MANAGEMENT OF PUBLIC INQUIRY FOR DISASTERS IN MALAYSIA

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Abstract

In most democratic countries, including Malaysia, inquiries are conducted into major disasters in order to investigate their underlying causes and make recommendations to avoid a recurrence. A case study was conducted on six disasters that had led to either a Public or Royal Inquiry in order to investigate the procedures and management of public inquiries in the country. A grounded theory approach utilizing a constant comparative method was used to analyze the content of the reports. The findings showed that there is no standard criteria and procedure in determining the type of inquiry, composition of inquiry tribunals and report writing. Legal status of the inquiry is unclear as it seems to have no power to require organizations or individuals to implement the recommendations made by the tribunal. Comparison with disaster inquiries from other nations was made and suggestions for improvement are discussed.

Key Words: disaster, royal inquiry, public inquiry, tribunal

Introduction

In most democratic countries, inquiries are conducted into major accidents. A major accident, or also termed as a disaster, is defined as an incident which disrupts the activities of a community and national affairs, involving loss of lives, damage to properties, economic losses and environmental destruction that is beyond the capability of the local community and requires extensive mobilization of resources (Directive 20, 2012). One of the main functions of inquiries into disasters is to establish the cause of these major disasters and to learn lessons from it so as to prevent a recurrence (Howe, 1999; Clarke, 2000). It also offers the opportunity for a communal catharsis; allows for the public venting of anger, distress and frustrations and exert pressure for policy changes (Howe, 1996; Wells, 1999). However the learning aspect is often curtailed due to two main factors: there is no guide as to when to call for such an inquiry, hence it leaves a significant discretion in the hands of the government in how to orchestrate the public response to a disaster; and they are not always the formalized, objective, truth searching bodies of the common public perception with no laid formal procedures, no power to require organizations or individuals to carry out recommendations, and sometimes have hidden political agendas to address

(Wells, 1999; Toft and Reynolds,1999). Besides the negative impacts of disaster on lives and properties of a society, lessons from them had also led to the development of important safety laws and regulations and establishment of specialized functional organizations and bodies. This research, therefore, was designed to investigate the process and procedures of public inquiry into disasters in Malaysia. The shortcomings of the conduct of the public inquiry into disasters should be addressed as inquiry into disasters will remain as one of the valuable sources of information for society and corporations to learn from past incidents (Gillingham, et. al, 1997).

Literature Review

Types of Inquiry

There are two main categories of inquiry following a disaster, namely technical and judicial inquiry. Technical investigations are those that have to be held following certain accidents undertaken by an appropriate inspectorate according to their own statutory systems of mandatory inquiry, for example, in the United Kingdom, the Marine accident Investigation Branch (under the Merchant Shipping Acts), the Air Accidents Investigation Branch (under the Civil Aviation Act 1982) and the HM Railway Inspectorate (under the Regulations of Railways Act 1871). For the case of Malaysia, Occupational Safety and Health Act 1994 (Act 514), Part VIII requires an employer to notify any accidents and the Director General of Occupational Health and Safety may request an investigation to be held into the nature and cause of the accident. The ensuing reports of such incidents do not generally generate public interest. Major incidents that cause substantial loss of lives and extensive property/ environmental destruction will usually lead to a more formal investigation, which is normally termed as a public inquiry. This type of judicial inquiry (formal legal investigation) assumes in two major forms namely 'Public inquiry' and 'Royal inquiry'. For example, arising from the Port Klang fire and explosions, the Minister of Housing and Local Government called for a Public inquiry into the fire and explosions at Port Kelang on 20 June 1992,under sections 45 of Fire and Services Act 1988 (Act 341). Under this section of the act, the same powers were given to the inquiry as provided by section 8, 9, 11, 12, 13, 14, 15, 19, 21 and 22 of Act 119 (Commissions of Enquiry Act 1950 revised 1973). Within the United Kingdom, public inquiry is the generic term used to describe mechanisms for investigating high profile disastrous incidents (Elliot & McGuinness, 2002). Disasters such as the Herald of Free Enterprise capsized with the loss of 192 lives off Zeebrugge in 1987, upon which the Minister of Transport of the United Kingdom ordered a formal investigation under Merchant Shipping legislation; and the King's Cross, London underground fire gave rise to a formal investigation under the Regulations of Railways Act 1871 (Wells, 1999). Royal inquiry is another type of judicial inquiry which is evoked following a major disaster that is of significant public importance and matters of wider public concern. This type of inquiry is termed Presidential Commission in the United States of America where it needs the authorization of the President whilst in Malaysia the Royal inquiry requires the authorization of the Parliament and the Agong is vested with powers to issue the commission and appointment of the committees for the tribunal. It is set up under the Commissions of Enquiry Act 1950 (Revised 1973).

In the United States, the explosion of the space shuttle Challenger had led to the setup of Presidential Commission to investigate into the disaster. The Aberfan disaster that killed 144 people in October 1966, where a waste tip of a colliery slid and engulfed a school and several houses had given rise to this type of inquiry in the United Kingdom. Edmund Davis inquiry into the Aberfan disaster heard 136 witnesses, guided by 9 teams of Counsel and solicitors over a period of 76 hearing days. The report itself was completed and approved for publications within nine months of the disaster (Bogdanor, 1997).

Issues arising in the conduct of Public inquiry

Apprehensions and concerns regarding the conduct of public inquiries in United Kingdom particularly had been raised by various individuals and parties from time to time and have resulted in establishment of various sets of guidelines and policies. An independent advisory body, named the Council on Tribunals was established in 1958 where among its functions is to keep under review the constitution and working of a large number of tribunals and to advise on administrative procedures relating to certain statutory inquiries. After the publication of the Scott Inquiry, the Council on Tribunals was requested by the British Government to view and offer guidance to the range of issues encompassed in public inquiries. The advice of the Council on Tribunal on this issue is summarized and is depicted in Table 1.

Similar and other additional issues regarding the management of public inquiries into disasters were raised by other scholars such as Elliot and McGuiness (2002), Wells, (1999) and Toft & Reynolds (1997). The issues include, among others:

a. What type of inquiry - According to Wells (1999), predicting which type of inquiry will be used is an inexact science but there are indicators that can be used: the more serious the accident, the more likely that a judge will chair it, and that a form of inquiry allowing witnesses to be compelled to appear and to give evidence on oath will be used. As a result, he concluded that the lack of uniformity between types of inquiry leaves a significant discretion in the hands of the Government in how to orchestrate the public response to a disaster. There is no written policy about which type of inquiry to hold, but the decision to initiate a public inquiry for example, in the case of rail disaster in the United Kingdom is generally made in a variety of circumstances (Hutter, 1992): a high level of public interest or concern following an accident; where there has been serious injury or fatality;where there is a potential for serious injury or fatality; when passenger trains are involved in a serious accident; fatal accidents at level-crossings; there is a need for public reassurance; and where the circumstances of the accident are unusual and the cause unknown.

Table 1: Advice of Council on Tribunal on procedural issues arising in the conduct of Public Inquiries

Issues	Points to consider
The setting-up of the inquiry	Preliminary consideration The form of the inquiry Concurrent Proceedings Inquiry committee members Terms of reference Counsel to the inquiry Secretariat and accommodation
The powers of the inquiry	All the powers necessary to enable it to perform the function for which it was set up
The procedure of the inquiry	Preliminary public hearing Inquisitorial or adversarial procedures Public or private hearing Putting witnesses on notice Legal assistance and representation
The report of the Inquiry	An executive summary of the findings and recommendations should be provided. The inquiry report is to be published even if the inquiry has been conducted in private.

(Adopted from the Council of Tribunals (1996), advice to the Lord Chancellor on the procedural issues arising in the conduct of public inquiries set up by Ministers)

b. Impartial- arises from either the characters or the skills of those appointed to investigate the disaster. Character includes the political nature of those appointed to lead and contribute to public inquiries. Skills refer to the professional background of the members of inquiry, for example engineers are likely to be appointed to consider technical issues, possibly to the detriment of social ones (Elliot and McGuiness,2002).

c. Process - setting the scope and scale of the inquiry from the outset can have a major impact upon its findings (Toft & Reynolds, 1997). For example, Hutter (1992) reported that there were controversies regarding the scope of the inquiries into the King's Cross and Clapham accidents where both investigations did not examine into the immediate circumstances of the accidents but wider organizational, political, social and economic contexts of the railway industry nor government policy towards the railway industry was considered.

d. Underlying purpose - Studies have shown that some public inquiry into disasters had focused explicitly on technical issues, which led to the recommendations on specific technical ones (Aini,2006). Given the body of evidence that disasters are socio-technical failures (Turner, 1976; Ibrahim et al, 2002) organizational learning from those events would be limited.

e. Status - Toft and Reynolds (1994) found that the inquiries are not always the formalized,objective, truth searching bodies of the common public perception. They attributed these circumstances as due to the nature of the public inquiries that have no laid formal procedures, are adversarial in nature, have no power to require organizations or individuals to

carry out their recommendations, and may sometimes apparently have hidden political agendas to address (Wells, 1999).

Judicial type of inquiry into disasters have been established for a long time in Malaysia and some landmark disasters in the country had led to the call for either public or royal inquiries. It is pertinent that studies are undertaken to examine the management of such inquiries in the country so that improvements can be made, as inquiry report remains One of the vital sources of learning from past disasters. In this vein, the objectives of this study were to examine the issues regarding the criteria used to decide the type of inquiry, appointment of inquiry commissioners, and reporting of the Public and Royal inquiry in Malaysia based on the reports of the six landmark disasters in the country. They are chosen as these are the only disasters in the country that had led to either a Royal or Public inquiry.

Methodology

This study utilized a qualitative case study design which entails an examination of depository of documents (Bogdan & Biklen, 1982) and in this case, reports of disasters which falls under the ambit of Directive 20 and have led to either a Public or Royal inquiry, were used. Directive 20 is the on-land guide for disaster management (response and relief) in the country and it excludes the marine and air disaster as they are covered by other guidance documents. Directive 20 is only related to response and recovery management of on-land disasters in the country and does not cover management of inquiry into disasters. Recognizing the importance of case study approach, Bignell had proposed teaching and learning about failures and safety to adopt this method in disaster analysis (Bignell, 1999).

i. **Collapse of a four storey building on Lot No. 503, Jalan Raja Laut, Kuala Lumpur, 19 October 1968

ii. **Collapse of part of the platform of a passenger waiting area, Sultan Abdul Halim Ferry Terminal, Butterworth, Penang, and 31 July 1988.

iii. **Fire at Sekolah Agama Rakyat Taufiqiah Khairiah Al Halimiah, Padang Lumut, Yan Kedah, 22 September 1989.

iv. **Fire and explosions at the Bright Sparklers Sendirian Berhad factory, 7 may 1991

v. *Fire and explosions at Port Kelang, 20 June 1992

vi. *Collapse of Block 1 and the stability of Blocks 2 and 3 of the Highland Towers Condominium, Hulu Kelang, Selangor, 11 December 1993

Note: * * Royal Inquiry * Public Inquiry

Grounded theory has become by far the most widely used framework for analyzing qualitative data (Bryman, 2001). Thus, it was decided that the most appropriate method of analysis for the collected qualitative data in this study is grounded theory. Support for this option comes from Martin and Turner (1986) who noted that grounded theory is particularly well suited to dealing with qualitative data of the kind gathered from semi-structured or unstructured interviews, and from case study materials of certain kinds of documentary sources. The grounded theory approach offers the researcher a strategy for sifting and analyzing material of this kind. Concepts and observations that are inductively arrived at from the data are

termed grounded theory by Glaser and Strauss (1967) and Strauss and Corbin (1994). Analysis of qualitative data in the study utilized constant comparative method, which was developed by Glaser and Strauss (1967). The basic strategy of the constant comparative method is to make comparisons constantly within and between levels of conceptualization until a theory can be formulated. Data are being organized and managed by developing codes in which some form of designations to various aspects of the data. Thus coding of qualitative data represents an operation by which data are broken down and conceptualized.

File folder method was used to organize the data in preparation for analysis. Constant comparisons were employed to identify recurring regularities in the data which will finally lead to emergingcategories. Based on the literature, the specific themes that the study aimed to transpire include the criteria for determination of the type of inquiry, the choice of inquiry committee members and reporting procedures. In addition, other disaster inquiry reports were used for comparison including: Fire at London King's Cross underground station; the Presidential Commission on the Space Shuttle Challenger Accident, 1986; Salmon Report, 1996; Thames Safety Inquiry, 2000; and Bristol Inquiry, 2001. They were utilized as they were notable international cases and their full report were available to be downloaded online.

Findings and Discussion

The results will be discussed according to various aspects in the management of disaster inquiry in Malaysia based on the six inquiry reports above namely: the criteria to determine the type of inquiry; selection of inquiry chairman and committee members and inquiry reporting mode.

Determination of public inquiry into a disaster

Out of the six disasters studied, four of them had resulted in Royal inquiries while two were of Public inquiries. In the case of the collapse of the four-story building, the Government initially called for a Public Inquiry but the Cabinet later changed it to Royal inquiry after appeals from various professional bodies. This disaster attracted a lot of attention because it was the first disaster in the nation associated with tall buildings and also related to the development of the nation.

The collapse of Block 1 of Highland Towers condominium was the first disaster that was associated with the development of highlands in the country. It was declared a national tragedy. This was the first national disaster that require search and rescue assistance from other nations. Experts from Singapore, Japan and France came to help with the search and rescue mission. There were many speculations in the media and public regarding the tragedy particularly with respect to the relationship of the occupants with some political figures. A public inquiry was set up and chaired by the Yang di Pertua of Majlis Perbandaran Ampang Jaya (MPAJ). MPAJ was the local authority that had jurisdiction to overseer the area where Highland Towers Condominium was situated. As claimed by S.S. Gue, a technical committee member of the inquiry and an ex- IEM President mentioned (personal communication, December 20, 2000) that from the onset, the focus of the inquiry was to look into technical failures.

As such it is not surprising to see that the report made by the main committee was

only 14 pages while the text report by the technical committee was 65 pages with a further five volumes of relevant technical aspects (containing about 426 pages excluding appendices) Consequently, many administrative shortcomings of regulatory bodies and the companies associated were not investigated thoroughly. Elliot & McGuiness (2002) had raised a similar concern where some public inquiry into disasters were shown to focus explicitly on technical issues because organizational learning would be restricted due to the implementation of specific technical recommendations only. Given the body of evidence that disasters are socio-technical failures, this is a fundamental weakness. Studies have shown that disasters are not caused by a single factor but are due to failures of human, organization, regulatory and technological factors and their interactions (Ibrahim et al., 2004; Aoki & Rothwell, 2013; Funabashi, 2012).

This is in contrast to the other five case studies where detailed investigations were made on the organizational and administrative aspects. When compared to the report of Choon Hong III ship, fire and explosion at Port Kelang where a Public inquiry was conducted, the text report itself was 165 pages. Overall, the report is comparable to that of Royal inquiry report. Compared with the other five disasters, it can be seen that the death toll for the Highland Towers case was the highest with 48 people. The disaster was also of general interest of the building professionals and public since this was the first disaster that was related to the development of the highlands. One would expect a Royal Inquiry was set up to investigate into the tragedy. The survey carried out among disaster experts in the country also showed that they were of the opinion that a Royal Inquiry should have been conducted instead of a Public Inquiry for the Highland Towers disaster (Aini & Fakhrul-Razi, 2008).

The data indicates that the choice of the type of inquiry to investigate into disasters in the country is very much subjected to interpretation and judgment of those in power. However, public pressure particularly from professional bodies can at times persuade and influence the decision of the Government such as that of the four story building collapse in Kuala Lumpur. A similar case was noted in the United Kingdom whereby pressure from the victims, public and media has led to reinvestigation of the Marchioness Passenger vessel disaster from technical inquiry to a Public inquiry (Clarke, 2000). A full public inquiry was announced in 1999, a decade after the incident happened. It was recommended because of inadequate and appalling investigation and report by the previous investigation committee. This serves to illustrate that different types of inquiry into a disaster may result in different findings and conclusions. This situation substantiate findings by Wells (1999) that shows how lack of uniformity and guidelines can lead to significant discretion of the Government in how to orchestrate a response to a disaster. Thus determination of an appropriate type of inquiry into an accident has great consequences.

It was noted that in all the disasters being studied, the call for inquiry and simultaneously the appointment of the Commissions of inquiry was rather immediate. It was made within a week after the disaster except for the case of Bright Sparklers, which was only announced after nine days after the tragedy. This was reported (Berita Harian, 13 May 1991) that the inquiry commissioners could not be

announced because the members of Cabinet had not come toagreement due to the absence of a number of Ministers. It is thus desirable that a public announcement be made as soon as practicable not only about the setting up of the inquiry and the person chosen to lead it, but also its committee members and scope. This is important as Public inquiry into disasters is also to be a means whereby all those affected by the events under investigations can feel that their concerns have been aired and heard so as to come to terms with the event (Howe, 1996; Wells, 1999). An appropriate decision has to be made regarding what type of inquiry to hold after a major accident by the Government or respective Ministry, within a short time, amidst pressure from media and public, on what type of inquiry to hold after a major accident. Table 2 and Table 3 show the criteria for the setting up of Public and Royal inquiry respectively as proposed by various individuals, organizations and selected inquiry reports. It is observed that all the criteria were subjective in nature and the demarcation line between the two is very vague. Based on the views expressed below, it indicates that what sets Royal inquiry apart from Public inquiry into disaster is that the call for Royal inquiry is only to be conducted if the incident affects a nation-wide crisis of confidence and of very urgent public importance.

Combining this outcome with results of a survey among Malaysian disaster experts (Aini & Fakhrul-Razi, 2008), an additional objective criteria is suggested which is the number of death as a result of the disaster, and the proposed criteria are:

Public inquiry - 10-20 people dead and public confidence in the Government is under scrutiny due to implications of the authorities to the underlying causes of the event.

Royal Inquiry - >20 people dead and nationwide crisis of confidence and the need for an impartial investigations due to implications of Government authorities, agencies or ministries.

If these criteria are used against the six disasters studied, the type of inquiry evoked matches except for the collapsed of Highland Towers. In hindsight, a call for Royal inquiry into the disaster would have unearth both technical and administrative short comings of all related professional bodies and relevant agencies with regards to the hill slope development in the country through appropriate framing of recommendations.

Table 2: Criteria proposed for establishment of public inquiry

Source	Criteria
Bristol Inquiry, 2001	❑ The issue to be examined is of significant public importance and wider public concern. ❑ Public confidence in government, local or national is under scrutiny. It can only be restored with an independent examination of the issue in public. ❑ The issue cannot be properly be dealt with in another way that is less expensive, less elaborate and speedier.
Thames Safety Inquiry Report, 2000	❑ The need for a full, fair and fearless investigation. ❑ To restore public confidence by providing recommendations that is to be implemented. ❑ Investigation in public and to expose the facts to public scrutiny.
Lost in care, 1999	❑ At times of public disquiet. ❑ Urgent public importance.
Salmon Report, 1996	❑ Vital public importance.
Lord Howe, 1996	❑ To promote understanding of what led to the events.
Councils of Tribunals, 1996	❑ Matters of public concern.

Table 3: Criteria proposed for the establishment of Royal Inquiry

Source	Criteria
Council of Tribunals, 1996	❑ Inquiring into a definite matter that is of urgent public importance ❑ The purpose of trying to ensure that the type of incident in question will not be repeated ❑ In reassuring public that the issue of the inquiry has been fully investigated and that there has been no cover up. Especially concerning public duties discharged by public officials
Salmon Report, 1996	❑ Involving something in the nature of a nation-wide crisis of confidence
Report of the Presidential Commission on the space shuttle Challenger tragedy, 1986)	❑ To ensure thorough and unbiased investigation

Inquiry Commissioners

The issues related to inquiry procedure deliberated in this study cover two aspects, namely the appointment of inquiry chairman and committee members and methodology of the inquiry. All the Royal inquiries were headed by either serving or retired High Court or Federal Court Judge while the public inquiries were led by the Yang di Pertua of a Local Council (president) or the Chief Secretary of a Ministry. With regards to the number of the commissioners, it varies from two (Collapse of Sultan Abdul Halim Jetty, Butterworth, Penang) to six persons (Collapse of a Four-Story Building in Kuala Lumpur). It seems that appointment of an eminent judge is rather a common practice both in Malaysia and United Kingdom. In practice,

it can be seen that other capable prominent individuals could also be considered to lead the inquiry, for example in the Presidential Commission of the Challenger disaster, a former United States Secretary of State was appointed. Similar notion was advocated by Malaysian disaster experts whereby besides judges, other legal professionals and individuals who have vast experience, profound knowledge in the related field, good credible personality and have no vested interest in the outcome of the inquiry. An example worth quoting here is the appointment of Dato' Radin Umar Radin Sohadi who was one of the country's top road safety engineering experts, as chairman of an independent panel to probe a Perak tour bus crash (2010) in which 28 people were killed and nine injured. It is also noted that there was no mention of the positions held by various commissioners in some of the reports studied and as such information regarding their professional background had to be searched elsewhere. As these reports will always be referred to in the future for reference or research purposes, a brief autobiography of the chairman and the other commissioners would be desirable. For the Royal Inquiry into the collapse of the four-story building in Kuala Lumpur, initially there were only four commissioners appointed. After pressure from professional institutions connected with the building industry, two more Commissioners were appointed to represent professional bodies. Encik Ikmal Hisham Al Bakri represented Persatuan Akitek Malaysia while Mr Bernard T.H. Wong represented Malaysian Master Builders Association (K.Loo, pers. comm.). The Public Inquiry committee that were appointed to investigate into the collapse of Highland Towers also consisted of six members of which five of them were Government officers representing Majlis Perbandaran Ampang Jaya, Institut Kerja Raya Malaysia and Jabatan Kerja Raya. When asked to comment in the choice" of inquiry committee of the Highland Towers, S.S. Gue (personal communication, December 20, 2000) who was one of the members of technical committee believed that it would be better to have inquiry committee consisting of balance number representing the public (Government) and private (e.g. professional bodies) sectors to ensure impartiality in order to safeguard the interest of the public.

Inquiry Reporting

Based on the six reports, it was found that four cases were written in English and the other two were in Bahasa Melayu. In our opinion, a Bahasa Malaya version should be produced as it is the national language of the country and they are official Government documents. Regardless of the language used, the language and terminologies used should be kept simple with minimum legal and technical jargons so that it can be understood by the public as the inquiry is a 'public one' and of public concern. Diagrams and charts have been used in some of the reports and they are found to be useful in understanding of the events. As there is no standard guide provided of how to write the report, it is observed that there are variations in the formatting and contents of the report. Spacing and font sizes vary from single spacing/double spacing to font size 8 to 12. None of the six reports were found to have executive summary and Tribunals of Inquiry (1996) strongly recommend that inquiry of any length should provide an executive summary. With regards to the faming of the recommendations, they vary from one to another. Some of the good practices which were benchmarked against other international inquiry reports

include indication of level of urgency and time frame of the implementations of the recommendations and specification of who are responsible over their implementations. For example, the inquiry report of the King's Cross underground disaster, the level of priority was attached to each with the following indicators namely: "Most important", "Important", "Necessary" and "Suggested". In addition, a laudable practice is also observed in the report whereby in the report itself, specifications weremade on how the implementation of the recommendations is to be monitored. Similar practice was noted in the report of the Presidential Commission of the Challenger where NASA was required to compile a report on her implementations of the recommendations to the Commission. Timely implementation of the recommendations put forward by the inquiry tribunals is crucial as one of the main functions of inquiries into disasters is to identify lessons learnt. This necessitates an appropriate framing of recommendations that are to be implemented and the public inquiry itself will not be able to restore public confidence unless remedial actions are taken (Clarke, 2000). As such a mechanism should be introduced so that recommendations made by the Malaysian inquiry tribunals can be monitored and regulated.

Conclusion and Implications

The main objective of the present case study was to investigate the procedures and management of public inquiries in the country based on six disasters that had led to either a Public or Royal Inquiry. The findings indicated that the choice of the type of inquiry to investigate into disasters in the country is very much subjected to interpretation and judgment of those in power. However, public pressure particularly from professional bodies can at times persuade and influence the decision of the Government such as that of the four story building collapse in Kuala Lumpur. The study also noted that appointment of an eminent judge to lead the inquiry is a common practice in the country. It is proposed that other capable prominent individuals who have vast experience, profound knowledge in the related field, good credible personality and have no vested interest in the outcome of the inquiry could also be considered. As to the composition of the inquiry committee, individuals representing the public sector (Government) seemed to be the preferred choice but balancing the number representing the public (Government) and private (e.g. professional bodies) sectors need to be given serious consideration in order to ensure impartiality and safeguard the interest of the public. With regards to inquiry reporting, the data indicates that there is no standard format in terms of language, layout structure, formatting and no indication of level of urgency and time frame of the implementations of the recommendations and specification of who are responsible over their implementations. As these inquiry reports are valuable national documents, it is suggested that a guide to inquiry reporting be developed by appropriate authority. Although disasters are unfortunate events but lessons learnt from them have led to many positive outcomes: incorporation into teaching curriculum in educational institutions; improvement in risk identification and reduction, imbue culture of preparedness, endorsement of various safety legislations, formation of various specialized bodies and others. Similar consequences are noted with respect to major disasters in the country which had led to formation of specialized

response teams (e.g. SMART team, HAZMAT team), evolution of safety and emergency laws and regulations (e.g. Directive 20, UBBL) (Aini et al., 2001). The management of disaster inquiry into disaster in the country has span almost 50 years and it is therefore timely to review and make some improvements to it, as it is and will remain as one of the most valuable tools for improvements in mitigation,preparedness and response to future disasters. Disaster scholars were of the opinion that despite inquiries being conducted and recommendations made, the far reaching and radical organizational, technical and regulatory changes needed for eliminating those identified underlying causes were implemented at a slow pace (Shrivastava et al., 1988) and inability to learn from past incidences have led to similar recurring tragedies (Holliday, 2004; Richardson, 1994). However, much more could be achieved if adequate learning were seriously taken into consideration by governments and organizations in implementing the recommendations made by the tribunal of inquiries.

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