Abstract: This study explores whether and how policy changes in the aftermath of a crisis. The authors ask why pre-existing regulatory regimes that are identified as contributory factors to “failure” are not necessarily reformed in the wake of a crisis. The investigation adds to the literature that addresses the classic tension between reformism and conservatism in post-crisis periods. Regulatory failure is identified as being largely responsible for two crises – the tainted drinking-water tragedy in Walkerton, Canada, and the collapse of a banquet hall in Jerusalem, Israel. Despite similarities in the nature of media coverage, institutional procedures for investigation and commission findings, these two tragedies differ dramatically in policy change outcomes. A policy streams prism is used to identify, characterize and analyse reasons for very different policy responses to crises associated with regulatory failure.

Sommaire : Cette étude examine si et comment les politiques changent à la suite d’une crise. Les auteurs se posent la question de savoir pourquoi des régimes de réglementation préexistants qui sont identifiés comme étant des facteurs contribuant à l’« échec » ne sont pas nécessairement réformés à la suite d’une crise. L’enquête apporte des éléments à la documentation portant sur la tension classique qui existe entre le réformisme et le conservatisme au cours des périodes postérieures à une crise. L’échec de la réglementation est identifié comme étant largement responsable de deux crises : la tragédie de l’eau potable contaminée à Walkerton, au Canada, et l’effondrement d’une salle de réception à Jérusalem, en Israël. Malgré des similarités dans la nature de la couverture médiatique, dans les procédures institutionnelles de l’enquête et les résultats des commissions, ces deux tragédies diffèrent radicalement dans les résultats des modifications de politiques. Un prisme des courants de politiques est utilisé pour identifier, caractériser et analyser les raisons des réactions très différentes en matière de politiques à des crises associées à l’échec de la réglementation.
When regulatory failures are significant and precipitate crisis and disaster, one might expect subsequent reform of these regulatory systems to reduce the risk of further fatal episodes. The democratic logic of this assumption is quite straightforward. As Christopher Hood, Henry Rothstein and Robert Baldwin suggest, risk regulation is “governmental interference with market or social processes to control potential adverse consequences to health” (2001: 3). Therefore, the greatest damage to a regulatory regime is likely to be when its weaknesses lead to death and disaster. We might reasonably expect that the ensuing loss of political and public confidence, coupled with inquiry findings that demonstrate that operational systems are not capable of performing the public safety functions for which they were designed, will lead to lessons and regulatory reform. In fact, given the prominence and scrutiny given to public health issues by the media, citizens’ groups, opposition parties and others, it may be difficult to conceive of a situation where there are no post-crisis/disaster moves to restore regulatory efficacy and the legitimacy of the regulatory system.

This logic seems initially to be reinforced by the literature on policy change. Students of policy change know that dramatic changes in policy are few and far between. Normally, the routines of politics predominate and policy change is incremental. Depending on which perspective we take, policy is controlled by relatively closed communities, advocacy coalitions, or constrained by path dependencies. However, crisis and disastrous episodes have the capacity to punctuate the normal rhythms of policy-making and produce rapid change (Boin and ‘t Hart 2003). Crises can act as trigger events (Cobb and Elder 1983), external perturbations (Sabatier and Jenkins-Smith 2003), stressors (Wilson 2000), focusing events (Birkland 1997, 2006) and produce “windows of opportunity” (Kingdon 2003) for policy change to occur.

If we dig deeper, however, the ideas on policy change and crisis management put forth in the literature are much more complex. They do not indicate that policy change is an inevitable product of crisis episodes. Crises believed to result from unintended and unguided actions, for example, are not likely to reveal a need for policy change in systems; at most, they result in the punishment of those individuals deemed responsible (Stone 2002; Birkland and Nath 2000). Furthermore, agenda-setting theory suggests that, while (system) crises will almost necessarily focus public attention on an issue, unless there are coherent advocacy coalitions (Sabatier 1993; Wilson 2000), perceived viable solutions, or favourable political climates, they are unlikely to lead to policy change (Birkland 1997, 2006; Kingdon 2003). Indeed, political realities and the actions of entrenched interests often thwart crisis-induced policy reform.

Recent thinking on the politics of crisis management (Boin and ‘t Hart 2003; Boin et al. 2005; Drennan and McConnell 2007) reinforces the complexity of the relationship between crisis and policy change. Crisis management
is deemed to be a “mission impossible,” with leaders facing in two directions in the wake of crisis. They need to offer some “learning” commitment to ensure that never again will society be exposed to the same risks, but they also need to offer reassurance that existing frameworks are essentially robust. This tension between reformism and conservatism in the aftermath of crisis is both an enabler and a constraint on policy change after crisis.

In this article, we add to existing literature by focusing specifically on the extent to which failures in regulatory systems lead to regulatory policy change in the wake of the crisis and disaster they helped precipitate. Previous studies have examined the effects of focusing events on policy change and on administrative values (Vaughan 1996; Busenberg 1999; Romzek and Ingraham 2000; Schwartz and Sulitzeanu-Kenan 2004). However, they do not relate specifically to learning and change from regulatory failures.

Accordingly, this article deals with two cases where regulatory failures were implicated as causal factors in tragedies, but subsequent processes of inquiry and broader lesson-drawing culminated in very different policy outcomes. The Walkerton water tragedy involved contamination of drinking water with the E-coli bacterium (Ontario, Walkerton Commission of Inquiry (2002). It produced seven deaths, caused some 2,300 to fall ill, and led subsequently to substantial reform of the environmental regulatory regime. By contrast, Jerusalem’s Versailles Banquet Hall collapse in 2001 caused twenty-three deaths and over four hundred injuries but did not lead to refinements in building codes (Israel, Commission of Inquiry into Safety of Buildings and Public Places 2004). In reality, changes were little more than symbolic gestures.

The article draws on a variety of primary and secondary sources, including investigative reports and interviews with stakeholder representatives. Our goal is case-oriented, viewing the Canadian and Israeli experiences through the lenses of literature on policy change and risk regulation. Our case comparison is essentially a “most similar” one (George and Bennett 2004), which seeks to explain why two regulatory-induced crises in systems with broadly similar policy and political characteristics, produced markedly different outcomes in terms of policy change. We recognize that a two-case discursive approach cannot provide a controlled comparison and rigorous testing of a single independent variable, but we do have the advantage of rich description and country specificity.

Our two cases share much common ground. Both were tragedies brought about (in part) by failures in systems on which citizens relied for basic needs – water and shelter. Both failures generated substantial national and international media scrutiny and coverage. The institutional configurations and democratic contexts of the post-disaster inquiries were also broadly similar. Both were (and are) liberal democracies, with parliamentary systems, and processes for independent post-disaster investigations. Furthermore, the
The article is divided into three broad sections. The first provides an overview of each case, focusing on the role of regulatory failure in the advent of the crisis. The second section compares the subsequent policy reactions and policy change patterns. It uses the “policy streams” model (Kingdon 2003) as a means of organizing and informing the analysis. The discussion focuses on explanatory variables from the politics stream (political context, process of investigation, stakeholder interests) that affect post-crisis policy change. As we will see, the respective interactions of the problems, solutions and politics streams help explain the different policy trajectories in the wake of disaster. The final section concludes by drawing out broader implications in terms of the relationship between societal risks and the regulatory regimes, which are, in theory, meant to mitigate these risks.

Case presentations: the role of regulatory failure in the advent of crises

Walkerton

The rural town of Walkerton in southern Ontario is home to some 4,800 residents. In May 2000, heavy rain washed manure from a farm into the source of the town’s drinking water, leading to contamination with the E-coli bacterium \( \text{Eshericha coli} \) \( \text{0157:H7.1} \). Failures in the operation and oversight of chlorination procedures resulted in the deaths of seven people who had ingested the deadly bacteria, and in excess of 2,300 illnesses – the adverse effects being long lasting for many individuals. Public panic and fear about drinking-water quality spread throughout the province, and the government appointed the Walkerton Commission of Inquiry, headed by Associate Chief Justice Dennis O’Connor.

The inquiry’s report found that two operators of the water treatment plant (the Koebel brothers) had acted improperly in not complying with, and indeed flouting, water treatment and reporting rules but that the responsibility to ensure compliance with regulations should rest with the Ministry of Environment, which had failed in this regards, as well as with the municipal government and the provincial government more generally. The Ministry of Environment had known for several years that there were substantive problems with Walkerton’s water treatment facilities, particularly in terms of microbiological sampling and chlorination. However, “[t]he MOE took no action to legally enforce the treatment and monitoring requirements that were being ignored . . . . I am satisfied that if the MOE had adequately fulfilled its regulatory and over-sight role, the tragedy in Walkerton would have been prevented (by the installation of continuous monitors) or at least
significantly reduced in scope (Ontario, Walkerton Commission of Inquiry 2002a: 27–30).

The banquet hall collapse demonstrated that the regulatory regime governing planning and construction was largely ineffective.

The inquiry report also highlighted the detrimental impact of budget cuts on the capacity of the Ministry of Environment to ensure safe drinking water for the residents of Ontario. Budget cuts introduced in the mid-1990s by the neo-liberal Harris administration led to a significant reduction in inspections and monitoring (by 1998–90 the ministry’s budget had been reduced by more than $200 million and staff numbers had been cut by over thirty per cent (Ontario, Walkerton Commission of Inquiry 2002a: 34). The regulatory regime was not only weak for drinking water but voluntary for non-point source water pollution, such as from agricultural waste, pesticide run-off and sewage overflow (Johns 2001). As the inquiry subsequently revealed, the pressures were sufficient for ministers and the cabinet to be warned in writing by senior officials of possible public-health risks, although the “impartial” status of public servants and their inability to make public comment, coupled with a lack of whistle-blowing procedures, prevented these warnings finding their way into the public domain. The Walkerton Commission of Inquiry also found that the Ministry of the Environment did not follow through on the findings of a 1998 inspection, which sought to correct deficiencies in monitoring and chlorination procedures. As the inquiry report suggests, “With the proper follow-up, these protective measures would likely have resulted in the [Public Utilities Commission] PUC’s adoption of chlorination and monitoring practices that would in turn very likely have substantially reduced the scope of the outbreak in May 2000” (Ontario, Walkerton Commission of Inquiry 2002a: 405–406).

Jerusalem

The collapse of Jerusalem’s Versailles Banquet Hall, in June 2001, grabbed the attention of the international media, particularly because it had access to spectacular video footage of the dance floor collapsing.¹ Twenty-three people died and over 400 were injured – many seriously. Initial investigations by engineers found a number of deficiencies. The building was designed for industrial use rather than for dynamic “loads” brought about by recreational use; a supporting column had been partially removed during renovations of the ground floor, and a new floor had been added. Crucially, the prohibited Pal-Kal method had been used to construct this new floor. Pal-Kal involves the use of cheap steel plates or boxes for structural support rather than the more expensive and traditional system of concrete supporting columns.
The banquet hall collapse demonstrated that the regulatory regime governing planning and construction was largely ineffective. Jerusalem’s city engineer, testifying before the Knesset Interior Committee, made public the fact that the banquet hall had never received an “approval for occupation” or a business licence (Israel, Knesset 2001a). Attempts made through legal channels to close the hall were unsuccessful. All along, the municipality had not scrutinized building plans closely enough to be aware that the prohibited Pal-Kal method had been used.

Explanations offered by city engineers for abdicating their legal duty to check building plans focused particularly on the meagre budgetary allocations afforded to engineering units by local authorities, resulting in a lack of sufficient numbers of qualified engineers to conduct detailed checks on building plans (Israel, Commission on New Building Methods 2001: 39; Israel, Knesset 2001b: 23). At the time of the tragedy, only eighteen out of thirty-three inspectorate positions were filled. Meanwhile, the municipal tax revenues that buildings generated for local authorities created strong incentives to get buildings operational. The scale of the problem became particularly evident when, at a meeting of the Knesset Interior Committee, it was revealed that there were almost 50,000 buildings constructed in breach of legal requirements in Jerusalem, each of which paid municipal taxes (Israel, Knesset 2001a: 18).

Early warnings of Pal-Kal deficiencies date back to 1987, when the head of the Station for Construction Research of Israel’s prominent engineering university, the Technion, sent a letter to the Ministry of Construction stating that the method was inappropriate and unsafe. Yet no action was taken by government oversight agencies until the mid-1990s, when the chief inspector in the Ministry of Labour, with responsibility for investigating accidents at work, linked the Pal-Kal method “with a very high probability” of having contributed to three roof collapse incidents, two deaths and numerous injuries over the period 1994—95. Nevertheless, problems continued. In 1996, a disaster was narrowly avoided when a crack was found in the ceiling of a shopping mall in the city of Rehovot. The ceiling had been constructed using the Pal-Kal method.

These dangerous incidents and near misses prompted some action. In 1996, the Ministry of Interior issued a circular to local authorities that stated that the Pal-Kal construction method was dangerous and in breach of basic engineering principles. The circular stated that local authorities should not grant building permits, or approve for use, any buildings constructed using Pal-Kal. Also in 1996, following tests conducted by the Israel Standards Institute, an amendment was issued to the standard governing roof construction that made it clear that Pal-Kal roofs did not meet the requisite safety standards. Two years later, in 1998, a second circular was issued by the Ministry of Interior that instructed local authorities to carry out visual in-
specifications of all buildings constructed using the Pal-Kal method. Later that same year, pressure intensified when the Association of Contractors in Israel recommended that the Pal-Kal method not be used by members.

These new requirements and strong recommendations seemed sufficient to mark the end of Pal-Kal and the public health dangers that accompanied it. However, as all policy scholars know, policy implementation does not always accord with decision goals. The banquet hall collapse was precisely evidence of this. Local authorities did not put requirements into practice. Local authorities in Israel suffered from chronic budget crises, brought about by a combination of security-dominated national budgets, as well as central-local tensions and blame-shifting for service failures (Brender 2003). Neither the Ministry of Interior nor municipal authorities were willing and able to commit a level of resources that would enable comprehensive and professional scrutiny of both building plans and existing structures.

**Reaction and regulatory policy change**

**Walkerton**

The Ministry of Environment, with backing from the Government of Ontario, took swift action to reassure residents throughout the province that their water was safe to drink. All municipal water systems were subject to immediate external review, with results reported back to the ministry. The Walkerton Commission of Inquiry was appointed, and the Ministry of the Environment began revamping its regulation of drinking water in accordance with preliminary findings. The reforms were backed by government resources. Roughly $18 million was provided initially for Operation Clean Water, followed by an investment of almost half-billion dollars over the period 2002—03 in order to implement Justice O’Connor’s recommendations (Ontario, Ministry of Finance 2002). Changes occurred in the three main components of regulatory regimes: standard-setting, information-gathering and behaviour modification (Hood, Rothstein, and Baldwin 2001). Let us deal briefly with each.

What were previously objectives and guidelines became standards. Ontario’s new water regulation regime became enshrined in three pieces of legislation: the Safe Drinking Water Act, 2002 (S.O. 2002, c. 32); the Sustainable Water and Sewage Systems Act, 2002 (S.O. 2002, c. 29); the Nutrient Management Act, 2002 (S.O. 2002, c. 4); and the Drinking Water Systems Regulation (O. Reg. 170/03), as well as (in the longer-term) the Clean Water Act, 2006 (S.O. 2006, c. 22). New requirements in 2002 and 2003 covered a range of issues, from water sampling to chlorination. For example, a new directive was put in place requiring owners of water treatment or distribution systems to
notify the medical officer of health and the ministry of sample results outside established parameters or of any other indicators of adverse water quality (s. 8);
— post warnings when sampling and analysis requirements have not been met (s. 10);
— make available to the public, free of charge, copies of reports and records in relation to water samples (s. 11);
— prepare written reports on a quarterly basis, submitted to the director, and covering comprehensive water data, analysis of results, and measures taken to ensure compliance with regulations and legislation (s. 12); and
— submit triennial reports to the ministry, conducted by an independent engineer with experience in sanitary engineering and water supplies (s. 13).

In terms of information-gathering, systems were reformed and the new regime included mandatory and yearly inspections of all systems for the distribution and supply of drinking water. The duration of each inspection often lasted several days, depending on the scale and complexity of each facility. New requirements with regard to sampling, analysis and reporting also allowed additional information to be gathered.

Finally, a behavioural change was evident on the part of inspectors. Prior to the disaster, inspectors and operators interacted on the basis of collegiality and advice, rather than on the basis of “inspector as enforcer.” Informal relationships and practices are typically the least effective in ensuring compliance with regulations (May 2005). However, in the aftermath of the Walkerton tragedy, the Ministry of the Environment introduced a “zero tolerance policy.” Breaches of standards were to be rigorously pursued and enforced according to stipulated time-frames. “Zero tolerance” also included administrative infractions – such as financial penalties for improper posting of certificates. Therefore, within a short time-period, the pendulum had swung to the opposite side of the regulatory continuum – to a mandatory approach (May 2005).

Jerusalem

In the wake of the Versailles Banquet Hall tragedy, the Knesset appointed the Commission of Inquiry into Safety of Buildings and Public Places (chaired by Justice Vardi Zeiler) to study the state of the regulatory regime for building safety (Israel, Commission of Inquiry into Safety of Buildings and Public Places 2003). Reporting some two and a half years after the disaster in December 2003, the inquiry found serious deficiencies in regulatory systems for the construction and safety of buildings. When the report was published, the Jerusalem Post (26 December 2003) described its findings as “nothing less
than a searing indictment of the whole building industry . . . the entire sys-
tem of construction in Israel is flawed to its core.’’ Such pessimism seems
warranted in the light of Zeiler himself stating that “it will be a miracle if
there isn’t a second Pal-Kal affair.”

Accordingly, the inquiry proposed a major overhaul of building-safety
standards and the establishment of a new national body for the regulation of
the construction industry. To date, however, no action has been taken on the
inquiry’s major restructuring recommendations. There have been minor re-
finements to business licensing, ministry instructions to enforce the business
licensing law, educative seminars, and some meetings bringing various au-
thorities together with a view to producing a more coordinated approach to
business licensing. Yet, such changes are clearly small and incremental.
There is no new legislation, new building standards, or new agency to pro-
duce a coordinated approach to regulation and its enforcement.

A framework for explaining different
policy trajectories in the wake of
regulatory failure

A study by M. Lodge and Christopher Hood (2002) identifies a number of
possible policy learning reactions to crises. Knee-jerk responses (swift reac-
tions to tragedy) tend to produce excessively rigid control regimes and leave
“regulatory tombstones” for years to come (Breyer 1993). “Crisis reform”
responses involve entrepreneurial exploitation of “windows of opportunity”
to launch incubated proposals – which characterizes turning points that lead
to institutional renewal (Boin and ‘t Hart 2000). “Dynamic conservatism” or
“system-maintenance” approaches protect borders and established modes
of operation and preserve as much as possible pre-existing ways of life
(Lodge and Hood 2002). Finally, organizations that manage to avoid the
most difficult changes and that focus on more readily practical, programm-
able or the internally valued aspects of changes can be said to have effected an
“institutional biases-coloured response.”

Applying this classification scheme, the two cases are clearly at opposite
ends of the continuum. Policy change after the Walkerton tragedy fits well in
the “knee-jerk” response category; although the term can carry negative
connotation, in actual fact, swift responses can also be measured and popu-
lar. By contrast, changes stemming from the Jerusalem tragedy can be
categorized by “dynamic conservatism” and an “institutional biases-coloured
response.” In the Walkerton case, new standards required that even very
small drinking-water facilities conduct frequent tests, that frequent routine
inspections be conducted of all facilities, and that a zero-tolerance strategy
be applied to even minor infractions. It seems, therefore, that there has been
a change in the allocation of attention and resources within the Ministry of
Environment, from areas of higher science-based risk to addressing the lower risk of contaminated drinking water. In contrast, Israeli policy-makers made only very minor adjustments to the regulatory regime governing building safety.

Existing literature on regulatory regimes is only of partial assistance in helping us explain these two different policy pathways after crisis. A major study of risk regulation regimes by Hood, Rothstein and Baldwin (2001) focused more on comprehending the characteristics of each regime itself than on explanations for change. It identified three main factors that help explain risk regime content (market failure, popular opinion and interest pressures) but also factors in organizational micro-politics as well as increased pressures for openness and transparency. There is a recognition that tragedy may bring about reform, although its principle focus is on how effective such (arguably) hastily introduced changes can be.

Hood and his colleagues concluded their study by recognizing the need for alternative ways of understanding divergences between risk regulation regimes. In this spirit, we use the “policy streams frame” (Kingdon 2003) to shed light on the conditions under which tragedy associated with regulatory failure leads to different types of policy response. Following this approach, we offer three propositions. They are parsimonious in nature but, we would argue, have sufficient explanatory power to be usefully applied to the Walkerton and Jerusalem cases:

1. The Problem Stream: The greater the perception that a flawed regulatory regime presents tangible and widespread risk to public health and safety, the greater the likelihood of significant regulatory policy reform, including knee-jerk policy responses.

2. The Solutions Stream: The more that proposed regulatory regime changes are perceived as technically and economically viable, the greater the chances they will be adopted.

3. The Politics Stream: a) The more a government is under political pressure for reform (e.g., in the media or in public opinion), is vulnerable in its capacity to govern (e.g., in relation to looming elections or slides in opinion polls), and reform does not challenge dominant governing values, the more likely it is that policy reform will occur in the wake of crisis; and b) the more powerful the stakeholders lobbying for change, the more likely it is that policy change will occur.

In applying each proposition to the Walkerton and Jerusalem cases, our analysis will attest to the importance of political dynamics in explaining risk regulation, despite the perceived ability of risk regulation to conduct precise calculations of relative risks. Our analysis is summarized in Table 1.
The problem stream

The risk issue at the core of the Walkerton tragedy was the risk that drinking water may be unfit for human consumption, resulting in illness and possible death. Water is a basic human need, and safe drinking water has become one of the signs of a modern society (Shiva 2002) – especially in comparison to many developing nations, where drought and water contamination is a way of life (and death). In the developed world, when public authorities fail to guarantee the safety of drinking water and its supply, this focusing event (Birkland 2006) is likely to produce an “agenda-setting crisis” (Boin et al. 2005), connecting with deeper societal concerns about the fragile nature of our environment. Walkerton was about water – a basic human need – raising the stakes and creating considerable impetus for something to be done to restore public trust.

Such arguments were reflected in much of the social anxiety and official investigation. In essence, there was widespread recognition that the Walkerton failure was fundamentally a systemic failure. Justice O’Connor’s inquiry made clear that issues surrounding Walkerton had ramifications beyond this small town. There were serious concerns about drinking-water safety for the entire province of Ontario and its twelve million residents. A citizens’ action group, set up in the immediate aftermath of the contamination episode, stated before the inquiry that “[b]efore May of 2000, most Canadians turned the tap on for a drink of water with the full confidence that the water was clean and safe for consumption . . . . Now, however, that sense of confidence and trust in the safety and security of drinking water supplies has disappeared” (Canadian Environmental Law Association 2001: 5). The agenda-setting nature of these concerns (coupled with a separate contamination incident in North Battleford, Saskatchewan, in March and April 2001) spread to almost every other province and territory in Canada, leading to an

Table 1. Strength of Factors Conducive to Regulatory Change in Walkerton and Jerusalem

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<thead>
<tr>
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<th>Walkerton</th>
<th>Jerusalem</th>
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<tr>
<td>Problem stream: perception of the risk and its challenge to public health and safety</td>
<td>Medium/High</td>
<td>Medium</td>
</tr>
<tr>
<td>Solutions stream: technical and economic viability of proposed regulatory regime change</td>
<td>Medium</td>
<td>Medium</td>
</tr>
<tr>
<td>Politics stream: conducive political context</td>
<td>High</td>
<td>Low</td>
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DO CRISSES HELP REMEDY REGULATORY FAILURE?

The collapse of the Versailles Banquet Hall in Jerusalem created a watershed change in public perception of the risks of building collapse
The collapse of the Versailles Banquet Hall in Jerusalem created a watershed change in public perception of the risks of building collapse. While previous Pal-Kal-related incidents were reported in the press, and while there was general knowledge of regulatory weakness, the shock of this tragedy— including the visual images broadcast repeatedly on public television— caused considerable concern about the safety of public buildings throughout the country. The perception of there being a real problem was fanned by media reports of hundreds of buildings with Pal-Kal construction, including schools, hospitals and shopping malls. While building safety is certainly vital to anyone entering a building, the enforcement of building codes, in comparison to ensuring safe drinking water, does not quite bring such strong symbolic connections to modernism and civic values. However, the wider implications of the discredited Pal-Kal method were that other buildings may be vulnerable to collapse. For both Jerusalem and Walkerton, therefore, media attention, parliamentary debate and the appointment of commissions of inquiry clearly indicate broad perceptions with the public and in the media of problems in need of solutions. Although the tendency was to see the banquet hall case as a tragic incident caused by failures to identify and apply appropriate building codes, there was no general sense that it was a systemic failure, stretching to and including the government of the day.

The solutions stream

All things being equal, the more the proposed regulatory regime changes are perceived as technically and economically viable, the more likely it is that they will be adopted. In both cases, respected commissions of inquiry produced recommendations that detailed specific solutions to the problems at hand. The proposed solutions were quite similar in nature and involved regulatory regime changes primarily in standard-setting and information-gathering, with some attention to behaviour change. Technically, none of these recommendations was particularly challenging, because there were well established standards and procedures for measuring and securing both the quality of drinking water and the safety of buildings. However, adherence to the recommendations would require, in both the Walkerton and Jerusalem cases, organizational changes and considerable resource investments to allow for sufficient quantity and quality of information-gathering and behaviour modification efforts. While correction of faulty water treatment facilities and unsafe buildings (i.e., those constructed with Pal-Kal)
incurs considerable expense, these would be borne primarily by private and local enterprises, not by the public purse.

One of the differentiating factors between the two sets of “solutions” was in terms of the locus of administrative authority. Reform potential was highest in the Walkerton case because changes would fall within the jurisdiction of one government department, the Ministry of the Environment, with a policy competence in that field (a point that O’Connor was clearly aware of). Justice Zeiler’s recommendations were not so straightforward because they involved the setting up of a new national authority. Therefore, despite the fact that both the Walkerton and Jerusalem recommendations received broad public support, the changes in Walkerton were probably more feasible because they constituted a form of administrative incrementalism, while the changes in Jerusalem were probably less feasible because they required a more radical administrative creation.

The politics stream

The broader political context of Walkerton was conducive to change. The tragedy was the subject of substantial public and media interest over the subsequent five years – partly because of the lengthy inquiry (almost two years) and partly because the trials of two Walkerton public utility workers (brothers Stan and Frank Koebel) was concluded only with their sentencing in December 2004. Also, the Concerned Citizens of Walkerton, represented by the Canadian Environmental Law Association (CELA), made good use of the media to ensure that water reform issues stayed on the political agenda. The media itself also used Walkerton as the touchstone for subsequent policy failures, such as the infected meat scandal in Alymer, Ontario, and the failed attempt to privatize Ontario’s electricity transmission grid. A further capacity for change may also be evident in the point made by Eleanor Glor and Ian Greene (2002) that Canada’s political culture places a particularly high value on integrity. A post-crisis policy change pattern similar to that in Walkerton was evident in the Human Resources Development Canada crisis (Good 2003; Sutherland 2003; Phillips and Levasseur 2004), suggesting that Canada may exhibit strong reaction to episodes where public officials fail in their duty to ensure public safety and financial probity.

The politics surrounding the Ontario government and its neo-liberal reform agenda were also important. Premier Mike Harris had proved a highly divisive figure, delivering tax reductions but pushing through budget cutbacks and unpopular education and urban reforms. A backlash had already
gained momentum prior to Walkerton; the government’s standing in the polls was poor and it was vulnerable generally, especially in relation to its neo-liberal attitude to regulation. With the advent of the failures in Walkerton, political divisions widened. The crisis acted as a catalyst for an array of counter-Harris interests among environmental groups, educational/legal élites, trade unions and citizens (Snider 2004). The Walkerton tragedy was also one of the reasons behind Harris’s resignation in April 2002 and the failure of his successor, Ernie Eves, to get re-elected in October the following year.

The points made here need to be tempered. We need to avoid the impression of a vulnerable Conservative government simply bowing down because of intense political pressures. Certainly, both the Harris and Eves governments needed to be seen as acting in the public interest on critical issues of public safety. However, it can also be argued that that post-Walkerton policy changes were pragmatic and piecemeal, rather than involving a paradigm shift away from neo-liberalism. Judith McKenzie (2004) argues persuasively that Walkerton did not bring about the end of “new public management” principles and policies in Ontario. She argues that Harris’s blame-game aimed at the Walkerton Public Utilities Commission and others enabled the government to portray the tragedy as evidence of the weaknesses of the traditional public administration model. Doing so paved the way for a new proposal for the privatization of Ontario’s electrical generation and distribution networks.

The official investigation, under the chair of highly respected Justice Dennis O’Connor, associate chief justice of Ontario, was also a force for change. Operating within a tight budget, he put together a panel of seven leading academics and practitioners and took a liberal interpretation of the inquiry’s terms of reference. Our extensive research has not produced any evidence of criticism of O’Connor and his handling of the inquiry. He seems to have been thoroughly professional, astute, fair, good humoured, and well organized in streamlining investigations by grouping witnesses into coalitions (Burke 2001: 197–200). Colin Perkel’s book, Well of Lies, on the Walkerton tragedy argues that “[i]n criticizing public inquiries as a cumbersome, ineffective, and seemingly never-ending process, Premier Mike Harris might have misjudged the man chosen to lead it, Dennis O’Connor” (Perkel 2002: 201). The risks to public water supplies, in conjunction with O’Connor’s leadership, meant that the inquiry was able to investigate and construct narratives around the pillars of modernism (science and the law), avoiding accusations of politicization yet nevertheless being critical of the Harris government, its budget cutbacks at the Ministry of the Environment and the privatization of water laboratories (Snider 2004). Therefore, the O’Connor-led investigation was clearly a catalyst for change, although – as indicated – we must exercise some caution in seeing the investigation as a revolutionary indictment of the
Harris years. As Laureen Snider argues, “The Report . . . is a liberal docu-
ment, not a radical script” (2004: 282).

The dominance of “high politics” and the threat of ter-
rorist attacks clearly contributed to the withering away of
political and public salience of the banquet hall collapse

Stakeholder interests were also important. A loose alliance of interests –
led by the Concerned Walkerton Citizens, CELA, various environmental
groups, and the Canadian Union of Public Employees and the Ontario Pub-
lic Service Employees Union – were the main proponents of regulatory
reform. In opposition were agricultural groups, which had been partly culpa-
ble (because manure was the primary cause of contamination) but which were
resistant to the idea of stricter regulation. However, the agricultural lobby
struggled to produce a counter-frame that the inquiry was prepared to legit-
imize. As Snider argues, “Science gave the Inquiry the stamp of ‘objective,
apolitical truth’ (Phillips 1996: 145—46) legitimating claims that public interest
groups, unions and environmentalists – demonized as ‘special interests’ by
the Conservative Government – had been making for years” (2004: 282).

Turning our attention to the banquet hall case, the wider context of Israeli
politics was crucial. Some momentum for change was evident. The fact that
the video footage was shown on international news networks ensured strong
citizen and media interest initially, but this heightened state of awareness
soon evaporated. The timing was such that Ariel Sharon, elected only three
months previously, had won a landslide victory over Ehud Barak – in a pol-
ity where a highly proportional electoral system and strong multi-party
politics are symptomatic of a highly fragmented society where vulnerable
coalition governments are the norm (Diskin and Hazan 2002). Sharon was
able to form a grand coalition strongly focused on security issues in the wake
of the second Palestinian uprising, which had begun in September the pre-
vious year.

The dominance of “high politics” and the threat of terrorist attacks clearly
contributed to the withering away of political and public salience of the ban-
quet hall collapse. Table 2 provides an indicator of the scale and types of
events that took place during the same month as the banquet hall collapse – a
period in which Israel was on a state of high alert. The events of that month
included a suicide bomb killing eighteen people in Tel Aviv, a baby being
stoned, mortar shells fired from Gaza, and several soldiers and settlers being
killed in a series of separate incidents. Indeed, the sirens that blared out after
the banquet hall collapse were assumed by Jerusalemites to be related to an-
other terrorist attack. In his study of the political and operational aspects of
disaster management in Israel, Alan Kirschenbaum notes the extent to which
people must live in close proximity to tragedy. At one time or another, roughly one third of the urban population had been involved in emergency situations that had resulted in death or injury (2004: 113).

Our observation, therefore, is that the public policy agenda in Israel is overloaded with crises. Most pertain to issues of security or defence, involving complex issues such as the nature of Israel as a Jewish state, greater (Eretz) Israel, democracy and peace (which for some involves minimizing conflict) (Arian 1995). Yehezkel Dror (1988) suggests that the crowded agenda means that accountability is effectively a non-issue in Israel. Even “routine” disasters and crises receive scant attention from senior policymakers. In this context, it is perhaps unsurprising that the building-safety crisis was of low political saliency. It did not naturally fit into any particular political agenda and so the cause was not taken up by any particular political party or politician. Therefore, despite the capacity of many crises and disasters to punctuate policy agendas, the banquet hall tragedy struggled to compete against issues of security and the escalating high politics of the

Table 2. Terrorism-Related Events in Israel during June 2001

<table>
<thead>
<tr>
<th>Date</th>
<th>Event</th>
</tr>
</thead>
<tbody>
<tr>
<td>1/06</td>
<td>Fourth terror killing this week</td>
</tr>
<tr>
<td>3/06</td>
<td>Eighteen dead, more than ninety wounded by suicide bomber (dolphinarium)</td>
</tr>
<tr>
<td>5/06</td>
<td>Separation: A loaded political decision</td>
</tr>
<tr>
<td>7/06</td>
<td>Terror alert continues</td>
</tr>
<tr>
<td>7/06</td>
<td>Masses rally against (IDF) restraint</td>
</tr>
<tr>
<td>8/06</td>
<td>Shiloh baby fights to survive after stoning</td>
</tr>
<tr>
<td>8/06</td>
<td>Three Israeli wounded in shooting near Ramallah</td>
</tr>
<tr>
<td>8/06</td>
<td>Six mortar shells fired in Gaza Strip</td>
</tr>
<tr>
<td>11/06</td>
<td>Deliberations to postpone Maccabiah games due to terrorist surge</td>
</tr>
<tr>
<td>11/06</td>
<td>Fatah terror cell responsible for bombings arrested</td>
</tr>
<tr>
<td>11/06</td>
<td>Three Bedouin women killed by tank fire</td>
</tr>
<tr>
<td>15/06</td>
<td>Underground Jewish group claims responsibility for Arab’s murder</td>
</tr>
<tr>
<td>17/06</td>
<td>IDF pull back from West Bank and Gaza marred by PA violations</td>
</tr>
<tr>
<td>21/06</td>
<td>Settler from Homesh murdered</td>
</tr>
<tr>
<td>22/06</td>
<td>Long-range mortar from Gaza</td>
</tr>
<tr>
<td>24/06</td>
<td>Two soldiers killed in Gaza</td>
</tr>
<tr>
<td>25/06</td>
<td>Hizbollah fires on IAF planes</td>
</tr>
<tr>
<td>25/06</td>
<td>Fatah leader blown up in Nablus</td>
</tr>
<tr>
<td>28/06</td>
<td>Multiple shootings in West Bank</td>
</tr>
<tr>
<td>29/06</td>
<td>Young mother killed by terrorist</td>
</tr>
</tbody>
</table>
Israel-Palestinian conflict. Added to this, the central role in Israeli society of memory and politics, notably the special place of bereavement (Weiss 2002; Lebel 2006), helps produce a very strong tradition of “debt” to victims of conflict. In sum, therefore, it can be argued that Israel has gone down a strong, historical pathway where the maintenance of social order is predicated largely on insulating the country from “external” threats (as well as remembering previous tragedies), rather than protecting it and remembering “internal” threats.

An initial examination of Justice Zeiler’s Commission of Inquiry into Safety of Buildings and Public Places seems to reveal some potential as a counter to the above; it seemed to be a driver for change – capable of breaking through historical pathways. Zeiler was a judge held in high esteem, and his four-strong committee examined the history of building codes over the pervious half century, engaging with over 200 witnesses and delved into building code practices throughout the world. The inquiry’s research uncovered clear evidence from an early stage that Pal-Kal posed a threat to public safety. Therefore, an interim report was produced with the intent of preventing further building collapses. The second and final report ran to twenty-nine chapters and was thorough and meticulous in its approach. Given, however, that the investigation did not have the remit to look at the banquet hall collapse as such (which victims’ families had wanted) but instead looked into the broader issue of building codes, the investigation had only low-level capacity to bring about “tombstone” reforms that symbolize “healing” and the debt owed to those who had suffered (Hood, Rothstein, and Baldwin 2001). Indeed, at a press conference to launch the inquiry, Justice Zeiler stated that the inquiry was largely about raising awareness and that he did not expect the government to fully implement its eventual recommendations (Lefkovits 2001). Even if such a statement reflects political pragmatism, it is also self-limiting because it frames the inquiry’s work in such a way that it anticipates its lack of influence.

Added to the foregoing, policy stasis was more likely because there were no significant stakeholders lobbying for changes in building codes and tighter enforcement of these codes. Regardless of the constraints of Israeli high politics, many interests had a stake in maintaining the status quo. Municipal authorities were struggling to operate within chronic budgetary constraints – a squeeze initiated by the Ministry of Interior in its quest for budget stringency. For both sets of interests, additional resources being devoted to building-planning and upgrading existing structures was not a financially viable option.

**Stream interactions**

For purposes of conceptualization, John Kingdon’s multiple streams approach focuses on each stream independently. However, one of the
particularly interesting features of Kindgon’s models is the way in which streams can interact to a point of confluence, which produces “an idea whose time has come” (Kingdon 2003: 1). Given the differences between our two cases, it is useful to consider the interactions among the streams in each.

Interactions of the problem and politics streams

The Walkerton case can be described as a positive feedback loop. The image of contaminated drinking water flowing out of kitchen taps coincided with an already unstable political situation, where a vulnerable government had little choice but to be receptive to policy change. This political receptivity further encouraged sustained action by policy change advocates (a loose coalition of anti-Harris, pro-public sector groups) to continue and strengthen actions in favour of stronger regulation of the quality of drinking water. By contrast, in Jerusalem, the image of unsafe buildings collapsing on innocent people could barely touch a political stream where a grand coalition had been formed to concentrate on pressing issues of high politics (i.e., security and the conflict with Palestine).

Interactions of the solution and politics streams

Proposed solutions to the problems of drinking water and building safety were similar in the two cases, in the sense that they were not tremendously costly and of reasonable administrative and political feasibility. However, in Ontario’s political context of the day, a policy solution of re-regulation was adoptable with relative ease because it gave the Harris and Eves governments the chance to restore their political legitimacy. By contrast, in Israel, building-safety “solutions” barely encroached on the political stream, except for a very short “issue-attention”-type arrival and dissipation. The efforts required to implement this policy solution was not huge but would not be worthwhile in terms of enhancing political capital.

Rather than “an idea whose time had come,” the prospect of regulatory reform in Israel was more akin to an idea that got lost in the ether of national politics

How all three streams interact takes these issues a bit further. Kingdon takes his cue from evolutionary biology and utilizes the metaphor of a policy “primeval soup” where ideas bubble away and the strongest come to the surface – not by chance but through factors such as changes in public opinion and vigorous lobbying. Punctuated equilibrium theory (see, for example, Baumgartner and Jones 1993; True, Jones, and Baumgartner 2007) picks up
and develops Kingdon’s model in this regard. Punctuated equilibrium theory seeks to explain when and why large-scale changes (punctuations) occur in the course of policy histories generally characterized by stasis and incremental change. Policy images play a critical role in expanding the control of issues beyond policy monopolies. A central premise is that policy change can occur when groups/coalitions and public opinion mobilize to overcome the power of existing policy monopolies. In Walkerton, one could argue that there was confluence of streams conducive to change – a problem (a significant public health hazard), a viable solution (regulatory reform), and a political situation that put a vulnerable government on the back foot to the point that embracing both the problem and the solution was the key to restoring political legitimacy. In effect, regulatory reform was “an idea whose time had come,” allowing a punctuation in the trajectory of a light-tough regulatory regime and the neo-liberal policy monopoly that supported it. By contrast, in Jerusalem, the three streams remained largely independent. Despite a well recognized problem (building-safety construction and regulation) and substantial overlap with a solution (new national authority on building standards), the security-focused policy monopoly in Israel meant that the politics stream continued to forge its own route. Rather than “an idea whose time had come,” the prospect of regulatory reform in Israel was more akin to an idea that got lost in the ether of national politics.

**Conclusion**

Orthodox thinking would imply that when regulatory failure leads to disaster, processes of inquiry culminate in corresponding and proportionate policy reforms in order to plug the regulatory gap. Our two cases challenge such an assumption. Both crises were broadly similar (public health tragedies, regulatory failures, due-process investigations) but they culminated in remarkably different policy outcomes. Walkerton produced a swift and decisive response, swinging the regulatory pendulum from deregulation to re-regulation. The Jerusalem case, by contrast, produced the most minor of fine-tuning to an already weak regulatory regime.

*Far from being an exact science, the regulation of risks is an inherently political activity, requiring that we locate it within appropriate historical, geographical and policy-sector contexts*

The policy streams prism proves valuable in understanding the different outcomes and in illuminating the magnitude of political context. Given the clear responsibility of regulatory failure in the advent of both tragedies, intuitively one would expect substantial regulatory policy change in both
cases. After all, we are dealing with tangible risks to innocent civilian lives. Yet, our analysis highlights the supremacy of politics over both intuition and straightforward reasoning. In Israel, a political context dominated by security issues was not conducive to policy reform in the regime of building-safety regulations, despite the near certain risk to human life. Conversely, the volatile political context of Walkerton displayed strong propensity for change, triggered by a water crisis and leading to regulatory reforms that were part of a broader turn against a radical, neo-liberal government.

Our two cases indicate the importance of political context when we attempt to comprehend the aftermath of disasters in which regulatory failures are heavily implicated. Far from being an exact science, the regulation of risks is an inherently political activity, requiring that we locate it within appropriate historical, geographical and policy-sector contexts. Ultimately, therefore, the fact that broadly similar tragedies produced markedly different outcomes in terms of regulatory reform should not come as too much of a surprise.

Notes
1 The video can be viewed on YouTube at http://www.youtube.com/watch?v=vt_AaFtmIk.
2 In January 2000, the media, public figures and opposition MPs demanded the head of a government minister, the disbanding of an entire department, and the termination of the Transitional/Canada Jobs Fund – a $125-million program to encourage the creation of sustainable jobs in areas of high unemployment. They charged the prime minister with abusing the program to promote job projects in his riding. They also accused the ruling political party of using the TJF/CJF as a “political slush-fund with no accountability at all.” Media sensationalism and political opportunism combined to make this what some termed Canada’s “biggest scandal ever.” In this case, the crisis (or manufactured crisis) is nothing but the failure of Human Resources Development Canada to properly oversee grants and contributions. The HRDC had consciously loosened control over the administration of these funds in the framework of “new public management” reforms, dramatic cutbacks and internal reorganization. It reacted to the media-generated crisis by immediately swinging the regulatory pendulum way back to the control side of the continuum. Within a short time, HRDC established a “comprehensive and elaborate set of administrative checklists and forms” (Good 2003: 115).

References


