Managing regulatory failure

Regulatory failure is associated with a number of sources and types. One possible way to categorise types of regulatory failure is to distinguish between analytical failure (the idea that the analysis of a situation was flawed), intervention failure (the idea that the regulatory activity was inappropriate in addressing a diagnosed problem or that the detection of a situation was wrong), co-ordination failure (the idea that regulatory intervention did not occur because of problems of jurisdictional over- and underlap among different bodies), political failure (the idea that in certain political circumstances, early intervention is not feasible) and, finally, design failure (the idea that the statutory basis and the resources of a regulator are insufficient to address a particular problem). The source of diagnosed failure also varies – ranging from those that link to identified problems in the production chain to issues triggered by natural events, such as volcanoes.

What is a regulatory failure?

There was no agreement on a single, clear-cut and universally applicable definition of what might constitute a 'regulatory failure'. Shortcomings may have occurred at different levels and stages. Different circumstances for the emergence of the perception of regulatory failure were identified. One example was where the potential occurrence of a risk had been identified, but where the decision had been taken, given resource constraints, to prioritise other activities. The focus on one risk had potentially led to a reduced attention on the potential consequences stemming from the actualisation of another risk, namely consumer confidence.

The perception of regulatory failure was potentially also influenced by the type of problem. Public concern was likely to be particularly high in areas where one could identify a 'yuck' factor, or where there was a particular fear or dread. Other areas may not

have the same problem. What was considered a 'failure' may also depend on the reputation of the agency and whether there had been other failures that the public remembered either recently or in the past - some failures cast a long shadow over the agency. The question of responsibility, furthermore, was also problematic. Some failures may be mostly due to failures in industry self-regulation, where the actual regulatory failure may be mostly about failing to validate the industry's own efforts. Ultimately, one could say that failure was to do with the occurrence of a 'manifestation of harm'.

Some regulators had established threshold-based frameworks to classify 'regulatory failure'. First, a 'detriment to the consumer' had to be established that went beyond a certain numerical threshold. Then, the question was whether the regulator had failed to perform its functions properly or not. However, this raised questions as to whether system-wide problems may have occurred that may not be fully within the jurisdiction of any one single regulator. Numerical targets were also problematic, as it was not clear how to handle smaller damages to a large number of individuals in contrast to much higher aggregate damages incurred to one major industry player.

Once things had gone wrong, then there was very little that could be done about concerns about regulatory failure.   It was also important to show a credible organisational response. Such responses may not necessarily be directed solely towards the prevention of the recurrence of the same regulatory failure, but it would show a commitment towards reflecting on one's own practices. Dealing with regulatory failure, therefore, was largely about establishing public confidence. In some cases, accusations of regulatory failure could be rebuffed, for example when independent reviews point to a lack of wrong-doing.

How do organisations handle regulatory failure when dealing with external audiences?
All regulators suggested that they had a certain degree of identified risk tolerance. None of them were keen to end up having a highly restrictive framework to guide responses to potential failure. One needed to think about two aspects of handling failures: handling the media and addressing the technical aspects of addressing the failure. One had to consider

how many individuals were affected and how these would respond to a particular incident. One had to interpret the potential reaction of the public in the light of the size of an event.

Having such a framework was helpful as there would always be demands for investigations when things had gone wrong. However, one needed criteria to justify decisions as to why one was investigating certain incidents rather than others. Staff needed a framework to respond to public pressure. Such frameworks could, in some cases, be discussed with the industry association. Such frameworks could offer a level of defensibility, but they could only offer limited protection in times of high public and political attention.

Regulators could be very risk averse in the light of particular risks. Similarly, the regulated industry could also be extremely risk averse. Elsewhere, industry could be seen to challenge regulators, demanding the revision of standards, and being successful in achieving such revisions in a relatively short timeframe. In other cases, blame was put on the regulator when the actual issue had mostly to do with the industry itself.

Regulators identified differences in attitudes towards compliance within any given population. There were always subgroups that were extremely skilful in evading regulatory attention, others were being dragged down in their performance by their wider dysfunctional organisational environment, and others were identified as 'strugglers', with limited resources.

How do regulators respond to incidents of failure?
It was important that regulators succeeded in managing public expectations, that they 'own the story'. Different examples were offered that pointed to different triggers for potential regulatory failure. In some cases, problems were identified by others at times of low trust in the regulator. In other cases, the identification of failure may occur in different jurisdictions. If such an incident was identified as a potentially major issue for public

confidence, it was important to be seen to respond immediately rather than concentrate on pointing to dispersed responsibilities in the sector. One had to respond by being transparent about one's own organisational response to perceived failure. In the end, regulators were publicly accountable bodies and therefore there had to be an expectation that one had to engage with the media, and increasingly with social media. Differences in industry response were also identified; in some cases, the industry had shied away from facing public scrutiny, thereby leaving the regulator completely isolated. This was particularly problematic when the sole interest of the media was in finding simple answers and in identifying individuals who were responsible.

Such periods could threaten the survival of regulatory organisations. There was always potential that different 'entrepreneurs' would seek to exploit a crisis to advance their own agenda. In fact, many regulators had been established as a result of a major crisis. It was important to show commitment towards improving internal processes. This involved extensive engagement with external audiences, such as interest groups, the media and with politicians. Timing was also essential; one could not wait for external inquiries to report; one had to respond proactively during the period in which inquiries were taking place. One needed to communicate with the media and offer credible information, as well as engage with politicians to establish trust in order to have a mutual 'no surprises' understanding. In an age of social media, being able to communicate one's position was difficult. In some cases, an immediate and repeated apology in any encounter was one way to reduce hostility.

One also had to acknowledge that there were different responses to incidents. In some cases, younger people had shown far more indifference to particular incidents than older people, for example. Such differences might emerge in particular when there was no actual harm involved.

In the wider context, a response to a regulatory failure was usually to put a new policy or protocol in place. In some cases, this might be to deal with the (low probability)

combination of factors that had been revealed in a previous incident. In other cases, the aftermath of perceived failure had led to an expansion in the scope of inspections. It was, for example, no longer simply about rectifying wrong-doing, but also asking the industry to respond to broader measures, such as perceptions of organisational culture. Such a response had advanced the information base for regulatory decisions.

More generally, learning from failure was possibly more about incremental learning rather than instituting large-scale reforms in the immediate aftermath of a crisis. It was important to avoid 'knee jerk' responses. Ultimately, compliance with 'better regulation' frameworks was not necessarily a recipe to avoid accusations of regulatory failure in times of crisis.

However, there were also differences among regulators. There were differences between those that were largely about 'avoiding harm', whereas others were largely about market liberalisation. In the former case, the response to regulatory failure was therefore to emphasise the importance of procedures. In the case of the latter, such pressures were less prevalent. In general, one of the key instruments to detect potential sources of failure was to rely on 'unusual sources' as information-gathering devices.

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