing] and decid[ing] on key issues; and issu[ing] instructions, policies and guidance to which all . . . will conform' (Cabinet Office, 2005, p. 8). In the field, co-working is expected in all key emergency centres.

Second, local authorities remain responsible for coordinating care and for meeting victim needs (HM Government, 2006). Local authority 'crisis support' teams (CSTs), it is suggested (HM Government, 2006, p. 26), might assist in:

- clarifying procedures and processes, keeping people informed, and letting them know the roles of the agencies involved;
- explaining common reactions to crisis and stress and helping to identify where specialist help is required;
- 'signposting' other support and services available in the community, helping people to access them, and assisting with form-filling; and
- fulfilling a listening role.

Third, the real 'lead' agency in the field is still the police. Its pre-eminence remains grounded in extensive powers and responsibilities. Officers usually chair Local Resilience Forums, established on the basis of police boundaries and to which all local authorities are not required to send representatives (Cabinet Office, 2005). During responses the police control disaster sites, coordinate searches, collect evidence, process casualty information, and identify bodies on behalf of the coroner. They may also enforce evacuations, as well as oversee criminal investigations, facilitate other enquiries, and assume roles in emergency centres. These responsibilities require, and attract, extensive resources. To consider just victim liaison, the Metropolitan Police Service (MPS) was able to make 350 FLOs available after the Indian Ocean tsunami of 26 December 2004. By 2007, some 1,100 MPS officers had received family liaison training.¹

¹ Author's interviews with Metropolitan Police Officers, London, 2007.

The Clarke Report, the Civil Contingencies Act 2004, and the associated guidance were major developments. What had only recently become recognised as legitimate ‘needs’ now became ‘rights’ and legal duties and reformed administrative structures now framed emergency planning. However, guidance and procedural reform do not secure effective change. General guidance frequently is difficult to ‘fit’ with the specific. Reforms can generate new problems or simply reshape older ones. Tensions, for example, are likely to remain between investigative/security agencies and psychosocial priorities, albeit dispersed more widely (*within* the police, and between the police, as well as among local authorities and corporate and third-sector responders). Reforms also can fail to confront some important issues, such as the implications of the instrumentalisation and deskilling of, and the decline in, humanitarian social work in the UK, issues that have given rise to significant concern among social work scholars.

Understanding difficulties in disaster response

There are many continua along which acute disasters may vary. It simplifies matters here to consider three sets of challenges facing acute disaster support. The first set has its roots in the *location, scale, and nature* of the incidents themselves. The second set arises from the *social contexts* within which disasters originate, impact, and attract a response. The third set—over which responders have the most direct influence—involves *organisational* factors within and between responders themselves. Before looking at this latter issue in detail, it is necessary briefly to recognise the importance of the first two sets of challenges.

Primary challenges: location, scale and nature of incidents

Whatever the level of preparedness and organisational resilience, disasters, by their nature, present three key sets of difficulties to responders. First, locations may be inaccessible, extensive, or hazardous. For instance, the bodies of the 852 people who lost their lives in the sinking of the *Estonia* car and passenger ferry on 28 September 1994 were at the bottom of the Baltic Sea, and the bodies of the 259 passengers and crew members who died in the Lockerbie bombing were scattered across 850 square miles of countryside. Sometimes uncertainty remains even as to the number of fatalities, not least because sites may be dangerous. As workers attended a suicide bombing in Jerusalem on December 1st, 2001, another bomb exploded some 50 metres away (Perliger, Pedahzur, and Zalmanovitch, 2005). After the terrorist attacks on the World Trade Centre in New York City on 11 September

2001, 'Ground Zero' remained hazardous (Kupferman, 2003; Tucker, 2004), owing, for example, to increased quantities of potentially hazardous contaminants in the dust and debris. Simply put, such circumstances will inevitably present severe tests to operations.

Second, the scale of the disaster often is overwhelming, sometimes damaging the response capacity itself. The 11 September 2001 attacks destroyed New York's Emergency Operations Center; 63 civilian police workers from Stockholm, Sweden, and 23 social service personnel died aboard *Estonia*; and the scale of Hurricane Katrina (August 2005) was such that approximately 950,000 applicants were deemed eligible for disaster assistance a year after the event and some 100,000 Federal Emergency Management Agency (FEMA) travel trailers were still in use (Norris and Rosen, 2009). Large-scale disasters may see the deployment of undertrained or inexperienced staff. The Hillsborough disaster, for example saw a call for volunteers within the social services department. – Indeed the sheer scale of some events and the urgency of victims' needs may make such deployments inevitable: there just will not be sufficient numbers of fully disaster-trained helpers immediately available. For instance, more than 500 Swedish nationals died in the 2004 tsunami and some 30,000 others were in the zone (Lennquist, 2004a). Even when the site is small, disaster communities can extend widely, and those affected may 'feel very isolated and very vulnerable' (Johnston and Beeson, 1993, p. 71). Support for victims as they return home may be minimal and based on scant understanding (Johnston and Beeson, 1993, p. 71). Evacuees may be as likely to encounter suspicion and hostility as compassion (Settles and Lindsay, 2011).

Third, the nature of incidents can compound distress. Relatives today expect the dead to be recovered, identified, and treated respectfully (Stoney et al., 2011). Yet, bodies may be irrecoverable, destroyed, or damaged. Collecting, collating, and identifying human remains require painstaking work. Modern technology has greatly improved the possibility of accurate identification but it requires time, during which waiting relatives will need considerable support.

Secondary challenges: social contexts, sense making and blame

Official discourse has little to say about the politics of victimisation. In fact, primary victimisation in a disaster can be exacerbated by social hostility and injustice. Victims often raise uncomfortable questions. The fragility and unfairness of life and the behaviour of people in extremity can be difficult to accept. Denigration of victims or the denial of their

accounts sometimes protect a belief that life is fair and help to maintain dominant beliefs in the face of countervailing evidence (Janoff-Bulman, 1992; Correia and Vala, 2003).

Moreover, sense-making develops within specific pre-existing popular, professional, and official discourses and, ‘given that there is a social distribution of interests, motives and knowledge . . . is inherently political’ (Gephart, 1984, p. 213). Victimisation is commonly interpreted using frames of ‘deservingness’ within which even victims of ‘natural’ disasters can be condemned (Taylor, 1999; Lukes, 2005).

Hours after 58 Chinese ‘clandestines’² were found suffocated in a lorry container at the UK port of Dover on 18 June 2000, parliamentary exchanges paid only minimal, condolences before moving quickly on to border security, with which, it was presumably judged, the electorate would be more concerned (BBC News, 2000). Even where victims themselves are not perceived as wholly to blame ‘accountability for these people’s victimization tends to rest with other immigrants and foreigners in the migration chain, and stops short of blaming citizens of countries whose demands for immigrants’ cheap services . . . are a reason for their presence in “our” country’ (Goodey, 2005, p. 231).

Prejudices towards some populations verge on hatred. If migrants can expect scant sympathy, prisoners can expect still less. When 355 inmates died in a fire at the National Penitentiary in Comayagua, Honduras, on 14–15 February 2012, readers of the *Daily Mail* took the trouble to make their views clear on news comment boards (Moran, 2012):

Well I only hope there were no innocents among these criminals.

If you can’t do the time DON’T DO THE CRIME!

If they had been in bare cells with bread and water this would not have happened.

If there had to be a fire somewhere in the world, I hate to say it, but a prison is the best place. Save the innocent first.

² This term suddenly appeared in official speech, designed seemingly to insinuate the possible illegal immigration status of the victims at a time when this had yet to be established. The tragedy occurred during a period of rising political concern in the UK with ‘bogus asylum seekers’.

There are examples from around the world in which constructions of victims as the ‘other’ are institutionalised. After Hurricane Katrina struck the south of the US in August 2005, newscasters condemned a mass, ‘animalistic’ frenzy, precisely ‘continuous’ with what many Americans had been persuaded to believe about poor black African-Americans (Frymer, Strolovitch, and Warren, 2005; Gilman, 2005). Emergency assignments were refused out of fear (Davis, 2006) of ‘combat operations . . . underway on the streets’ (*The Army Times*, cited in Dynes and Rodriguez, 2005, p. 2). With tens of thousands awaiting food, water, and rescue, officials set up a temporary centre to book criminals (Kaufman, 2005).

Denigrated victims may be individuals held to have made mistakes, such as pilots, drivers, captains, or crew. Popular bifurcation may not recognise that the blameworthy may be victims too. More broadly, disaster victims may be members of groups held up for social opprobrium: the criminalised; ‘hooligans’; migrants; protestors; or members of communities accused of supporting terrorism. Official guidance, technocratic in tone, understates the politics of heterogeneous victimisation, the marginalisation of some victim groups, and the potential ambivalence of their relationship to the state and vice versa. Nor can officials simply be assumed to be above such processes. The Mayor of New Orleans, Ray Nagin, told US talk-show host Oprah Winfrey that “‘hundreds of armed gang members’” were raping women and committing murder in the Superdome’ with occupants “‘in an almost animalistic state’” (Davis, 2006, p. 248). The New Orleans Chief of Police, Eddie Compass, told Oprah Winfrey that ‘we had little babies in there getting raped’ (Davis, 2006, p. 248). After Hillsborough, the ‘recollections’ of police officers were altered to remove criticisms of the force itself, but with ‘no corresponding removal of criticism of the fans’ (Stuart-Smith, cited in Scraton, 1999, p. 191). Public relations strategies aim to minimise and deflect blame, if necessary on to the victims.

Tertiary challenges: organisational issues in response

Although crisis support teams may not be entirely impotent before the unforeseeable specificities of incident and context, they can influence the organisational factors that will determine the speed, efficiency, and appropriateness of the response to such contingencies. Few needs are entirely unpredictable. The bereaved—the prime focus of UK local authority

crisis support teams—will need information, for example, which can go well beyond confirmation of death. One bereaved father explained:³

you are thinking, ‘did she cry out? . . . did she feel the pain?’ . . . ‘Did she want her mum and dad? Was she scared? Was there time to be scared?’ Somehow . . . you want . . . to experience as much of what she experienced as possible.

Needs such as these clearly may never be met (Eyre, 2002). Moreover, even in the case of more straightforward information, the circumstances of rescue may make detailed recording difficult and uncertainty frequently is the rule (Fennell, 1988, p. 160). The general need of bereaved people (and others) for information, though, should come as no surprise and should be an obvious focus of disaster preparation. Experience suggests, however, that problems within and between agencies often prevent the fulfilment of information needs. Where disasters ‘threaten elites by highlighting policy failures’, authorities may be strongly motivated to deny, suppress or distort inconvenient perspectives (Birkland, 2004, p. 181). The French heatwave disaster of summer 2003, which resulted in thousands of deaths across the country, was at first denied by authorities whose agenda was ‘reassurance’ (Lagadec, 2004). After Hillsborough police officers were instructed not to record events in their notebooks as part of a ‘reconstitution of truth’ (Scraton, 2007, p. 80). Following the events of 11 September 2001, official impetus towards a speedy return to ‘business as usual’ denigrated concerns about the serious health risks around Ground Zero (Kupferman, 2003).

Another primary need, or even right, of bereaved relatives is to see the deceased (Clarke, 2001). In cases where the recovery and identification of a body are protracted processes, family and friends may require considerable support. ‘Linking objects’, such as place and personal effects, also becomes important here. This is likely to be an enduring experience and once the critical moments have passed they cannot be reclaimed.

But these are difficult times for responders too, and a range of organisational factors militate in favour or against successful crisis support. It is to such issues that this paper now turns, discussed in reference to the experiences of a humanitarian support emergency response group operating as part of a UK local authority. Between 2007 and 2010, 44 in-depth interviews were conducted with local authority and other personnel and intra- and inter-

³ Personal interview with the author, Worcestershire, UK, May 1st 1998.

agency meetings were observed. In addition, the author was able to draw on numerous informal conversations about local authority emergency response and its challenges, and departmental and team documents also were examined. Key issues and themes were then coded and compared. Draft findings were circulated for accuracy, clarification, and discussion, and in some cases were amended accordingly.

Objectives and methodology

The aims of the research were to consider whether and how failures in services for bereaved people after UK disasters had been addressed at the level of local humanitarian responders and to understand the problems facing such a response from the perspective of those in the field. While managers and workers reflected on deployment at more than 30 incidents, the research was narrowed to examine in detail responses to three of the larger incidents, evaluated here as case studies:

- Incident 1 was the drowning of shoreline workers trapped by rising tides. It involved multiple fatalities and survivors. Many of these were migrant workers. Crisis support workers (CSWs) provided shelter and physical and emotional support to survivors and bereaved. The incident was complicated by conflicting priorities between investigative, immigration, health, and support agencies.
- Incident 2, the crashing of a helicopter servicing offshore gas platforms involved several fatalities and there were no survivors. CSWs worked jointly with police FLOs to support families in their homes and during their visits to the Family and Friends Centre established during the event.
- Incident 3, the derailment of a passenger train involved the intervention of CSWs in an incident resulting in one fatality and more than 100 survivors, as part of a joint response between local authorities and various public and private providers.

Data on the team's experiences in these and other situations were considered in relation to five main themes derived from the literature: (i) planning and preparation; (ii) resources and capacity; (iii) organisational flexibility; (iv) the quality of inter-organisational relationships; and (v) the degree of *continuity* of crisis support work in relation to pre-emergency work, a theme running through each of the first four points. It is in relation to these themes that the

experiences of the respective crisis support teams, and the broader issues raised, are discussed below.

Planning and preparation

Specific emergency plans were viewed by CSWs and their managers with considerable caution. According to one manager, the Emergency Planning Team ‘have to tick boxes as far as plans are concerned. [But] it does not matter what the plan says. . . . Whenever an incident happens you never lift a plan and read it anyway and most of the incidents we have had don't fit the plan’.

Incident responses originated in pre-planned ‘call out’ sequences but they developed flexibly rather than along the lines of pre-determined plans. ‘You have to prepare but you can't be prescriptive’, as another senior manager put it, ‘because each incident is different’. These views, widely echoed, chime with observations in the literature. These warn, in turn, that disasters cut across the local jurisdictions within which plans are framed and that plans edit out uncertainties, depicting partial or distorted data as if it were precise (Smithson, 1990; Blanco, Lewko, and Gillingham, 1996; Smallman and Weir, 1999). Perry (2004, p. 65) criticises ‘lengthy plans that attempt to anticipate every possible event and prescribe correctives’. Plans also may ‘miss’ people. Where language is technocratic and methodologies quantitative, ‘persons, communities and their concerns . . . [can be] . . . reduced to mass, collective units, statistically described data points, and functions of abstract dimensions’ (Hewitt, 1995, p. 321). Indeed, it has been argued that overly-prescriptive plans allow organisations to avoid facing their real unpreparedness (Smithson, 1990). Horlick-Jones (2005, p. 257, citing Nikolas Rose) suggests that ‘contingency’, a state of uncertainty about outcomes, has been supplanted by ‘a more recent, technical notion of “risk” . . . which has “brought the future into the present and made it calculable”’. Such ‘flawed certainty’ is ultimately exposed when ‘precisely the situation . . . occur[s] [that] has not been considered’ (Andersen, 2003, p. 130). This was the sentiment behind the comment of one experienced CSW that ‘incidents don't read plans’. It is an important point in a field where over-bureaucratisation often is rewarded (Lennquist, 2004b).

Crisis support managers and workers distinguished between planning and preparation, highlighting the basic assumption that, although incident specificities may not have been foreseeable, this did not preclude anticipatory investment in worker skills, flexibility, and

understanding. The establishment of a humanitarian Emergency Response Group⁴ in the County had preceded the Civil Contingencies Act 2004 and its associated guidance. The experiences of several key personnel in major disasters prior to assuming their current roles, rather than the new statute, provided the central motivation to its development. This was bolstered rather than initiated by the elevation of resilience among central government priorities -that occurred subsequently.

A principal aspect of the group's approach was on learning through responses to smaller-scale incidents. This grew as a practical means of giving non-emergency service workers direct experience of emergency situations and of responses to them. Preparing for the 'big one' is difficult to sustain when large-scale incidents are relatively uncommon. As one manager underlined, 'the problem [in terms of major incidents] is that you more than likely only get the experience once'. Knowledge was gained and skills were honed in responses to building collapses, fires, floods, landslides, and police sieges. These 'low-profile' responses crafted a core of workers who grew increasingly familiar with, and confident in, each other.

Learning occurred *between* incidents and lessons were fed quickly into revised arrangements around, inter alia, call out, management capacity, and administrative support. Significant difficulties in relationships between local authority and police during Incident 1 led to the establishment of joint training and protocols between police FLOs and local authority CSWs— with clear improvement being evident by the time of Incident 2, two years later.

Although senior management accorded preparation a progressively higher priority over the time frame, some difficulties persisted. First, not all potential (or, as it transpired, *actual*) responders participated in training or exercises. In two of the three case study incidents significant difficulties emerged in inter-agency relationships with 'unfamiliar' actors whose work had not been integrated into preparation. Second, problems arising from this were exacerbated by initial under-recognition of the potential for inter-agency conflict during responses. This was addressed after inter-agency difficulties during Incident 1, but only in so far as joint working between local authorities and the police was concerned. While relations

⁴ This Emergency Response Group included a wide range of volunteers, many of whom were concerned with planning for and operating rest and other centres. A smaller group of personnel *within* the group focussed on direct engagement with bereaved people. This was 'crisis support' work and it was these staff who were organised into 'crisis support teams'.

between them improved dramatically across incidents, relationships with agencies that had not participated in preparation proved problematic. Third, the stress on attending small incidents came to rely on a relatively small group of workers. Managers called out workers whom they knew to be experienced and reliable, leaving others with few opportunities to develop their knowledge or skills, and threatening resilience in the face of larger incidents.

Resources and capacity

UK local authorities are usually expected to finance disaster response from contingency funds (HM Government, 2007). Central assistance typically applies only ‘after the authority has spent 0.2% of its revenue budget on eligible works in the financial year’ (HM Government, 2007, p. 24) and predominantly to bad weather incidents. The overriding rule is that where there is already a programme financed by government expenditure, further spending will not be met. The assumption is that resources will be found at the local level. Public sector organisations, though, cannot easily find ‘spare’ capacity or relax their ‘everyday’ functions to deal with emergencies. Local authority social work, from where most crisis support volunteers are drawn, ordinarily experiences staff shortages, inadequate accommodation, poor information technology (IT), and increasing burdens (Social Work Task Force, 2009a). Preparing for remote contingencies does not seem pressing and relies heavily on a few motivated individuals (Smith, Lees, and Clymo, 2003). Local authorities, unsurprisingly in this context, have seen advantages in developing low cost models, relying on workers to volunteer in an emergency.

While this system has resulted in some impressive responses to incidents, and although there is considerable evidence of skilled and committed engagement, it was approaching the limits of its capacity when confronting relatively large-scale incidents, such as Incidents 1 and 3 where there were large numbers of survivors. Only a brief time-limited service in these cases was offered to victims and CSWs were expected to be back in their normal jobs quickly. Both bereaved and survivors were commonly referred elsewhere, especially if from outside the locality. The relatively small number of personnel who tended to be called upon in emergencies were overstretched. In Incident 2 the under-resourcing of management became a problem. This may have been related to the fact that it happened during a period of public holiday when supporting cover was thin. More generally overstretch and, in some cases exhaustion were sometimes made worse by workers’ own high level of motivation and enthusiasm for their work. Those working peripatetically found themselves struggling to

access basic accommodation and resources when called out. Administrative support during Incident 2, for instance, operated from the spare bedroom of an officer's home. There were shortfalls in IT and a heavy reliance on other agencies' facilities. Workers were not paid during their time off and sometimes had to keep on top of their 'day jobs' as they supported bereaved relatives. There was acknowledgement that larger incidents would have required the swift redeployment of significant resources from elsewhere in the system and there was concern that the relative 'success' of this low-cost approach to smaller events was, ironically, reinforcing a degree of complacency among senior managers that emergency planning was 'in hand'. The relatively few personnel called out to incidents also meant that experience tended to become concentrated, raising risks associated with staff absence or departure. In the view of some this was exacerbated by the distancing of this sort of work from that demanded in everyday social work.

Organisational flexibility

Bureaucracies are comfortable 'work[ing] on stable data . . . their basic frameworks of reference are established rules, clear and fixed partitions of areas of competence and levels of responsibility, top-down dynamics and a programmed time frame' (Lagadec, 2004, p. 162). The literature suggests that there often is an immediate drift away from the formal and familiar once incidents occur (Supermaniam and Dekker, 2003). Disasters undermine linear, centralised administration:

Those at the top do not typically know what to do. In fact . . . a dissociation of knowledge and authority . . . creat[es] a paradox of power. People . . . either have the knowledge . . . (because they are there, locally, in the field but they lack the authority to decide in implementation), or people have the authority to do it (but then lack the knowledge) (Supermaniam and Dekker, 2003, p. 313).

Procedures can become redundant and key resources may be disabled or destroyed. Agencies need to recognise the diversity, variety, and creativity that 'chaos' may offer (Browning and Shetler, 1992; Comfort, 2002; Sellnow, Seeger, and Ulmer, 2002). Variables that become important are the ability to improvise, a shared conception of the response system, and an ability to question, to understand the limits of knowledge, and to interact respectfully (Weick, 1993). Flexibility requires trust in individuals and groups to act without close supervision (Corbacioglu and Kapucu, 2006, p.215). Where established approaches are inadequate or

inappropriate, they should be discarded or amended (Weick, Sutcliffe and Obstfeld cited in Kendra and Wachtendorf, 2003, p. 42).

Improvisation involves groups 'self-organising' in ad hoc networks (Weick, Sutcliffe and Obstfeld, cited in Kendra and Wachtendorf, 2003). Although research points first to the limitations of a centralised hierarchical response, people 'often make their missions work anyway . . . despite the countervailing pressures of procedure and protocol' (Supermaniam and Dekker, 2003, p. 313). They do so by taking charge, through 'a process of mutual adjustment that involves a "flattening" or apparent disregard of formal hierarchy' (Supermaniam and Dekker, 2003, p. 314). 'Unprecedented action requires . . . a kind of panic of empathy that trumps organizational habit and individual postures' (Molotch, 2006, p. 2).

The case studies contained significance evidence of flexibility, imagination, independence, and initiative. Practice was not entirely without hierarchy, but important decisions concerning the delivery of death notifications and adapting procedures for body viewing, for example, were taken in consultation with those in the field, or delegated to them. Senior managers came to value CSWs and were prepared to grant considerable autonomy and flexibility even to fairly 'junior' workers. When major incidents did arise, workers generally had previous experience of working together on minor incidents within the county, in minor evacuations for example and had become used both to each other and to acting in fairly flattened hierarchies in which lateral communication and initiative were valued.

Two main problems arose in this context. The first was when the local authority 'gave way', in the view of the CSWs who had been involved in Incident 1, to the security priorities of other agencies (discussed in the following section). That is to say, workers and their managers regretted that they had been *too* flexible. The second pertained to bereaved relatives from outside of the area during Incident 2. Even as the latter arrived to view the deceased it was being impressed on the CSWs that responsibility for supporting them should be passed on as soon as possible. In the event, counter-arguments by the CSWs themselves were accepted and these families were supported while in the authority. For one CSW, however, 'it was made very clear that . . . [He was not to] offer any follow-up support'. CSWs did not know what provision, if any, had been arranged for victims returning to their home authorities. The concern was that home services might not be sufficiently familiar with the

needs of the victims, including support via inquest and inquiry processes. Such concerns are reinforced by research evidencing victims' poor experience of non-emergency services in cases of corporate killing (Snell and Tombs, 2011).

Inter-organisational working

'Incident organisations' are 'temporary configuration[s] of otherwise disparate resources' and communication and coordination are major challenges (Smith and Dowell, 2000, p. 1154). Agencies have different cultures, knowledge bases, priorities, procedures, resources, and technologies. Whatever a plan prescribes, agencies often act according to their own routines, interacting with others only when this is absolutely necessary (Berlin and Carlstrom, 2008). Coordination requires regular updating and re-familiarisation among organisations at multiple levels as breakdowns can be serious. After Incident 2, CSWs were denied access to hospital wards and local authority senior managers were barred from the hospital's control room and had to work from a public waiting area instead. The implications of disbanding hospital social work teams—the traditional interface between a local authority and health providers—were exposed only when an emergency occurred.

In an era of regular organisational restructuring, and the fragmentation of provision, as one actor disappears, others appear, which may not have been included in emergency preparation. A private sector Incident Care Team (ICT) appeared unheralded on the scene during Incident 3. While its apparently bottomless fund of resources encouraged CSW responders to engage positively, time was wasted orienting ICT personnel and integrating them into the response. There appeared to be a lack of understanding of the lead role of the local authority, the role of the police in securing the incident site as a crime scene, and the responsibilities of both in terms of confidential information. ICT assistance was welcomed, but the broader rationale behind such a deployment, as acknowledged by industry personnel themselves, was to protect the corporate image. This matter may become particularly sensitive when ICTs respond to incidents with origins in which the corporations are, or are perceived to be, complicit. The possibility is raised of officials scrambling for resources, dispensed by image-conscious corporate criminals.

The enhanced role of the FLO, while signifying enhanced police concern for victims, is not unproblematic either. Lord Justice Clarke (2001) viewed the deployment of FLOs to the

scene of the Ladbroke Grove, London, train crash on 5 October 1999 [OK?] as model practice, yet according to the police's own account:

The FLOs were unsure of the role of social services, who were in turn equally unsure of the roles and functions of the FLOs. [Neither knew] . . . the counselling organisation nominated by the [train operating companies] (Harrison, 2000, p. 3).

All of the actors saw 'counselling' as someone else's role. Although agencies eventually 'came together' social workers were 'reluctant to initiate early contact with the families as they felt their role was unclear, and to an extent superseded [*sic*] by the role of the FLOs who had access to the resources provided by the [train operating companies]' (Harrison, 2000, p. 4).

This was clearly not a happy operation. Police were unhappy about recording practices and what they perceived as some partner agencies' reticence to treat what they were told by their service-users as potential evidence (Harrison, 2000). In fact, evidence set before Lord Justice Clarke highlighted considerable role confusion. The function of the police, it is easy for health or welfare partners to forget, is primarily *investigative*. From the point of view of the police, as one officer explained, 'there can be 'no absolute guarantee of confidentiality'. The same officer noted debates within the force about the possibility of using FLOs as 'cover' for counter-terrorism officers. A key issue here is that post-incident organisational politics cannot be approached naively by those responsible for psychosocial support. Where support and security agencies are too close, victims who are apprehensive about the 'authorities' might be easily deterred from accessing support. Official interests and motives may be complicated further when responder agencies feature in controversies regarding blame. Public relations were important for the ICTs referred to above in Incident 3. Countering or deflecting criticism may seem vital to state agencies, too (Scruton, 1999). Police pressed the mother of one *Marchioness* victim to keep secret the severing of her deceased daughter's hands on the grounds that this was a 'one-off' mistake and that disclosure would distress others (Davis and Scruton, 1997). The easy assumption of benevolent official neutrality lying at the heart of official discourse does not withstand scrutiny. The exposure during the Leveson Inquiry (into the culture, ethics, and practices of the UK press following the News International telephone hacking scandal) of deeply troubling relationships between media, police, and former police personnel, together with allegations of media surveillance of disaster victims, has deeply

troubling implications for all high-profile victims, as well as for those charged with their support.

The virtues of coordination indeed, can be overemphasised. ‘Coordination’ may be read either as implying mutual agreement or as implying direction by one agency (Hills, 1994). ‘Cosiness’, trading on ‘vagueness, ambiguity, non-specificity and even distortion’ can breed a reluctance to confront errors (Smithson, 1990, p. 225). At the ‘directive’ end of the scale, meanwhile, a lack of feedback can allow mistakes to develop unchecked. In either case, consensus can become authoritarian and emergency measures can become repressive (Alexander, 2002). In Incident 1, according to the CSWs and their managers, too much emphasis was placed on cooperation and not enough on the humanitarian priorities of the local authority itself. At one level, there was conflict concerning what might be thought of as fairly minor issues, such as issuing and recording individual cigarettes and bars of chocolate, which infantilised victims. As one CSW recalled:

If [survivors] wanted a cigarette they had to have a police escort. Cigarettes could only be given out one at a time and you had to ask the police to go and supervise them . . . in case they did a runner. I don't think there was anywhere to run because they had no proper clothes. . . . They had no money at all. There were people on gates. I [gave] them three or four ‘fags’ at a time, I wasn’t bothered. . . . I thought [it] was controlling and I wasn’t there to control.

At a more serious level, CSWs had to wrestle with the extreme reluctance of some survivors to engage with officials from their home country’s embassy. Survivors in Incident 1 were also said to have been held in ‘unofficial’ custody for three days while officials proceeded with investigations. This was a complex intervention: there were multiple fatalities and survivors with immediate psychosocial needs, but there were also official concerns about potential criminal and immigration offences. In short the survivors could be seen as victims of tragedy or potential criminals. In retrospect, CSW personnel argued, they should have done more to assert *their* priorities—of humanitarian assistance. That they did not, they put down to a combination of a lack of experience of the team at this time, the marginal and ‘suspect’ status of some victims, and the heavy emphasis placed on cooperation in official guidance. Crisis support may sometimes need to focus less on ‘coordination’ and more on its role in a system of inter-agency checks and balances.

'Continuity' and crisis support work

'Continuity' emphasises the importance of pre-disaster arrangements throughout impact and in the aftermath of the event (Dynes, 1994; Tierney, 2007; Henry, 2011). Disastrous harm does not stand apart from, or above, social arrangements. Rather, it is 'closely connected to issues of social change and power played out at the micro- and macro-social levels' (Henry, 2011, p. 221). Although 'continuity' can be employed analytically, it is also used prescriptively, suggesting that responders should build 'on everyday working practices' (Cabinet Office, 2007, p. 7). As Dynes (1994, p. 150) states, '[t]he best predictor of [organisational] behaviour in emergencies is behaviour prior to the emergency'. Disasters are difficult enough without expecting organisations to act in radically new ways. In this context, extensive changes to the everyday purposes, forms, and methods of UK social work raise questions as to its role after a disaster. Social work certainly is in a serious crisis, at the heart of which lies the commodification and instrumentalisation of care (Blaug, 1995; Dominelli and Hoogvelt, 1996; Munro, 2004; Parton, 2008). 'Care' is now packaged and accessed through bureaucratised assessments applied in straitened financial settings. Management of 'risk' and 'care' ties social workers to their keyboards (Social Work Task Force, 2009a, 2009b) and underscores longstanding worries that '[social work's] concern with . . . therapeutic work [and] with . . . adaptive responses to life situations has virtually disappeared' (Dominelli and Hoogvelt, 1996, p. 46). Statutory work on child protection, disability, and mental health, together with 'care management' of those discharged from hospitals, consume social services. Bereavement rarely is a priority. The clear danger is that many responders will face needs beyond their regular experience and unamenable to normal, bureaucratised ways of working. After the Ladbroke Grove rail disaster, social workers declined to work with bereaved victims because they did not feel competent to do so (Harrison, 2000).

In relation to the overall philosophy of crisis support across and between the major incidents observed, managers underscored 'non-specialist' skills and qualities: empathy, the ability to communicate, to quickly assess situations, prioritise and improvise in unfamiliar and unpredicted situations, for example. In this approach 'transferrable' skills, together with commitment, reliability, and willingness to attend training, rather than formally accredited professional qualifications in social work or previous experience with 'trauma', were the key desirables. Having said this, there was also a sense in which this philosophy was sometimes more rhetoric than reality: qualified social workers actually did assume most principal roles

during incidents. . Either way, both social work and non-social work colleagues had many opportunities to grasp ‘real’ experience through involvement in numerous small-scale incidents that interspersed the major incidents themselves. Volunteers responded to 34 incidents between 2004 and 2007. Thus, preparedness for large-scale incidents was enhanced by regular smaller-scale ‘crisis’ experience. ‘Continuity’ developed between these emergencies, albeit of different scales helping to offset the *discontinuities* that pertained between ‘normal’ and emergency roles. If experience developed cumulatively, though, it was notable that it tended to be the same individuals who tended to be called upon to respond in many of these smaller incidents. Attempts to introduce ‘new blood’ were made but there was a balance to be struck between this and the value of experience to response.

As discussed in the previous section, however, continuity was easy to establish and maintain at inter-agency levels. A new, unforeseen responder appeared on the disaster scene during Incident 3, one unfamiliar with the overall response or with those responsible for its coordination. The financial resources that they brought to the response were quickly put to use, yet there were difficulties with having to achieve proper integration rapidly. While ICT personnel publicised the success of their intervention to others in the industry, emergency personnel were rather more ambivalent. Some suggested that the ICT found it difficult to comprehend that the incident did not ‘belong’ to the company. The refusal of the police to let staff on to the crime scene and their reluctance to hand over casualty lists were not understood to be so by the corporate responder. The integration of national or international private sector organisations into local preparations requires ongoing commitment at the local level. Public relations ‘rewards’ may be scant. Whether or not companies are willing to commit resources to collective and long-term preparation, under local authority leadership, remains unexplored.

There were questions here as to whether or not the demands of planning and preparation were resourced realistically. A wide range of organisations might be caught up in an emergency, and linkages have to be renewed regularly. Yet, the local authority manager responsible for the humanitarian aspects of all three major emergency responses had to attend to preparation with only part-time administrative support. Coordinating planning, preparation, and response clearly is sometimes an extraordinarily difficult endeavour. ‘Success’ is dependent in large part on other organisations and their willingness to participate in emergency preparation. Where responders have been ‘out of the loop’—and the fragmentation of service provision

across health and social services may make this increasingly likely—it may be too late to rectify this during a crisis.

Discussion and Conclusion

As flaws in the responses to disasters in the UK in the late twentieth century became evident, pressure for improvement mounted. Legislative reforms raised national and local expectations and established frameworks for their realisation. Unsurprisingly, these centred on preparation for major emergencies themselves, augmenting Clarke's (2001) principles for response to victims and support for an enhanced FLO role with the confirmation of a local authority lead within a multi-agency approach.

This paper has explored, at the local level, organisational issues in the delivery of services to disaster-bereaved people. The case studies generate questions rather than answers and the issues they raise can only be generalised with caution. It is not argued here that the experiences of one local authority should lead to policy review or change. However, the experience of CSWs and their managers suggests some areas worthy of further thought and research. These pertain to planning and preparation, resources and capacity, organisational flexibility, the quality of inter-organisational relationships, and the continuity of emergency and non-emergency tasks and conditions.

The most interesting and innovative aspect of work to crisis support personnel themselves was joint training with other agencies. This was seen, with some justification as innovative and important. This was less interesting to the author however, than the grounding of major incident preparedness in regular experience of smaller incidents. In other authorities minor emergency incidents may have been left to the emergency services with occasional support from local non-governmental organisations (NGOs). In this county by contrast, the managers saw an opportunity both to provide an important service in and of itself, *and* an opportunity to practise arrangements for larger incidents should they arise.

It was perhaps instructive that the longstanding and committed efforts to forge an effective crisis support response to both large and small incidents relied on a volunteer model in which personnel were unpaid, negotiating some time off in lieu for emergency work - if their everyday line manager was amenable. It was a model with fairly obvious limitations, not least its reliance on continuing goodwill. Since the research was completed in 2009, UK local

authorities have been in the frontline of severe budget cuts as part of government-driven ‘austerity’. Although the attractions of a low-cost model for employers in such circumstances are obvious, it would be interesting to know whether goodwill among prospective volunteers has accompanied these economies. Putting such possibilities to one side, the fieldwork provided examples of financial stringency vis-à-vis the lack of adequate accommodation, equipment, and relief. Staff responded with initiative and flexibility. Protocols were sometimes set aside when necessary, decision-making was delegated, and experienced workers were trusted. One problem, indeed, was that once workers ‘proved’ themselves during incidents, they tended to be called out repeatedly, limiting the opportunities available to others and limiting the size of the ‘pool’ from which future responders might be drawn.

The most serious issues that arose across incidents were inter-agency difficulties. First, notwithstanding the exhortation in guidance that agencies act with a ‘single authoritative focus’ (Cabinet Office, 2005, p. 8), the reality on the ground was sometimes sharply conflicting priorities. In Incident 1, these centred on the balance to be struck between security and investigation on the one hand and humanitarian assistance on the other. In Incident 3, the corporate mitigation of reputational damage came into play. In the latter case, no significant deleterious effects resulted, although one can envisage scenarios where they might. In the former instance problems remained unresolved throughout the intervention. In retrospect, the CSWs themselves felt that they had let down their service users owing to a lack of assertiveness. Second, problems arose when responders had not participated in emergency preparation. In the first place, the investment required if only in terms of time, at the level of coordination, and its regular renewal, on the one hand, and in terms of frontline workers training together on the other, is difficult to sell to management in an agency with pressing immediate demands. In the second place, more generally, public services have become subject to seemingly endless ‘reform’, restructuring, and fragmentation. The manager with overall responsibility for humanitarian emergency response in the County expressed frustration with the multiplication of health providers in recent years. This and the potential commercial barriers to transparency in their working relationships have yet to be researched adequately.

Key here are continuities between arrangements and relationships before a major event and the way in which these play out during incidents themselves. The downside of the ‘continuity principle’ (Dynes, 1994) is that there is unlikely to be an easy escape during a crisis from pre-

existing arrangements that are dysfunctional or lacking in legitimacy. Where agencies *do not ordinarily* come together cooperatively at the requisite levels they are unlikely to find it easy to do so in emergency. As social service provision is increasingly characterised by fragmentation, competition, and attendant social work bureaucratisation, one can expect emergency responses to bear similar characteristics. One emergency services manager considered the future of broader UK emergency response with concern:

the next scandal will be about organisations which we commission to deliver services but which hide behind commercial confidentiality: private and third sector organisations . . . which have their own commercial interests and agendas, dip into integration when it suits them, and operate without effective governance, scrutiny and transparency.

There has been scant research into the ‘on-the-ground’ realities of crisis support and its links with everyday practice in the UK. Taken together, the experiences of field workers and the contemporary pace of broader structural change suggest that this deficit needs to be addressed.

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