



**UNIVERSITY
OF LATVIA**

**Summary of
Doctoral Thesis**

**Ieva Daniela
Beinaroviča**

**POLICY LEARNING AND
CHANGE AFTER EMERGENCY
SITUATIONS IN LATVIA**

Riga 2022



**UNIVERSITY
OF LATVIA**

FACULTY OF SOCIAL SCIENCES

Ieva Daniela Beinaroviča

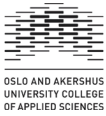
**POLICY LEARNING AND CHANGE
AFTER EMERGENCY SITUATIONS
IN LATVIA**

SUMMARY OF DOCTORAL THESIS

Submitted for the scientific doctoral degree of Political Science
Subfield: Public policy and administration

Riga 2022

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The thesis is available at the Library of the University of Latvia, Raiņa blvd. 19.

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ABSTRACT

The thesis analyzes policy learning and change after emergencies in Latvia from the point of view of emergency management as a subject of social sciences. The goal of the thesis is to perform an ex post evaluation. The aim of this thesis is to analyze the ability of Latvian public administration institutions to implement policy learning and policy change after emergencies by analyzing policy documents, media, public and political agendas, as well as other related documents in the context of three different emergencies, in order to provide recommendations for corrective action based on the diagnosed factors that are promoting or hindering consonant activities. To achieve the goal, an algorithm for continuous analysis of policy learning and change has been constructed. Quantitative and qualitative research methods are applied to perform document analysis and media monitoring. Based on the evidence obtained during the case studies, all three incidents analyzed in the thesis can be classified with the result F3: “Policy learning not attempted / action simulation”. Based on the conclusions that have emerged from the analysis of factors that promote and hinder policy learning, it has been concluded that Latvia needs a paradigm shift in emergency management, while improvements in policy development are needed to reduce complacency and integrate international experience and standards into policy documents.

Key words: *emergency management, catastrophe, disaster management, policy learning.*

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INTRODUCTION

Despite the technological progress and the improvement in the quality of life associated with it, the trends in the field of emergency management can't be denied: the number of people whose lives are affected by disasters increases, the scale and cost of disaster damage as well as the number of disasters *per se* is on the rise (Coppola, 2006). Despite the frequency of various emergencies, lessons provided by don't always get identified, formalized in policy documents and implemented afterwards. This causes a disruption in the disaster cycle – valuable knowledge is lost, the risk, that loses in the event of a repeated emergency situation will be greater and will require more resources to be mitigated, increases.

Justification for choice of the subject and relevance

In European Union (EU) the global trends regarding natural and technological hazards can be identified: an increasing number of incidents, increasing costs and number of people affected. (EEA, 2011) In policy documents recommendations for overcoming these challenges include preparedness and mitigation, implementing knowledge-based approach, community involvement, performing risk analysis, promoting coordination and cooperation, learning and dissemination of knowledge, as well as identification of available resources in order to ensure their effective use and adaptation to changing needs (Council of the European Union, 2016; Council of the European Union & European Parliament, 2014; European Commission, 2009, 2010b, 2010a).

In Latvia emergency management gained importance in 2013 when three incidents focused attention from policymakers – spring floods, that took the life of one woman; fire at the Riga castle in June; and supermarket Maxima collapse, that took the lives of 54 people. These incidents were followed by the development of Civil Protection and Disaster Management Law. The law came in to power on 1st October, 2016, however the potential of it being fully implemented was questioned long before that. Thus one must inquire – has policy learning happened and the new law was created using an evidence-based approach, or was it only a gesture with the purpose to imitate action in solving the problem.

Emergency management is a subject of social sciences, because it has the potential for directly or indirectly affecting the lives of many people. From the perspective of public administration and management emergencies test the capabilities of public administration institutions to act effectively and efficiently; test the capacity and utility of policies as well as the capabilities for communication and multilateral cooperation of the officials in charge. The events of 2020, especially the impact caused and vulnerabilities unearthed by the Covid-19 pandemic, starkly illustrate the need to create evidence – based on the research of past experiences and current, actual situation – based policy documents.

Innovativeness of the study, scientific and practical significance

The research topic of this thesis is innovative and relevant because emergencies of various categories are a part of everyday life and they have the potential to affect the lives of many people as well as important economic and societal processes. The topicality is underlined by Section 21 of the Civil Protection and Disaster Management Law: “In order to facilitate the development of the system of civil protection, the State and local government authorities, legal and natural persons may implement scientific research work in the field of civil protection and disaster management.” (Saeima, 2016) as well as the first priority Sendai Framework for Disaster Risk Reduction 2015–2030 “Understanding disaster risk” (UNISDR, 2015), that includes data collection and analysis, periodical risk assessment, disaster influence and impact analysis and understanding, as well as dissemination of the knowledge and lessons acquired; and the education and capacity building of local public administration officials, civil society, communities and volunteers.

The innovativeness of this thesis stems from these factors listed below.

1. The thesis explains various concepts used in the field of emergency management. The categorization of various emergencies is explored in depth, based on various characteristics. This assumes a contribution in both research and policy practice by developing a unified understanding about emergency management and promoting the consequent use of concepts related to this field.
2. The genesis of emergency management as an independent discipline is explored in the context of public administration and management paradigms, thus clearly illustrating the interconnectedness of both fields. This assumes a contribution to both research and policy practice, by attempting to establish emergency management in Latvia as an independent research discipline in the context of public management and administration for the first time, as well as contributing to the promotion of evidence-based policy making.
3. As part of these and algorithm for continuous analysis of policy learning and change was developed. This assumes a contribution to both research and policy practice by offering a tool for policy analysis, that lowers the researcher’s subjective bias and demands that objective evidence be gathered and analysed. The events of 2020, especially the impact caused and vulnerabilities unearthed by the Covid-19 pandemic, starkly illustrate the need to create evidence – based on the research of past experiences and current, actual situation – based policy documents. The algorithm for continuous analysis of policy learning and change can be classified as a useful, practical tool for the future analysis of policy learning and change after Covid-19.
4. Factors that promote or hinder policy learning are gathered and analysed in this thesis for the purpose of analysing the context of policy learning and

change, in order to gain a deeper understanding about the behaviour of policy elites and to generate proposals regarding needed corrective action.

5. The innovativeness of the thesis in international context – the algorithm for continuous analysis of policy learning and change – can be used to analyse the process of policy learning and change in democratic systems.
6. Due to emergency management as an independent discipline being a relatively new, the detailed analysis of three emergencies in Latvia assumes a contribution to the global emergency management knowledge pool from the perspective of a post-communist country.

Research aim, tasks, research questions and methods

Technological development provides never before seen possibilities for gathering, analysing and exchanging information, knowledge and experience. However, despite these opportunities for learning, **the process of institutions learning from emergencies is not guaranteed, due to the institutional and organizational resistance to change.** This central thesis serves as the base for formulating the **research problem** of this thesis – the dissonance between normative demands for continuous development and the actual policy reality. Said dissonance can only be corrected by understanding its causes and by deliberately and consequently applying corrective actions to turn this dissonant action into consonant one. By analysing empirical cases this thesis aims at providing policy recommendations for correcting the identified dissonance between normative demands and actual policy reality.

The **aim** of this thesis is to analyse the capability of Latvia's public administration institutions to perform policy learning and policy change after emergencies, by analysing policy documents, media, public and political agendas and other relevant documents in the context of three emergency situations based on the diagnosed factors that promote or hinder the consonant or dissonant action.

To reach the aim this research, three research questions were formulated that are aimed at understanding the specific context of each case:

Q1: How does policy learning happens in practice compared to the theoretical model constructed in this thesis?

Q2: What critical failures were identified and corrected or mitigated in each of the selected empirical incidents?

Q3: What factors that promote or hinder policy learning can be identified in each of the selected empirical incidents?

The following **tasks** for doing this research were put forth:

1. Construct a conceptual framework, that:
 - a. Is based on theoretical literature on theories of policy learning and change. A tool for analysing policy learning and change is created.
 - b. Is supplemented with factors, that promote or hinder consonant behaviour – policy learning and change after emergencies;

2. Analyse the framework of emergency management in Latvia;
3. Choose three emergencies (incidents) and analyse them by applying the constructed conceptual framework;
4. Based on the acquired information, draw conclusions about policy learning and change after emergencies in Latvia in the context of the specific cases.

To answer the research questions formulated in this thesis, both qualitative and quantitative research methods were applied to gathering and analysing information; case analysis, media monitoring and document analysis were performed. The gathering of empirical data was partially structured.

Approbation

Development of the research has been tested in international conferences and doctoral schools. Also, teaching practice, participation in doctoral school in Potsdam, Germany and the enhancement of knowledge by completing on-line courses offered by foreign universities has helped the better and extensive exploration of aspects useful to the thesis, discussion of research result with wider audiences and has provided networking opportunities with emergency management researchers from abroad.

Participation in international and national level conferences

- Participation in the 73rd conference of the University of Latvia, political science section (05.02.2015). Presentation “*The adequacy of Latvia’s public administration organization emergency plans as it pertains to pandemics*”.
- Participation in conference “*Good governance at local self-government: theoretical and practical transformations*”; Siauliai University, Lithuania (16.10.2015). Presentation: “*Empowerment – a double edged sword?*” co-author: D. Kleins.
- Participation in conference “*Urban governance in Europe: Preparing for diversity, social sustainability and migration*”, Oslo and Akershus University College of Applied Sciences, Norway (28.09.–30.09. 2016). Presentation: “*Crisis and Emergency Risk Communication and Diverse Urban Populations. The two very different cases of Latvia and Norway*”.
- Participation in PhD training seminar, Oslo and Akershus University College of Applied Sciences, Norway (28.09.–30.09.2016). Presentation: *PhD thesis summary*.
- Participation in conference “*Good governance at local self-government: opportunities and challenges for developing collaborative*”, Siauliai University, Lithuania (13.10.2016). Presentation: “*Collaborative governance and emergency management: A Latvian case study*”.

- Participation “Nordic-Baltic defense estates cooperation annual conference 2018”, Tallinn, Estonia (09.–11.09.2018) Presentation: “Putting the horse before the carriage: Implementing process-based management at the State Centre for Defence Military Sites and Procurement of the Republic of Latvia”.
- Participation Nordic-Baltic defense estates cooperation “Benchmarking – Investment process”, Stockholm, Sweden (26.–27.03.2019). Presentation-report: “Investment (construction) process in Latvia: State Centre for Defence Military Sites and Procurement of the Republic of Latvia”.
- Participation in Nordic-Baltic Defense estates cooperation “Quality and Processes Management Workshop”, Helsinki, Finland (09.–10.04.2019) Presentation-report: “Quality and process management at the State Centre for Defence Military Sites and Procurement of the Republic of Latvia”.
- Participation in Vilnius University Šiauliai Academy International Scientific Conference *Young researchers for smart societies*, online, (13.05.2021). Presentation – report: “Missed opportunities for policy learning and change: two Latvian case studies”.
- Participation in “Nordic-Baltic defense estates annual conference 2021”, online, (07.09.2021). Presentation – report: “Tackling the next big thing: reforming the management of movable property”.
- Participation in “Questions of Accountability”, online, (01.–05.11.2021). Presentation – report: “Accountability and Procurement During the First Wave of the Covid-19 Pandemic: The Latvian Experience” (<https://www.worcester.ac.uk/about/academic-schools/school-of-humanities/humanities-research/international-conference/international-conference-presentations-and-papers.aspx>).

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- “Collaborative Governance and Emergency Management: A Case Study of Latvia”, “Socialiniai tyrimai / Social Research”. 2016, Vol. 39 (2), 28–39, ISSN 2351-6712.
- “Policy learning from influenza and the preparedness of the public health sector: season in Latvia”, forthcoming in *Science Open Research*, 2021. DOI: 10.14293/S2199-1006.1.SOR.2021.0002.v1, pp. 1–16.
- “Initial and continuous training of local public agents and local elected representatives in Estonia, Latvia and Lithuania”, co-authors: Laffranque R. (Estonia), Reinholde I., Vonda A. (Latvia), Astrauskas A. (Lithuania),

forthcoming in *“The training of public officials and elected local officials in Europe: Different perspectives from 33 European states”*, pp. 185–224.

Taught lectures and seminars

University of Latvia faculty of Social sciences bachelor’s and master’s study program “Political science” subfield “Public policy and administration”:

- Lectures and seminars in the courses of Prof I. Reinholde “Public sector management”, “Organization theory”, “Policy analysis”, “Introduction to public administration”, “Topical issues of public administration”, “Governance in the EU”, “Human resources in politics”, “Public sector management” (2014–2021).

1. CONCEPTUAL FRAMEWORK

1.1. Model of Event-related policy learning

Drawing from eight theories on policy learning and change Thomas A. Birkland offers the model of Event-related policy learning. Birkland developed this model to 1) explain and illustrate the process of policy learning and change after focusing event in a cause-to-effect fashion, drawing from various theories on the actions of stakeholders involved in the policymaking process, and 2) to “suggest the data needed to understand a given event” (Birkland, 2006, p. 17). Birkland’s model is based on the definition of **(policy) “learning”** given by Busenberg: **“process in which individuals apply new information and ideas to policy decisions”** (Busenberg, 2001, p. 173) The assessment of whether learning occurred is qualitative and context specific – **the conclusion cannot be generalized** (Birkland, 2006, p. 21).

The necessary empirical data for making an assessment are suggested by six prepositions:

- 1) Most if not all participants in a policy domain want to address or solve the problems revealed by focusing event, but that the proposed solutions are likely to vary with the interests and motivations of these participants;
- 2) Few events will gain the most attention;
- 3) Group mobilization is linked in time to particular focusing event;
- 4) Group mobilization will be accompanied by an increase in discussion of policy ideas;
- 5) There is a relationship between policy ideas and change. In particular, change is more likely when ideas become more prominent after events than when they do not;
- 6) It is possible for learning to decay over time. (Birkland, 2006, pp. 17–20)

1.2. Algorithm for continuous analysis of policy learning and change

By using theories used by Birkland to construct the Model of event related policy learning and change and applying elements from the Taxonomy of organizational learning from rare events an algorithm (e.g. a **standard** against which the information acquired is to be compared) can be constructed that potentially allows to make judgements about more than just the fact *prima facie* policy learning (Figure 1.2.1). The conclusions still remain context specific and can’t be generalized, however the algorithm helps to decrease the subjective nature of said judgements by demanding an objective assessment of indicators against the identified critical failures.

The catalyst of the process is an emergency – a specific incident (Incident 0 or the incident that is going to be used as the basis for comparison), that shocked the system. Next step (1.1.) is exploring the incident. This process takes place only when the Response phase of the Disaster management cycle has ended and Recovery phase is nearing its conclusion, and the Mitigation phase has begun. After exploring the incident the identification of critical failures¹ (Q1), that caused the incident, must be assessed. If the problems that caused critical failures are not identified policy learning is impossible. As in step 1.1. – if the critical failures are not identified, preventing them from repeating in the future is impossible (F1).

The next critical step is acknowledging the problem (Q2). It must happen at the highest possible level of hierarchy. The problem must be acknowledged by actors who have the rights and power to make the implementation of corrective actions binding. If the problem is not acknowledged it can't be solved – policy learning is impossible (F1).

After acknowledging the problem, the next step is to identify and propose essentially relevant solutions (1.2.). The solution proposed is essentially relevant if, when critically assessed, it has the potential to eliminate or mitigate the root cause problem or problems of the critical failure. The acknowledgement of the problem is critically important factor for the development of an essentially relevant solution, because it requires an in depth understanding of each root cause or causes of the problem. To gain this understanding, the competencies of a single institution might not suffice – consultants, academics and representatives of NGO's might need to be involved. Ensuring necessary competencies requires the authorisation of resources. If the necessary resources are not provided and no search for solution takes place, policy learning is impossible (F1).

After the potential solution for the root-cause problem have been identified, they need to be formalized in policy documents (1.3.) via policy decisions. After the formalization of proposed solution has taken place – policy decision has been made – an assessment must be made whether these solutions are based on analysis of the situation or have been adopted automatically (Q4). The automatic adoption, by replicating practices accepted and implemented elsewhere, is a strategy that can be applied when there is a lack of necessary competencies and resources or there is a need to demonstrate visible action to solve the problem. If the automatically adopted solutions show improvements in the future, it is luck and not a conscious achievement.

¹ “Critical failures” refers to “turning points” or “crossroads” (actions, inaction, decisions, etc.) in the chronology of the emergency that were detrimental to the following course of events.

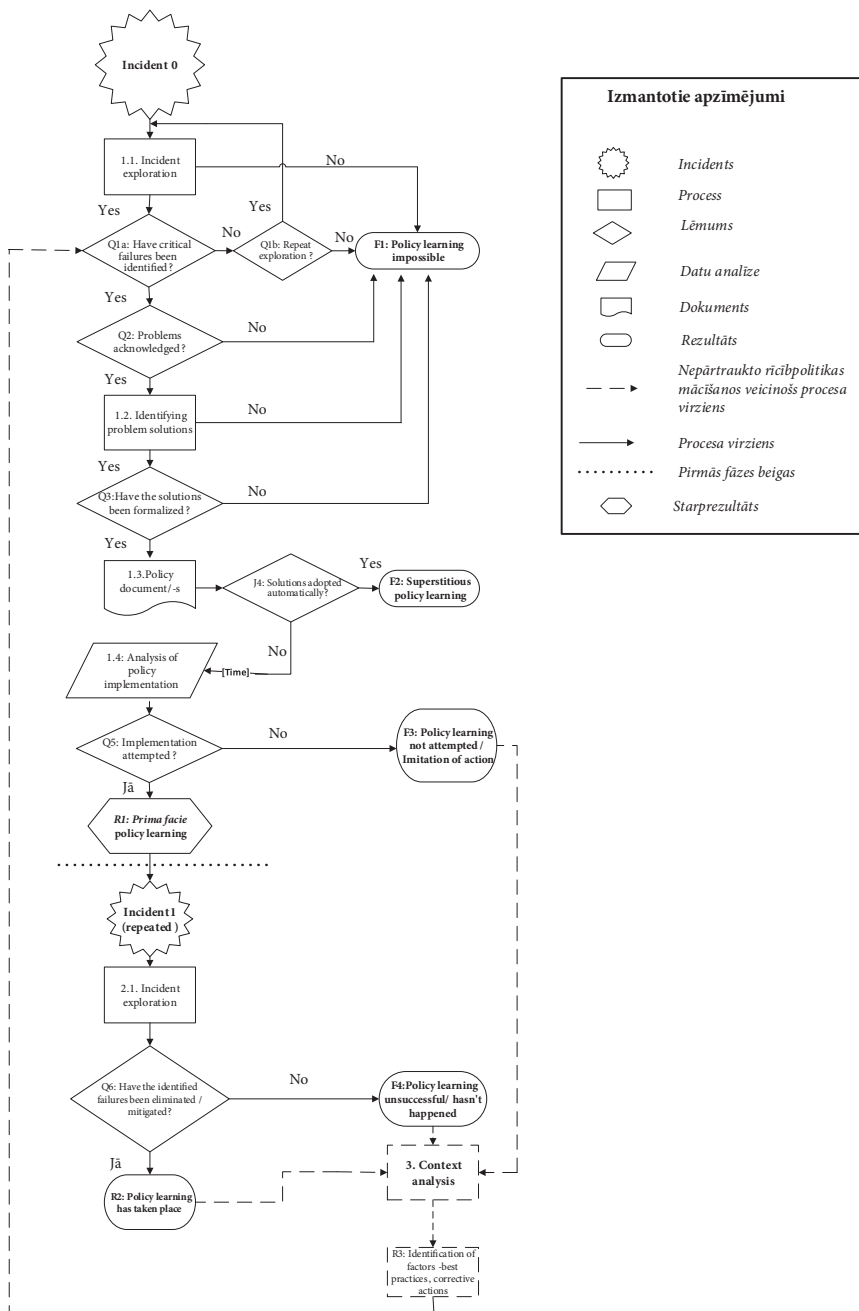


Figure 1.2.1. Algorithm for continuous analysis of policy learning and change

After policy decisions have been made, policy documents – developed and entered into force, time is needed for the solutions included in the policy documents to be implemented. The implementation deadline can be used as the first point of reference. Additionally, a medium-term assessment can be performed to identify any problems in the implementation process and address them via corrective actions. If no deadline is set, an alternative point of reference is the ten-year time period set by Sabatier or a yearly assessment can be performed by producing a progress report.

Based on the assessment of numbers and facts, as well as *prima facie* evidence proposed by Birkland, acquired during the policy implementation, experts must give the judgement on whether policy implementation has been attempted (Q5). If the data and *prima facie* (policy) learning evidence suggest attempted implementation of solutions for root cause problem or problems of critical failures, it can be concluded that *prima facie* policy learning has taken place (R1). Thus it is possible to anticipate that, should a similar incident take place in the future, response and recovery activities will be carried out more efficiently and effectively.

However, should the evidence not suggest successful policy learning (F4), a discussion is possible about why policy learning was not attempted; has there been imitation of action, for example, the institution's annual reports list various policy implementation activities, however data, numbers and evidence presented in a third party assessment do not suggest a real progress in achieving policy goals.

The judgement about *prima facie* policy learning concludes the first phase of the algorithm. To judge the true effectiveness of the implemented policy solutions, practical testing is required – a repeated incident (Incident 1) that is as similar as possible to the original one. It must be emphasized that two identical incidents – emergencies – are not possible.

After a repeated incident has taken place (Incident 1), it should be explored (2.1.) to understand, if the failures identified during the exploration of previous the incident have recurred and if their root-cause problems have been eliminated or mitigated (Q6). If this has happened, it is possible to make a substantiated statement that policy learning has taken place (R2). If during the exploration of the incident no evidence suggests that the actions taken have eliminated or mitigated the critical failures identified during the exploration of Incident 0, it is possible to conclude that policy learning has been unsuccessful. Additional analysis the circumstances of Incident 1 might reveal new critical failures that had not yet been identified. For continuous policy learning to take place it is necessary to analyse to context in which the policy learning has or hasn't taken place (3.).

If it is concluded that policy learning was not attempted or policy learning has been unsuccessful (F4), context analysis (3.) is a tool for identifying factors that have impeded policy learning and change in this specific case. Based on

this information, corrective actions can be developed and implemented (R3) and it is possible to attempt the first phase of the policy learning (and change) algorithm anew. However, in cases when the evidence suggests that policy learning has taken place, context analysis provides information about factors that have promoted policy learning, thus creating best practices that might be of use to other institutions. Now “Incident 1” becomes “Incident 0” and the process of continuous policy learning and change restarts from the step of identifying critical failures.

1.3. Factors that promote or impede policy learning and change

The analysis of background factors that promote or impede policy learning create a basis for the explanation of a particular course of events. These factors can be a part of both the **institution’s internal and external environment**.

As illustrated by Figure 1.3.1, the successful policy learning is endangered *per se*, because the number of factors that can impede policy learning is much bigger than the number of promoting factors. The danger posed by the impeding factors can be mitigated only when policymakers are informed about these factors and are working purposefully to mitigate them. Thus those factors, whose promoting or impeding quality is dependent on the context, media quality as well as the knowledge and openness to new knowledge of policymakers, academia and practitioners, as well as the values prominent in the particular society, are of much importance.

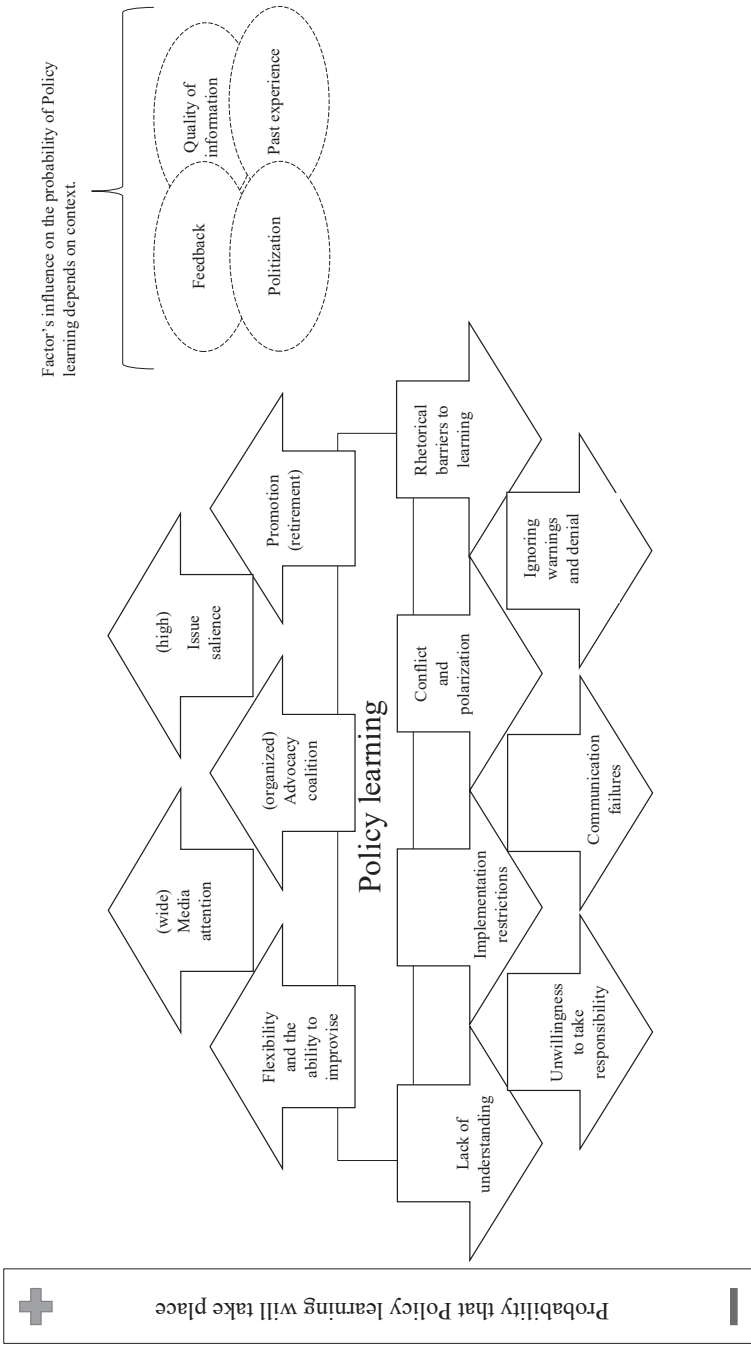


Figure 1.3.1. Summary of factors that promote or impede policy learning

2. RESEARCH DESIGN AND METHODOLOGY

This thesis is designed based on Joseph A. Maxwell's **Interactive research design model**. This model was chosen because it is flexible, and the research questions are a central element and not the starting point, which is closely connected to other elements. That means that the research questions can be modified during the research, based on changes in goals or new knowledge acquired. The research design of this thesis is illustrated by Figure 2.1.

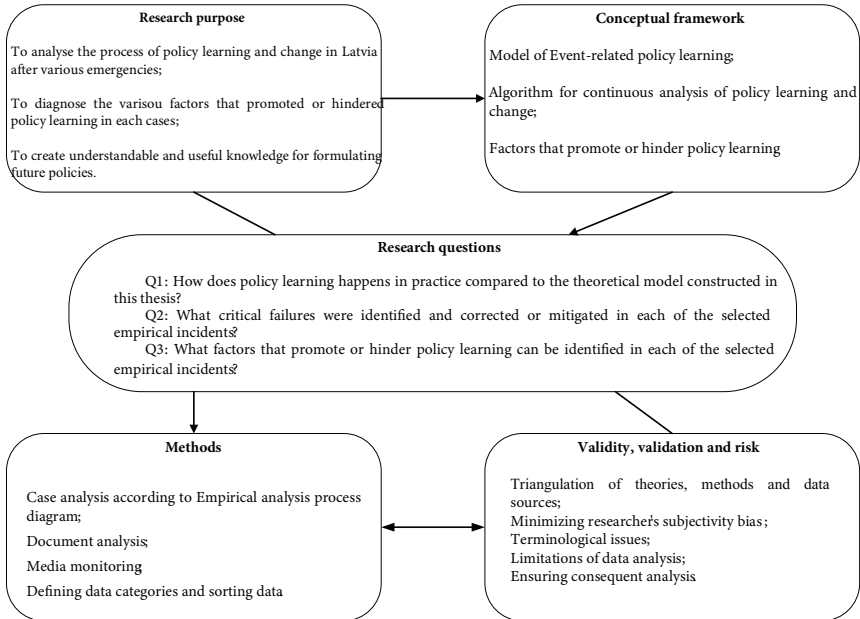


Figure 2.1. Research design

The object of this research is Latvia's public administration organizations that are responsible for effective and efficient emergency management and the mitigation and elimination of their impact, as well as preparedness planning for emergency situations. The **research subject** is the ability of aforementioned organizations to learn from emergency situations and formalize the lessons learned in policy documents of implement other identified solutions to the problem.

The research purpose of this thesis is to analyse the context of policy learning and change in Latvia after various emergencies. This definition of the research purpose determines that this is a qualitative research, that is oriented toward

understanding the context, in which the events developed. Understanding the context helps to formulate causal explanations for how events – or emergencies in this case – have influenced other developments, in this case – policy learning and change.

The research goal is to carry out an *ex post* assessment. The research **aim** is to analyse the capability of Latvia's public administration institutions to perform policy learning and policy change after emergencies, by analysing policy documents, media, public and political agendas and other relevant documents in the context of three emergency situations based on the diagnosed factors that promote or hinder the consonant or dissonant action.

The practical purpose of this research is derived from the research purpose: to create knowledge “that is understandable and experientially credible, both to the people being studied and to others”. (Maxwell, 1996, p. 21) In particular, the comprehension of the specific context gained from the qualitative research has more expected practical utility for further policy making for practitioners – policymakers in the context of this thesis – as well as for the academia. Understanding the specific context allows to identify failures and weaknesses of the system thus answering the question “Why the situation developed like this and not differently?” and creating a basis for propositions on how to eliminate or mitigate identified failures and weaknesses and their impact in the future.

The conceptual framework is based on the Algorithm for continuous analysis of policy learning and change created by the author. To gain more detailed understanding of the context of each specific case, the model of *Event-related model of policy learning* created by T. A. Birkland was also applied during the empirical analysis. This model is based on eight theories of policy learning and change thus providing a wide conceptual framework. Additionally, *Factors that promote or impede policy learning* were identified.

To reach the aim this research, three research questions were formulated that are aimed at understanding the specific context of each case:

Q1: How does policy learning happens in practice compared to the theoretical model constructed in this thesis?

Q2: What critical failures were identified and corrected or mitigated in each of the selected empirical incidents?

Q3: What factors that promote or hinder policy learning can be identified in each of the selected empirical incidents?

Since both the conceptual framework of this thesis and the research questions are qualitative and aimed at context specific analysis to diagnose the causes of effects, no hypothesis was formulated.

The wicked nature of the issue being analysed makes the formulation of a hypothesis unproductive, since crucial testing of a hypothesis is not possible. Wicked problems are societal problems which have no clear definition or solution. (Rittel & Webber, 1973) These problems have 10 properties, that make them wicked:

- 1) There is no definitive formulation;
- 2) They don't have a stopping rule;
- 3) Their solutions are not "true-or-false", but "good-or-bad";
- 4) There is no immediate and no ultimate test of a solution;
- 5) Every solution is a "one-shot operation";
- 6) "They do not have an enumerable (or an exhaustively describable) set of potential solutions, nor is there a well-described set of permissible operations that may be incorporated in the plan";
- 7) They are unique;
- 8) "Every wicked problem can be considered to be a symptom of another problem";
- 9) The discrepancies representing a wicked problem can be explained in numerous ways;

The planner has no right to be wrong (Rittel & Webber, 1973, pp. 136–143)

Q1 was answered, based on the incident outlines. Q2 was answered by comparing answers to Q1 with normative acts and policy documents that were developed and entered into force after the incident. Q3 was answered by comparing the factors that promote or impede policy learning and change with the context of Latvia regarding the elimination of the identified critical failures.

Both qualitative and quantitative **methods** were utilized in this thesis for the collection and analysis, that were logically derived from the conceptual framework. **Case analysis** was performed utilizing Empirical analysis process diagram (Figure 2.2).

Based on the diagram, the **Algorithm for continuous analysis of policy learning and change** and the **model of Event-related policy learning**, the empirical analysis of the thesis was mainly based in **document analysis**. The following analysis units were defined: 1) individual entries/publications derived from LETA archive (media agenda) and from stakeholder homepages and other news sources (public agenda); 2) The Cabinet of Ministers minutes that were derived from sites *tap.mk.gov.lv* and *www.likumi.lv* (political agenda) and 3) legal acts and policy planning documents, that were derived from sites *www.likumi.lv* and *polsis.mk.gov.lv*.

Categorization strategy was applied to the qualitative data needed to construct the overview of media agenda. The collected data was **coded** by applying inductively created topical **data categories that were individually created for each case**. If needed the topical data categories were re-defined, supplemented and the data was sorted anew in accordance to the new categories. Data coding was performed using the function "*Conditional formatting*" in MS Excel. When the data was fully sorted, it was filtered and figures were generated.

In order to limit the policy documents analysed in the step Policy learning and change analysis, data search on the site *www.likumi.lv* was conducted by applying the **Issue attention cycle model** by Anthony Downs. The model consists of five stages: 1) The Pre-problem stage; 2) Alarmed Discovery and Euphoric

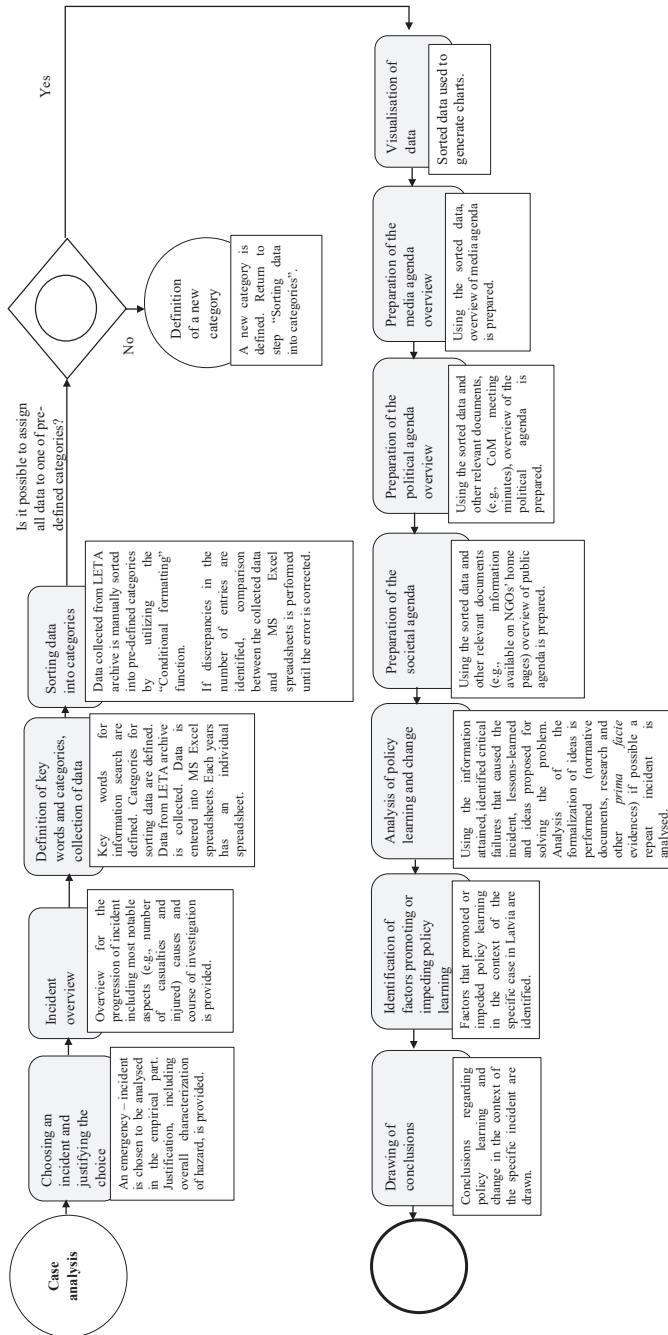


Figure 2.2. Empirical analysis process diagram

Enthusiasm stage; 3) Realization of costs stage; 4) Decline in intensity of interest stage; and 5) the Post-problem stage (Gupta & Jenkins-Smith, 2015).

The cases analysed in the empirical part of the thesis were chosen based on the following criteria:

- The category, type and frequency of the emergency;
- The potential of the emergency to attract attention;
- Societal values embedded in managing the specific emergency;
- Special characteristics, e.g., precedence, the number of casualties/injuries.

3. LIMITING FACTORS AND RISKS OF THE STUDY

The following risks and limiting factors of the study were identified:

Terminological insufficiency. The terminology of the emergency management domain reflects one of the issues of social sciences – the lack of unified, non-disputed definitions of terms. Thus different terms are commonly used as synonyms or different authors use different terms when referring to the same incident. Additional challenges are posed by the characteristics of Latvian language since there are several terms that do not have a translation or have the same translation, which leads to crucial nuances of the original term being lost. In order to resolve the terminological limitations and risks emergencies were defined by using definitions proposed by Bill Faulkner because they differentiate between emergencies by identifying specific characteristics of each type of emergency thus providing opportunities for operationalization. Additionally, a new term “katastrofisks notikums” was introduced to differentiate between the terms “disaster” and “catastrophe”, that were thus far translated by using the same word – “katastrofa”.

Limitations of data analysis. Corresponding to the conceptual framework of the thesis, specific context analysis for each case requires a large amount of data. Data analysis and sorting was performed manually which creates human-factor based risks. To resolve the limitations and risks stemming from data availability, firstly, keywords that were used in the data collection stage were defined and adjusted using search options offered by the data bases. Secondly, categories for data sorting in the context of each case (incident) were defined and adjusted as the study progressed. Thirdly, to mitigate risks stemming from human-factors, the functions of data validation, duplicate entry identification were used and rechecked; the numbers of entries in the data sets were compared with the numbers of data units (entries) collected, by performing repeated manual checks, comparison and modification if needed.

The risk of ensuring consequent analysis. As has been stated, every emergency is unique. Thus the incident analysis is also context specific. To ensure the consequent analysis of cases (incidents), every case (incident) was analysed using Empirical analysis process diagram (Figure 5).

Integration of results into policies. It is difficult to objectively evaluate risks present in this context. Firstly, policy learning is the deliberate action of individuals and organizations that must be embedded in the culture of the particular organization. Since emergencies, depending on their scale and magnitude, can be wicked issues, policy learning oriented culture should be present throughout public administration as a whole and on all levels. Secondly, learning from emergencies can be ignored, because disasters and catastrophes are low-probability high-cost events. The low probability can serve as a demotivational factor for assigning resources to incident investigation un the

formalization of lessons learned in policy documents. Thirdly, since the agendas of academia and policymakers rarely overlap, there are issues with “policy transfer”. Additional limitations and risks for integrating the results of this study into policies will be presented in the Conclusions section of this thesis after analysis of policy learning promoting and impeding factors in the context of chosen cases (incidents) will be performed. Based on the results of the analysis solutions for the identified limitations and risks will be provided.

4. CONCLUSIONS AND POLICY RECOMMENDATIONS

Policy learning and change after emergencies is a comparatively under explored field. Policy learning and change is mainly researched by analysing documents and attempting to identify *prima facie evidence*. Researching policy learning and change is important for several reasons. Firstly, it allows to identify the views of the leading political elite regarding existing reality, based on its actions or inaction regarding policymaking. Secondly, awareness of policy learning and the factors that facilitate or impede it reduces the vulnerability that stems from repeating the same mistakes. Thirdly, researching the policy learning process allows the making of conclusions regarding the values prominent in the certain society.

Three cases were analysed in this study: fire in the state social care centre (SSCC) “Reği”, flu seasons across 17 years and Zolitude tragedy. The main results of the study are outlined in the Appendix.

4.1. Event-related policy learning and change

In the context of the Model of Event-related model of policy learning T. A. Birkland puts forth 6 prepositions, that point to the expected direction of policy learning and change process after emergencies as well as data, that need to be analysed (Birkland, 2006).

1st preposition – Only few events will gain the most attention

Although media direct their attention to small emergencies, e.g., by mentioning them in among the events of the previous day, or in the section about Crime news, only events that create the most loss – material and human life – get the most attention. The incident analysis reflects this logic. Zolitude tragedy gained more attention than the other two incidents. Zolitude tragedy also maintained the said attention longer than the other two incidents. In the case of “Reği” fire media attention diminished drastically a month after the incident, and in the case of flu this attention fluctuates in correspondence to the progress of the flu season in the Northern hemisphere. In the case of Zolitude tragedy media attention is periodically attracted by the court proceedings that only concluded in 2020.

Conclusion – in the context of this study 1st preposition is proven true.

2nd preposition – Focusing events create group mobilization

Emergencies, dependant on their scale and magnitude, and the number of policy failures they expose, have the potential to mobilize a wide range of public groups. Group mobilization is an important factor, because interest groups and

coalitions serve as generators of ideas, and as a factor that promotes policy learning and change, by continuously attracting the attention of the wider public, media and policymakers to the identified problems. In the cases analysed in this study wide range of interest advocacy coalitions was not identified: in the case of “Reģi” fire it is impossible to discuss mobilization of interest groups; in the case of the flu group mobilization is minimal and inward – toward the members of the group – directed; and in the Zolitūde tragedy case a small interest advocacy group was formed, that cannot be attributed significant influence over the ideas and issues circulating on the political and public agendas.

Conclusion – in the context of cases studied in this thesis it is impossible to discuss the influence of interest group activities on policy learning and change – 2nd proposition proves to be untrue.

3rd proposition – The relationship between events, ideas and policy change

T. A. Birkland states, that new ideas are not created after emergencies, however the opportunity to discuss already existing ideas – is. In the case of Latvia, the policy elites have demonstrated a tendency to preserve the existing *status quo* and to make small adjustments to the existing policies, as well adopting already existing international practice and standards. Thus it is impossible to discuss innovative ideas. Additionally, evidence that would signal the potential policy learning and change can only be identified in the case of Zolitūde tragedy (Theory of Social learning, characteristics of Second-order learning and change in the construction domain).

Conclusion – in the context of this thesis 3rd propositions is proven true.

4th proposition – Only few issues are completely new

None of the cases studied in this thesis are unique in the context of global – or Latvia’s – experience, thus this proposition was clearly proven true in the context of this thesis.

5th proposition – Focusing events and the presumption against change

T. A. Birkland writes that meaningful discussion of ideas and the resulting policy learning and change after focusing events is not guaranteed. In the context of the Latvian cases analysed the changes identified happened without a discussion about ideas. The evidence collected during this study prove this proposition true. In Latvia, in the context of cases studied, the identified changes took place without a discussion of ideas. Both in the cases of “Reģi” fire and Zolitūde tragedy created a feeling that change is needed. Thus copying/imitation of ideas, e.g., adapting EU standards to Latvian context without widely

discussing them. In the case of flu Latvia has failed to adhere to internationally recommended norms or implement other solutions, e.g., signing a guaranteed flu vaccine delivery contract or stockpiling medications.

A reason for the lack of discussion is the missing mobilization of interest groups, that would offer ideas and foster a discussion about them. Even if an interest advocacy coalition – a coalition of groups – do mobilize, this mobilization is sporadic and short-term. The evidence suggests that in the context of the incidents analysed the media were more interested in the political entanglements. Thus the political elites had the chance to adopt and slightly modify already existing ideas without seriously endangering the existing *status quo*.

Conclusion – in the context of this thesis 5th preposition is proven true.

6th preposition – Relationship between learning and time

As suggested by the controversy around the dangerous technical conditions of Deglava bridge, April of 2019, in Latvia the lessons provided by emergencies are quickly forgotten. The chronical, years-long disregard of the fire safety recommendations made by State fire and rescue services regarding compliance to fire safety regulation proves, that the lessons of “Reģi” fire have disappeared from public and institutional memory. Additionally, the fact that the preparedness for emergencies in the domain of public health is in a critical condition even after the shock of Zolitūde tragedy proves, that the complacency existing in the public health domain is more powerful than the impulse created by emergencies to learn or at least to implement change without learning by adopting international practice, standards un adhering to recommendations.

Conclusion – in the context of this thesis the 6th preposition about the negative relationship between time and learning is proven true.

4.2. Algorithm for continuous analysis of policy learning and change

Based on the evidence acquired during analysis, all 3 incidents analyzed in the thesis are classified with outcome F3: “Policy learning not attempted/imitation of action”. *Ex post* analysis (3.) identified factors that promoted or hindered policy learning and change, thus allowing to judge the best practices to be adopted or needed corrective actions(R3).

A conclusion can be made that in the context of the incidents analyzed there’s a high institutional resistance/inertia against changing the *status quo* and implementing policy solutions into practice. The tendency to deny and ignore warning is very prominent, as are the attempts to dismiss taking responsibility for a materialized or potential hazard and the attempts to “move” the blame to another person or institution. Thus no “benevolent soil” was identified that could foster policy learning and change after emergencies.

In the case of the “Reģi” incident policy learning and change hasn’t happened – it was impossible *per se*. Although the critical failures and problems were identified and corresponding solutions formalized in a short-term policy document “Plan for improving the fire safety situation in state social care centers”, repeated inspections suggested that the identified problems still persist. Situation was made worse by the fact that the Minister of welfare dismissed the SFRS inspections results thus dismissing the problem, strengthening complacency of SSCC and other healthcare institution, and questioning the professionalism and trustworthiness of the SFRS.

The evidence of 2006/2007 flu season *ex post* analysis suggests that the problems covered in the 2005 report by the Ministry of health “On action in case of pandemic flu” still remain – no contract on guaranteed vaccine deliveries was signed; the highest achieved flu vaccination level in Latvia is 1,1% that is far below the WHO and ECDC recommendations of 75%; healthcare workers pay for their own vaccinations; the healthcare domain still doesn’t have enough funding to pay for overtime and less than half of all state hospitals take part in the epidemiological surveillance.

In the case of Zolitūde tragedy it is too soon to judge whether *prima facie* policy learning and change has taken place (R1). According to Sabatier at least ten years need to pass to judge policy change. Big changes have been made in construction regulations, new standards have been adopted, “Civil Protection and Disaster Management Law” has been adopted, new “State disaster medicine plan” has been developed, civil defence course has been introduced into schools with defined minimal requirements and evacuation has been made mandatory in case of alarm. However, to judge the practical application of these solutions, practical testing is required which can only happen in the context of an emergency of the same type. If we take into account the agiotage around Riga Deglava bridge technical situation in April 2019, negative *prima facie* evaluation must be suggested. Zolitūde tragedy shook Latvia’s society by placing a hazard in the centre of the situation that had thus far been ignored. Despite that a situation was allowed to develop where the bridge had to be closed for safety reasons. This in turn fosters the presumption that there has been institutional resistance to implementing problem’s solutions into practice.

4.3. Factors that promote or impede policy learning and change

In the cases of “Reģi” fire and the flu all external environment factors – media attention, issue salience and a strong advocacy coalition – that could potentially promote policy learning and change are missing. Policy learning and change failed despite the fact that there was clear understanding about the needed action and there was no self-censoring or use of highly technical language. In both cases it is possible to discuss an unwillingness to take responsibility and the ignoring of warnings as factors that impeded policy learning and change. As

mentioned, in the case of “Reģi” fire, the Minister of Welfare refused to accept the results of inspections carried out by the State fire and rescue services thus denying the warning about existing hazards. Additionally, attempts were made to shift the responsibility about the incident onto the night-shift employee on-duty at the time of the incident. In the case of the flu the ignoring of warnings is proven by not correcting the identified critical failures and relying on the effectiveness of past actions in the context of future hazards.

In the case of Zolitūde tragedy it is mostly possible to discuss the imitation of policy learning and change, promoted by media attention and issue salience, created by the uniqueness of the incident. Technological progress allows for the near real-time witnessing of the development of events on the scene of the incident and thus added further humanity. Search and rescue services received praise from both political elite and the public. However, despite the scale of the incident and its lessons, there is a reason to doubt the proposition that there will be no ignoring and denying of warnings in the future. The main reason for this doubt is the aforementioned case of Deglava bridge. Discussions about the need to invest in improving the technical condition of bridges began in media in 2011 and were renewed in 2013. However, despite lessons provided by Zolitūde tragedy, people expressed their discontent with the bridge being closed and inconvenience it created on social media, thus ignoring the safety concerns behind this decision.

The historical context of Latvia can be proposed as an additional root cause to the internal and external environmental factors of institutions that hinder policy learning and change. Lessons provided by emergencies are lacking from the institutional memory. This “not-remembering” is created both by the censorship of the USSR regime, and the period of uncertainty and confusion that followed the collapse of USSR created by the necessity to create new institutions. The desire to integrate into the Western world, including the EU and NATO, created certain priorities, e.g., international recognition of independence, resolving human right’s issues and creating a functioning state apparatus. Thus low probability-high cost events unless of military nature, were not the centre of the public or political agenda.

Additional forgetting, ignoring and denying hazards/warnings also create complacency risk, that fosters a vicious cycle thus lowering the probability that conscious and successful policy learning and change will take place even further. The risk that changes, should they take place, will be a reaction to the pressure to act – imitation or superstitious learning, or automatic adoption of practices used elsewhere – also increases. This in turn creates the risk that the adopted changes and policy documents and action plans based on them will not practically applicable.

Based on the evidence it is possible to suggest that from the perspective of the Genesis of emergency management Latvia is in transition between “the Civil defence era” and “the Holistic defence paradigm” because the military threat perspective still dominates policy documents.

4.4. Recommendations for improving policy documents

Evidence-based approach to policy making requires justification, the correct representation and analysis of data, definition of responsibility and competences, clear definition of goals and tasks (Banceviča, 2016) as well as regular monitoring and flexibility towards making adjustments in accordance to the progress identified. Below are listed several recommendations logically stemming from the flaws diagnosed during this research:

- Surveying existing situation;
- Including the principles of proportionality and logic in policy documents;
- Applying international experiences and standards to developing policy documents;
- Conscious, goal-oriented change management and human resource development;
- Increasing the competitiveness of public administration institutions;
- Educating the society and attitude change.

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Table 1. Summary of research results

The type and frequency of the emergency event (focusing on event)	SSCC “Reği” fire	Flu	Zollitüde tragedy
Year	2007.	2006/2007 (seasonal)	2013.
Q1: How does policy learning happens in practice compared to the theoretical model constructed in this thesis?	<p>The incident was explored (1.1.) and critical failures were identified (Q1a – yes). Solutions were proposed (1.2.) for the identified and admitted problems (Q2 – yes) that created critical failures which were formalized in a short-term policy document and a new construction standard (Q3 – yes; 1.3.) The formalized solutions were not adopted automatically (Q4 – no). The process halted at the practical implementation of the solutions (Q5 – no).</p> <p>Result – F3: policy learning not attempted/ imitation of action. Taking into account the specific context of the case – policy learning was impossible.</p>	<ul style="list-style-type: none"> • Disaster (natural) • Infectious disease • Regular/periodic emergency • Quasi-incident – a warning that signalizes about system's flaws and vulnerabilities in case of pandemic flu. <p>Exploration of the incident (1.1.) – superficial and insufficient – was performed. Critical failures and problems, and action scenarios to eliminate them formalized (Q3 – yes; 1.3.) in an informative report. Thus problems have been admitted (Q2 – yes).</p> <p>The solutions were no adopted automatically (Q4 – no). Process halts at practical implementation (Q5 – no). Result – F3: policy learning not attempted/ imitation of action.</p>	<ul style="list-style-type: none"> • Crisis • Structural failure • “Black swan” <p>Incident was explored (1.1.). As the public commission disbanded before their work began, decision was made to establish a parliamentary investigation commission and attempt exploration anew (Q2b – yes). Identified critical failure – lack of regulation – identified and admitted (Q1a – yes; Q2 – yes). Solutions – (1.2.) Translating <i>Eurocodes</i>, national annexes and their registration – were formulated and formalized immediately (Q3 – yes; 1.3.). New Construction law implemented. Policy solutions were not adopted fully automatically as illustrated by the need of national annexes (Q4 – no). Process halts at practical implementation (Q5 – no). About 1/3 of the parliamentary investigation commission's recommendations implemented.</p> <p>Prima facie result – F3: policy learning not attempted/ imitation of action.</p>

<p>Q2: What critical failures were identified and corrected or mitigated in each of the selected empirical incidents?</p>	<ul style="list-style-type: none"> • Inadequate fire safety activities in SSCC “Reģi” (and in state social care centres in general), including inadequate education of employees, inadequacies in regulations regarding smoking and the exploitation of electronic devices – partially resolved. • Lack of human resources and inadequate shift planning in SSCC “Reģi” unresolved. • Inadequacy of funding for delegated functions – not resolved. • Disregard of construction regulation and electrical safety measures – partially resolved. • Outdated firefighting equipment (State Fire and Rescue Service of Latvia) – unresolved. • Outdated policies for caring for people with mental disabilities and the resulting human rights violations – unresolved. 	<ul style="list-style-type: none"> • Inadequate number of vaccines (in case of pandemic) – unresolved. • No guaranteed flu vaccine delivery contract. • Low level of vaccination – unresolved. • No guaranteed vaccination of people responsible for maintaining public order – unresolved. • Insufficient stock of antimicrobials for treating complications of (pandemic) flu – unresolved. • Insufficient financing for epidemiological monitoring, remuneration of medical personnel overtime, and for the provision of communication and logistics activities (in case of a pandemic) – unresolved. 	<p>Disorderly regulation of the construction domain, the reorganization (liquidation) of the State Construction Inspection in 2009. Without an adequate regulation (as in – standard), the domain is not transparent, e.g.:</p> <ul style="list-style-type: none"> • No unified understanding about quality and safety measures; • Lack of necessary oversight; • Hazards and corrective actions are not identified. • Corrective actions (imitation) taken: • 48 (out of 58) standards and their amendments translated; 21 national annex (2015). • On October 1, 2014, the State Construction Control Bureau started operation.
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<p>Q3: What factors that promote or hinder policy learning can be identified in each of the selected empirical incidents?</p>	<p>Lack of all external environment factors that promote policy learning; insufficient media attention; incident was not followed by serious discussion about the solutions of the problem; and advocacy coalition was not identified in this policy domain that would ensure placing the issue on the agenda. Additionally, ignoring and dismissal of warnings, unwillingness to take responsibility and uncritical complacency, as well as high level of organizational inertia/resistance (SSCCs) were identified.</p>	<p>Media attention and issue salience cannot be classified as factors promoting policy learning and change. In this domain an advocacy coalition that tries to promote the issue, however their attempts are sporadic and have not had notable success. In the context of factors impeding policy learning it is possible to discuss about unwillingness to take responsibility, rhetorical barriers to learning and ignoring warnings, and denial. Available information is limited and of low quality.</p>	<p>Policy learning was promoted by the incident's uniqueness and shock value, and aided by increased media attention and the issue's salience to the public as a whole – potentially every citizen was vulnerable. There is an interest advocacy coalition in the domain whose activities are rather sporadic. Their main resource is the shock created by the incident to the status quo and the emotional component. At the moment the risk that denying and ignoring of warnings in the future is diminished. Regarding feedback, search and rescue workers were highly acclaimed both by politicians and the population. Most negative feedback in the context of this incident was received by Riga city Council, who have thus far failed to resolve the issue of a memorial as well as the court proceedings finishing in 2020.</p>
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