The Reckoning That Never Comes

Why formation, not another framework, is what breaks the pattern of British institutional failure

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This week, after years of the families' campaigning, MPs finally passed the Hillsborough Law. The Public Office (Accountability) Bill places a duty of candour on public officials: lie or evade during an inquiry into a disaster, and you can now be prosecuted for it. Andy Burnham, who first introduced the law as a private member's bill in 2017, called it "truly a rewiring of the state" – a way to "put decency back at the heart of the British state."

It is a genuine victory that belongs to the families: "we have shown that true power belongs to ordinary people," the Hillsborough campaigners said. But the deepest line in their statement was not about the law at all. It was "not just about legislation," they said, "but about changing the way the bereaved and survivors are treated, and a change in culture." Burnham named the same thing as a wound: people "suffer the trauma of the initial bereavement," he told the Commons, "and then they are re-traumatised by the behaviour of the state."

A duty of candour is a rule. It can compel honesty; it cannot create the disposition from which honesty comes. And the thing the families are pointing at – a change in culture, an end to the reflex by which an institution protects itself before the people it exists to serve – is not something a statute can bring into being. That is the difference between changing what officials are permitted to do and changing what they are disposed to do. It is also, as the last forty years show, the difference between a reckoning that arrives and one that never does.

Britain is living through a prolonged reckoning with itself. The inquiries accumulate, the findings are published. The families wait – for years, for decades – and when the reports finally land, they are forensic, authoritative, and largely unacted upon. The Hillsborough families waited twenty-three years for the truth to be formally acknowledged.[1] The survivors and bereaved of the infected blood scandal waited forty years.[2] The Grenfell families are still waiting for a full account of who knew what, and when, and why the cladding went up anyway.[3]

This is not a record of bad luck; it is a pattern and patterns have causes.

"Public inquiries are one of Britain's only growth industries," wrote Camilla Cavendish in the Financial Times in December 2023.[4] Between 1990 and 2017, 69 statutory inquiries were launched, compared with just 19 in the preceding thirty years; since 1997, there have never been fewer than three running simultaneously.[5]

The costs have escalated in step. According to analysis by the Institute for Government, the average statutory inquiry has ballooned from £8.2 million in the decade to 2014 to £69.4 million today, with the child sexual abuse inquiry costing £180 million over seven years, the Grenfell inquiry at least £170 million, and the infected blood inquiry £140 million. In 2023/24 alone, the government spent £130 million on inquiries running simultaneously.[5] The contrast with comparable democracies is instructive. As Cavendish noted, Japan and France resolved their own contaminated blood scandals – the same failure, the same era – with compensation paid and the matter closed.[4] Britain spent forty years obfuscating, handed the question to a judge, and is now facing a bill of up to £12.8 billion.[6] Shirking responsibility early has served neither victims nor taxpayers.

The mechanism is also structurally incapable of producing the accountability it appears to promise: unlike most European countries, where parliamentary committees initiate and oversee investigations with genuine independence from the executive, British inquiries are established by government ministers, who set the terms of reference, appoint the chair, and hold the power to close them early. The Netherlands completed three separate Covid-19 investigations between 2020 and 2023, with recommendations already being implemented.[4] The UK Covid inquiry's own timetable states that it will conclude its findings in 2027. Australia has long used implementation monitors – experts whose sole function is to ensure inquiry findings translate into real-world change.[4] Britain has never adopted the equivalent.

What the UK has built, without quite deciding to, is not an accountability mechanism. It is an accountability aesthetic – one that costs more with each cycle, takes longer with each cycle, and leaves the families inside each cycle waiting on a clock that runs entirely on the institution's terms, not their own.

The pattern

In 1987, the Herald of Free Enterprise capsized in the English Channel and 193 people died.[7] The subsequent inquiry found a systemic failure: officers who hadn't communicated, a culture that penalised speaking up, a company whose safety procedures existed on paper but not in practice. A framework was proposed, regulations were tightened. The lesson, everyone agreed, had been learned.

In 1999, Ladbroke Grove.[8] In 2005, Buncefield.[9] In 2017, Grenfell Tower.[3] In 2024, the infected blood findings.[2] In 2026, Nottingham maternity.[10] Between each of these, hundreds of smaller failures that never made the headlines but share the same anatomy: a warning that wasn't heard, a decision made under economic pressure, a human being whose concern was structurally incapable of reaching the person with the power to act on it.

The historian Gwyn Bevan has documented a century of this pattern in British governance.[11] A century. Each cycle produces the same sequence: crisis, inquiry, findings, framework, silence and then, eventually, another crisis with the same features as the last.

The question that Bevan's account, rigorous as it is, does not fully answer is: why? Not why did these failures occur – the inquiries answer that, painstakingly – but why does the pattern of failure persist across a century of learning? Why does a country that has now conducted some of the most thorough post-mortem analyses of systemic failure in the world keep producing the same thing it is analysing?

The answer is not that the frameworks are bad, they are often excellent. The answer is that frameworks cannot touch the thing that fails.

What actually fails

Read the Grenfell inquiry findings carefully and what you encounter, repeatedly, is not a story of ignorance or malice, though there is negligence and there may yet prove to be worse.[3] What you encounter is a story of human systems failing to function as human systems.

Residents who raised concerns through the proper channels and found that the proper channels led nowhere. Procurement processes that selected cheaper cladding because the human relationships that might have said *wait, this is wrong* had been replaced by contractual ones that only said *sign here*. Professionals who knew, in some part of themselves, that something was wrong but who were operating inside institutional structures that made that knowledge professionally dangerous to voice.

The Hillsborough inquiry found a police force whose command culture made it structurally impossible for information to travel upward accurately.[1] The infected blood inquiry found a medical establishment whose professional self-conception made it structurally impossible to acknowledge iatrogenic harm.[2] The Post Office Horizon scandal found an organisation whose legal and executive culture made it structurally impossible to consider that the software, rather than the sub-postmasters, might be wrong.[12]

In each case, what failed was not technical knowledge. What failed was the human infrastructure inside the system: the quality of relationships, the conditions for honest communication, the presence or absence of psychological safety at every level, the capacity of people under pressure to stay curious instead of defensive, to hold uncertainty without closing it down, to hear a voice from below the hierarchy rather than suppress it.

These are not soft skills. They are the load-bearing layer of every system that depends on human beings to function; which is to say, every system.

The error that keeps being made

After each failure, the response is structural and legislative. New bodies. New regulations. New competency frameworks. New codes of practice.

These things are not worthless; some of them prevent specific recurrences. But they share a common limitation: they operate at the level of behaviour and compliance, and they assume that if people are told clearly enough what to do, they will do it. This assumption has been falsified, repeatedly, across a century of

British governance. People inside complex systems under pressure do not primarily respond to frameworks. They respond to the relational field they are operating in: the quality of trust, the conditions for honesty, the degree to which their concern is structurally capable of being heard.

The most recent illustration of this error is a single sentence from the Southport Inquiry's findings, delivered on 13 April 2026 by its chair Sir Adrian Fulford.[13] Having traced the merry-go-round of referrals, assessments, case-closures and hand-offs through which Axel Rudakubana passed – each agency dealing with him in good faith, each passing him on, no one holding the whole – Fulford concluded: "This culture has to end."

It is a sentence that means everything and prescribes nothing. Not because Fulford is wrong – he is entirely right – but because culture is not a thing that can be directly ended, any more than it can be directly created. Culture is what emerges when the dispositional capacity of individuals, the structural conditions for their agency, and the shared narrative of purpose align, or fail to. It is the visible pattern produced by things that can change: the inner orientation of the people in the system, the architecture that enables or prevents them from acting, and the story that gives their action meaning. When those three things develop, the culture changes; as a consequence, not as a target.

Telling a culture to end is like telling a shadow to move while leaving the object that casts it in place. Every inquiry of the last century has, in effect, addressed the shadow. The object – the dispositional, structural, and narrative conditions that produce the culture – has been named, at most, in passing. It has never been the primary site of intervention.

You cannot regulate or framework your way to that. It requires something that no post-incident analysis has yet named as a policy recommendation, because it sits below the level at which policy normally operates: the deliberate, measured, longitudinal development of the human capacity to function well under genuine uncertainty.

Every inquiry names this absence in one register or another. None has found it, because finding it requires admitting that the problem is not structural. It is a problem of human growth and evolution which is slower, less visible, and less politically satisfying than a new framework.

The cost of not naming this

Margaret Aspinall has been campaigning since 1989 to get the truth about Hillsborough formally acknowledged.[14] Edward Daffarn warned publicly that Grenfell Tower was a fire risk a year before it burned.[15] Sir Brian Langstaff described the infected blood scandal as "the worst treatment disaster in the history of the NHS" – one that could and should have been identified decades earlier.[16]

Behind each of these names is a person who was functioning as the human infrastructure was supposed to function: noticing something wrong, raising it,

attempting to be heard. And behind each of them is a system that was constitutionally incapable of hearing them; not because the people inside it were wicked, but because the relational and developmental conditions for hearing had never been built.

The cost of not building those conditions is not abstract. It is measured in lives, in grief that has no proper object because accountability never fully arrives, in a civic trust that has been hollowed out inquiry by inquiry. And it is measured in the peculiar British cruelty of asking people to become their own advocates for justice while the system that failed them runs on its own clock, in its own language, at its own pace.

What formation requires

If the pattern is to be broken – not managed, not administered, but actually broken – something has to change at the level of how people who hold institutional power are formed. Not trained. Formed.

Training produces people who know what to do in the scenarios they have been trained for. Formation produces people who can think in scenarios they have never encountered, who can hold the complexity of a system that is failing around them and remain oriented to the human beings inside it rather than the institutional requirements above them.

This happens over time, in relationship, through sustained engagement with genuine difficulty – not simulated difficulty, genuine difficulty. It requires being confronted with the cost of getting it wrong in a way that is real enough to change something on the inside.

This is why the families matter; not as victims to be sympathised with, but as the most authoritative teachers of what is at stake. When an engineer trained to think about systems encounters the mother of a child who died at Grenfell, something becomes available in that room that no case study can produce. The stakes become real in the body, not just the intellect. The system the engineer has been taught to optimise suddenly has a face, a name, a grief that will not close. That encounter – structured, held, reflected upon – is formation. It is the learning experience that the frameworks were always trying to produce and could never reach.

An engineering student who has sat in that room, and thought carefully about what it means, and measured their own dispositional response to it, is not a different kind of engineer in the sense of having different technical knowledge. They are a different kind of engineer in the sense of being harder to capture – by cost pressure, by institutional hierarchy, by the professional cowardice that is just the ordinary human response to speaking up in systems that punish it. They carry something that makes the human infrastructure work. It is not guaranteed, nothing is. But it is the only thing that has any prospect of making the pattern different.

This is not an abstract proposition. Consider HS2: a programme that has now spent over £40 billion, whose governance failures have been documented in three successive independent reviews, and which the Public Accounts Committee called in 2025 “a casebook example of how not to run a major project.”[17] Engineers are debating it in their thousands on LinkedIn, applying their professional toolkits – contract structures, risk allocation, procurement design, political interference – to diagnose what went wrong. They are right about all of it, and they are missing something. The CEO of HS2 Ltd himself identified the root cause not as a single decision but as “a build-up of vulnerabilities over time, compounded by insufficient timely intervention.”[18]

Years before that reckoning, a professional services firm had been engaged to do precisely the diagnosis meant to catch it. It built an industry-first framework to assess the organisation's delivery capability, and by February 2020 had signed off all twenty-four assessed capabilities as having reached target maturity.[19] In 2025, the current CEO named delivery capability – the very thing that framework had certified – as one of three root causes of the cost and schedule crisis.[20] That is not proof the assessment failed; HS2's problems are multi-causal. But it is the argument in miniature: a capability assessment without a validated instrument underneath it cannot tell you whether that capability holds under years of sustained pressure. Warnings that couldn't travel upward. Decisions driven by political schedule rather than engineering reality. A system that couldn't hold uncertainty honestly because the human architecture for doing so was never built.

If you are one of those engineers commenting on LinkedIn, the question this essay puts to you is not whether your diagnosis is correct; it almost certainly is. The question is what you were formed to see, and what you were formed not to see. The contract structures, the risk allocations, the procurement designs: these are the things your training equipped you to read fluently. The human layer beneath them – the warnings that didn't travel upward, the meeting where someone knew and didn't speak, the cost pressure that quietly reshaped a hundred decisions before any of them reached your desk – these are the things your training equipped you to treat as background. They are not background: they are where the failure lives. And the next system you sign off on will fail in exactly that place, unless something changes about what you attend to.

Britain is not short of analysis; the inquiries are among the most thorough post-mortem processes in the world. What Britain is short of is formation: the deliberate, serious, longitudinal development of the human capacity to function inside complex systems in ways that keep the human being – the resident, the patient, the sub-postmaster, the child – structurally audible.

This means taking human infrastructure as seriously as physical infrastructure. It means measuring it, governing it, resourcing it as a load-bearing layer, not an optional add-on. It means accepting that the timeframe over which humans grow and evolve is months and years, not a two-day workshop, and funding accordingly.

It means, most immediately, that the institutions that form the people who will lead and manage and engineer the next generation of complex systems – the universities, the professional bodies, the public sector leadership programmes – need to include in their formation the unmediated encounter with what it costs when the human layer fails. Not the PowerPoint about Grenfell, the person who was there.

The inquiry findings are the curriculum, families are the faculty. The question is whether there are institutions prepared to receive that teaching in the seriousness it deserves, and to build, from that encounter, the kind of formation that might, eventually, make the next inquiry unnecessary.

It has happened before, once, in the same kind of programme.[21] At Hunter Water in Australia, under the chief executive Jim Bentley, a group of infrastructure leaders went through what the organisation called a Learning Journey – a sustained, relational process, not a workshop. The board built in something that most institutions claim to want and almost none actually build: genuine permission to fail. Innovation Challenges were framed as experiments, and when some of them fell short of their own targets, that outcome was named openly, examined for what it taught the team, and folded back into the next round of work. No one's career quietly paid the price for an honest attempt at something hard.

The measurable result, across successive cohorts, was that leaders began proposing harder, riskier, more interesting work than the culture would previously have permitted – not because anyone told them to, but because the space of what could be tried had genuinely widened.

Then something happened that no framework asked for. The leaders who had been through the Journey – who had spent months being treated by their peers and their own senior team as people with histories and stories, not roles to be optimised – began asking a question of their own: could the utility treat its customers the same way? The standard model for a water utility managing customer behaviour is top-down: rules, warnings, restrictions, fines, the regulator's voice delivered downward to the household. The leaders who had just been formed by a different kind of relationship wanted, instead, to hold a learning conversation with the community they served.

Australia's National Performance Report 2019-2020 states leakage in the Hunter region was down 34% across three years and consumption down 10.8% year-on-year rising to 15% below baseline by year three. This was the largest year-on-year drop of any urban utility in the country, against a comparable utility elsewhere in Australia that saw consumption rise over the same period.[22]

This is the moment the HS2 engineers on LinkedIn are one encounter away from. Not a diagnosis correction. A change in what a person, having been treated differently themselves, decides the people below them in the system deserve.

It is a small case which did not end a national pattern, but it is exactly what the strongest objection to all this demands: a place where the counter-move was not absorbed, where formation reached all the way down to how power was actually exercised over the people the system existed to serve.

None of this is settled. The argument that human infrastructure is a load-bearing part of a system, not a soft layer around it, is still being made – right now, inside the very infrastructure sector Hunter Water belongs to – against models that have no cell in their architecture for a relationship, only for entities. The people making that argument are met, still, with the same instinct to separate the human layer out and set it aside that produced Grenfell, HS2, and everything this essay has named. That the argument still has to be made is not a weakness in the case; it is the case, confirming itself in real time.

A meeting at a GP practice[23]

A person I know spent months reading patient survey responses for a GP practice they were closely involved with. Not skimming them. Reading them – hundreds of free-text accounts of what it was like to try to access care, to be triaged, to be referred, to be followed up, to fall through the gaps between one part of the system and another. They convened a working group. They read the responses together. They identified patterns: not isolated complaints but structural signals, recurring dynamics, the kind of thing that only becomes visible when you read enough accounts to see the shape underneath each individual story.

What they found was not negligence. What they found was a system – well-intentioned, staffed by people trying to do their jobs – that was producing harm in the gaps between its own parts. Access shaped triage. Triage shaped continuity. Continuity shaped communication. Communication shaped trust. No single person was responsible. The system was responsible. And the system, left unexamined, would go on producing the same signals in next year's survey as this year's, and the year after that.

They presented the findings to the practice's senior staff. They did so carefully, rigorously, in the language the NHS itself had provided: its own patient safety policy, which states explicitly that improving safety requires improving the safety of systems of work, and not focusing on individuals.[24] They were not freestyling; they were doing exactly what the national policy framework asks patient participation groups to do.

The meeting did not go well.

What the practice heard

A working session that had been arranged to take place face-to-face was moved online at the last minute. The patient group was not consulted, they were informed.

In the meeting a senior member of staff described the safety framing as approaching what amounted to a statement of medical negligence. A second

senior colleague suggested that without proof of harm in a specific, verifiable individual case, the signals could not be acted on. The systems map – showing several mutually reinforcing patterns – was received as a list of items to be accepted, deferred, or challenged one by one. The conversation was redirected to a more junior colleague who would “take it forward.”

It was, on the surface, a difficult meeting that hadn't gone well. These things happen. But something else was also happening, and they named it afterwards, in words they put down with precision: the meeting didn’t fail to take in what they’d found. It repeated it.

In the room, between the practice and its own patient body, the precise dynamic that hundreds of patients had described in their own words was replayed in real time. The closing of ranks before listening. The conversion of structural critique into communication problem. The dismissal of unverified accounts as if their unverifiability rendered them silence, not signal. The redirection of substantive engagement to a more junior colleague. The pretence of partnership while preserving the asymmetry of who decides what is real. Every one of these was documented in the survey. Every one of these happened in the meeting. The meeting had become part of the data.

The epistemology of the closed system

This is not a story about a bad GP practice; the practice is, by most measures, a conscientious one. The people in that meeting were not indifferent to their patients. They were operating inside a professional epistemology – a way of knowing what counts as real, what counts as evidence, what counts as a legitimate claim on their attention – that had been built over decades of clinical training, regulatory requirement, and institutional culture.

Inside that frame, the patient survey data had a limited status. It was feedback. It was qualitative. It was unverified. It could not, without individual case evidence and a named responsible party, constitute an actionable safety signal. This is not wilful blindness, it is the individual approach to patient safety that the NHS strategy says must be moved away from; the approach that focuses on specific incidents involving specific people rather than on the structural conditions that produce incidents at scale.

The practice, in other words, was operating inside the model the national policy is explicitly trying to displace. And it was doing so not cynically but structurally, because that epistemology is embedded in clinical training, in medical defence culture, in the instinct to reach for “who did what” before “what conditions made this possible.”

What the patient working group was offering was something the system did not yet have the architecture to receive. Not better feedback: a different way of knowing.

This is not a healthcare story

I want to dwell on that phrase – a different way of knowing – because it is the key to why this story matters beyond the individual surgery where it happened.

The NHS Patient Safety Strategy's distinction between the individual approach and the systems approach is not a healthcare-specific insight. It is a description of two fundamentally different epistemologies for understanding how things go wrong in complex organisations – and the conditions under which human beings inside those organisations can be heard.[25]

The individual approach – find the person responsible, verify the incident, assign accountability – is not wrong; it catches some things. But it is blind to the category of failure that now produces most serious harm in complex systems: the failure that emerges from the interactions between parts that are each functioning as designed.

Grenfell, Hillsborough, the infected blood scandal: none was produced by a single negligent decision, but by a system whose parts – regulatory bodies, procurement processes, professional cultures – were each operating within their own institutional logic, with no layer above capable of holding the whole and asking what it was producing for the human beings inside it.

The families who campaigned for decades to have these failures properly understood were, in a very direct sense, doing what that patient working group was doing. They had evidence. They had patterns. They had hundreds of responses – or their equivalent, multiplied across years and bereavements and failed appeals. And they were told, repeatedly, in different registers and different rooms: this is not the kind of evidence we can act on. Bring us a named individual. Bring us a verified incident. Bring us something our system can process.

The Hillsborough families waited twenty-three years.[1] The infected blood families waited forty.[2]

Last minute switch

There is a detail in that meeting that's important: the switch to an online meeting at the last minute.

Working sessions on substantive, difficult material are not moved online at two hours' notice by accident. They are moved that way when one party needs to control the temperature of the room – to limit the duration of engagement, to retain the option to disengage cleanly, to prevent the kind of extended, uncomfortable, generative encounter that face-to-face sitting with difficult data sometimes produces.

It is a small thing. It is also, in miniature, a form of institutional self-protection that operates at every scale. The public inquiry that runs for a decade is, in one reading, the national-scale equivalent: the appearance of taking the thing seriously while structurally managing its consequences. The distance is different, the mechanism is the same.

What both have in common is that they maintain the form of engagement while controlling its consequences. And genuine encounter – the willingness to sit with evidence on its own terms, to be changed by it, to let it surface something you didn't already know, and then to act on the human infrastructure it exposes – is precisely what systems that fail their human beings do not carry through. The encounter itself sometimes happens – the Ockenden review met the humans inside the story, and the human impact. What reliably fails is the follow-through. It is also, not coincidentally, precisely what they would need to do in order to stop failing them.

Not a report. A mirror.

The person who read hundreds of patient responses was not, in the end, offering the practice a report; they were offering it a mirror.

The systems map – the several mutually reinforcing patterns that they and their working group had identified – was a map of the system the practice had built, seen from the inside by the people living inside it. Not a criticism, a reflection. An invitation to look at what the system was producing and ask whether that was what anyone had intended.

This is what patient participation is supposed to be. It is also, when done well, a form of the developmental human infrastructure that complex organisations need and rarely build: a structured way of receiving information about yourself from people whose relationship to you is constitutively different from your own. People who experience the system as it lands, not as it was designed.

Receiving that information requires something specific. Not just professionalism, not just goodwill, not just the right policy, though all of those help. It requires a particular quality of relational openness: the capacity to be genuinely uncertain about whether you are right, to hold the discomfort of being told that your system is producing something you didn't intend, to remain curious instead of defensive in the face of evidence that implicates you.

This is a dispositional quality.[1] It develops over time, in relationship, through sustained practice of exactly the kind of encounter the practice avoided by moving online. It is not a competency you can framework your way to. It is something that has to be cultivated: in individuals, in teams, in the professional formation of everyone who will one day sit across a table from people trying to tell them that their system is harming someone.

We are living through a period in which British institutions are being forced, inquiry by inquiry, to confront what they have produced. The findings accumulate. The recommendations are implemented, or not. The next failure occurs.

[1] 'Dispositional' is used here in the Aristotelian sense of hexis (ἕξις) – a stable, active disposition, distinct from an innate capacity (dynamis) or a passing state (diathesis). For Aristotle such dispositions are formed through repeated activity – we become just by doing just acts, temperate by doing temperate acts – until acting well becomes a trained capacity that no longer requires deliberation. (The Latin habitus, used by the scholastics, translates the same idea.)

The missing piece is not more rigorous post-mortem analysis. The missing piece is the formation of people who can receive difficult evidence – about their own systems, their own practices, their own professional habits – without the defensive conversion that turns structural critique into communication problem, systems evidence into individual incident, patient voice into feedback to be managed.

That formation begins earlier than the boardroom. It begins in professional training – in the architecture of how doctors and engineers and civil servants, accountants and managers learn to know what they know and to encounter what challenges it. And it requires, at its heart, something that no competency framework has ever been able to specify: the genuine, unmediated encounter with what it costs when a human being cannot be heard by the system that is supposed to serve them.

Not a case study or a PowerPoint. Not a trigger warning and a managed discussion. The person, in the room, telling you what happened to them when the system closed against them.

The person who put hundreds of patient responses into a systems map and sat in an online meeting while the practice received it as a list – they are that person. So is every family that has ever sat across a table from an institution that could not yet hear them.

The question is whether we are building the institutions, the programmes, and the formation processes capable of receiving what they are offering, before the next inquiry is necessary to make it impossible to ignore.

How care became unspeakable

Something happened in Britain in the late 1970s – not only a political or economic shift, though it expressed itself in both, but a change in the legitimating grammar of public life: the language in which decisions had to be justified to be taken seriously, the way of knowing by which institutions recognised what was real. Before it, a case could be made in terms of community, solidarity, collective welfare, and be heard as serious in the rooms where decisions were made. After it, those terms required translation into economic ones to carry weight. The market became not just a mechanism but a way of knowing.

This is about what that shift did to the relational infrastructure that makes institutions capable of functioning humanly – the capacity to attend to persons, to hold the complexity of their experience, to be changed by what they bring. That infrastructure did not disappear, but it was devalued, defunded and eventually rendered almost inaudible in the registers institutional power responds to.

Add and stir

In 2015, the educator and writer Elizabeth Debold published a reflection on fifty years of the women's movement.[26] Her central observation was precise and devastating: the idea that you could add women to public life and change the

world had been naïve. What actually happened was the opposite; not only did the entry of women into professional and political institutions fail to disrupt the values of those institutions – it devalued the sphere those women had come from.

The private sphere of human intimacy and care – the domain that had historically, however unjustly, been associated with women – did not gain status when women left it for the public world. It lost what status it had. The work of relationship, of attention, of the slow labour of growing human beings, was simultaneously vacated by professional women and abandoned by institutions that had never valued it.

Debold calls this the neoliberal takeover of feminism.[24] The goal of equality was redefined – quietly, structurally, without anyone quite deciding to do it – as the equal right to participate in the existing system on the existing system's terms. Women were invited to lean in, whilst the system remained standing.

What was lost in this process was not only justice, though it was that. What was lost was the possibility that the entry of a different kind of person into public institutions might bring a different kind of knowing with it.

That possibility was not defeated in argument: it was absorbed. The master's tools, as Audre Lorde had warned, did not dismantle the master's house.[27] They furnished another room in it.

From the late 1970s onwards, British public institutions were progressively rebuilt around a particular logic: the audit culture, the target regime, the competency framework, the performance indicator.[28] The NHS internal market. New Public Management. The privatisation of public goods. The outsourcing of human services to providers whose accountability was contractual rather than relational. Each was an architectural decision that made one way of knowing structurally dominant – the kind that strips out the relational, the contextual and the particular, and renders what remains visible to a system that can only process objects.

The consequences were predictable and predicted. When you organise institutions around the measurability of objects rather than the complexity of persons, persons become objects. Not through malice, through the grammar of the system. A patient becomes a waiting list position. A resident becomes a service user. A student becomes a data point in a performance table. A sub-postmaster becomes a unit in a productivity system; and when the productivity system says they are wrong, the system is right, because the system is the legitimate knower and the person is just an input.

This is what instrumentalisation means. Not that people are deliberately treated as means, but that the institutional architecture processes them as such regardless of anyone's intentions.

The shame of care

There is a British dimension to this that is not purely structural. It is cultural, and it is about shame.

Somewhere in the decades between the Thatcher reforms and the austerity programmes of the 2010s, care became embarrassing in professional and leadership culture. Not care as a private sentiment – people were permitted to care about their families, their health, their own wellbeing. But care as a professional register, care as a legitimate basis for institutional decision-making, care as a value that could be named in a boardroom or a policy paper without requiring immediate translation into economic terms: this became associated with a kind of weakness, sentimentality, or pre-modern naivety that serious, rigorous people did not traffic in.

The vocabulary that arrived to replace it is revealing. Human resources. Human capital. People assets. Talent management. Each of these terms performs the same operation: it acknowledges that human beings are present in the system, while encoding them as instrumental to purposes that are defined elsewhere. You manage talent. You deploy capital. You resource a programme. The human being who has a history of learning and growth, a relational context, a particular way of engaging with uncertainty and difficulty – this person is not the unit of analysis. Their visible outputs are.

The leaders who navigated this culture most successfully were often, for understandable reasons, those who had most thoroughly internalised its grammar. The result was not a generation of uncaring leaders but something more insidious: a generation of leaders for whom care had become professionally unspeakable; present in their private lives, suppressed in their professional ones, and systematically absent from the institutional architectures they inherited and reproduced.

What got lost was not only leaders' capacity to care. What got lost was the institutional capacity to receive care; to be changed by the evidence of human experience, to hold the complexity of what people bring, to remain genuinely uncertain in the face of evidence that implicates the system. When care is unspeakable, the systems built by leaders who cannot speak it are constitutionally closed to the human beings inside them.

A different system

The temptation, when faced with this analysis, is to propose adding care back in. More empathy training. More wellbeing programmes. More diversity and inclusion initiatives. More frameworks that include the human dimension alongside the technical and managerial ones.

This is the add and stir error, repeated. These interventions are not worthless: some of them prevent specific harms. But they operate within the existing frame rather than challenging it, and that frame absorbs them. The patient participation group that receives genuine data from hundreds of people and converts it into a list of feedback items.

The alternative is a different account of what institutions are for: one that starts not from the clarity of outputs but from the psychosocial complexity of human experience and treats the relational field – the quality of trust, the conditions for honest communication, the capacity to hold uncertainty without collapsing it – as the primary variable in whether institutions function humanly. This is not care added to efficiency; it is a different account of what efficiency requires.

What it would take

Is the pattern of inquiry, framework, absorption, recurrence truly inescapable?

I don't think it is, but I think the conditions for a different outcome are narrow and demanding.

It requires formation, not training; the deliberate, longitudinal development of people who can operate inside complex systems without being wholly captured by them. People who have been genuinely changed by encountering what it costs when the human layer fails, who carry that encounter as a dispositional orientation rather than a remembered case study.

It requires structural weight, not rhetorical presence; human infrastructure that has a budget line, a governance role, a procurement requirement, a senior person whose professional future depends on whether it performs. Not a module in the leadership programme. The operating system of the organisation.

It requires a different legitimating grammar; one in which the relational field is a primary variable rather than a soft background condition, in which evidence of human growth and learning is taken as seriously as financial evidence, in which the testimony of a person living inside a failing system is processed as intelligence rather than complaint.

And it requires, perhaps most fundamentally, the willingness to name what has happened. To say clearly that the last forty years of institutional design produced systems that are constitutionally closed to human experience, and that this is not a bug to be patched but an architecture to be rebuilt. To refuse the add and stir solution and insist on a different model.

But the inquiries accumulate. The bills mount up. The pattern is visible enough that even the systems that produced it are beginning to recognise it. The question is whether recognition, this time, produces formation, not another framework.

The master's house will not dismantle itself. But it is possible – it has always been possible – to build something alongside it that works differently. Something that starts from the right question: not what can this person produce, but what does this person need in order to grow and evolve? Not how do we make the system readable, but how do we make the system worthy of the human beings inside it?

That is what human infrastructure means. And it is, now, urgent.

Twelve sessions

What follows is a set of facts.

On 29 July 2024, a 17-year-old walked into a Taylor Swift-themed dance class in Southport and killed three little girls: Alice da Silva Aguiar, aged nine; Elsie Dot Stancombe, aged seven; Bebe King, aged six.[13] He seriously wounded ten others. He stabbed a businessman who put himself between the attacker and the children. He left a dance teacher with injuries she will carry for the rest of her life, and a guilt she described to the public inquiry as crushing.

The parents of the children who survived rushed to the studio. Some found their children gravely injured nearby, others searched the building in chaos and horror, not knowing. Several now live with post-traumatic stress disorder: flashbacks, night terrors, the body's refusal to accept that the worst moment is over.

These parents were entitled to twelve counselling sessions from the charity Victim Support.[29]

Twelve sessions. Not with a specialist psychiatrist – with a counsellor. For parents who had run into a building full of stabbed children searching for their own.

Daisy's father was refused more sessions because there was no funding. Daisy's mother described what the family had been forced to do: ration the sessions, hold some back. Not use them immediately, when the trauma was raw and screaming for attention, but save them – for the criminal trial, for the public inquiry, for the institutional moments when the system would need them to perform their grief.[30]

“Our experience has been more frustrating than we would have liked,” she said, with a restraint that should shame every person who made the funding decision she is describing. “It's hard to have to justify why you're traumatised, and really quickly we realised the basic counselling offer was not fit for purpose for what we had gone through.”[28]

Hard to have to justify why you're traumatised. To whom? By what measure? In what register does a parent need to explain that watching their child be carried out of a dance class has caused them suffering?

In the register of the system. The system that processes grief as a resource, trauma as a cost to be managed, and healing as something that requires a funding line before it can be authorised.

Now some other numbers.

The riots that followed the Southport attack – fuelled by disinformation, by far-right mobilisation, by a country whose grief had nowhere legitimate to go – resulted in £2 million in compensation claims.[31]

Public inquiries in Britain cost, on average, tens of millions of pounds. The Grenfell inquiry cost over £170 million. The infected blood inquiry ran to over £140 million.[5] The Chilcot inquiry into the Iraq war cost £13 million.[32] These are not criticisms of the inquiries. They are a measure of where the system's attention

goes: an unlimited effort to understand what went wrong, and almost no equivalent effort directed at the people it went wrong for.

The families most directly harmed by the Southport attack were offered twelve counselling sessions each. The inquiry examining the systemic failures that preceded the attack will run for years at a cost no one has thought to cap. The support offered to the people it harmed was capped before it began, at twelve.

This is not a coincidence. It is the grammar of the system, made visible in its starkest form.

The grammar works like this.

The inquiry produces findings: these are recordable, institutional, archivable. They can be acted on, or not acted on, but they exist in a form the system can process. They have authors, chapter headings, recommendations, a publication date. They cost what they cost because the cost is recoverable in institutional terms: the money flows through established channels, it is auditable, it produces a product.

The psychological recovery of a bereaved parent produces nothing the system can process. It is interior, relational, slow, particular. It does not generate findings. It cannot be audited. It has no publication date. It is, in the grammar of the system, a cost without a product: and in a market logic, costs without products are costs to be minimised.

Daisy's mother was not refused adequate support because anyone decided her suffering didn't matter. She was refused it because the system does not have a category for her suffering that would trigger the funding required to address it. Twelve sessions is what the category allows. The category was designed without reference to what parents who run into buildings full of stabbed children actually need. It was designed around a budget line, and the budget line was designed around what the system could afford to acknowledge.

This is what instrumentalisation looks like at ground level. Not malice, a logic that cannot see persons; only cases, categories, funding streams, and the countable costs attached to each.

The Hillsborough families waited twenty-three years.[1] The infected blood families waited forty.[2] The Windrush victims – many of them elderly, many of them dead before the compensation scheme began to pay out – are still waiting, in some cases, for acknowledgement of what was done to them.[33]

In each of these cases, the families did not receive justice slowly because the system was cruel. They received it slowly because the system was organised around a different way of knowing; one in which their experience was not, in itself, sufficient evidence of anything. It required translation, into verified incidents. Named individuals. Documented harm with a clear causal chain. The kind of evidence that the system's grammar could process. The kind of evidence

that takes decades to assemble, while the people it is assembled from age, and grieve, and in some cases die before the findings land.

The parents of children murdered in Southport have entered the system knowing that the inquiry will take years. They are rationing their counselling sessions in preparation for the institutional moments that lie ahead: the trial they have already been through, the inquiry that is running now, whatever comes after. They are managing their own psychological collapse around the calendar of institutional process, because the system needs them functional at specific moments and does not particularly require them to be healed in between.

This is not an accident of poor policy design. It is the predictable consequence of a fifty-year shift in what British institutions think human beings are for.

Everything up to this point has been argument: about the structural causes of this shift, about the way of knowing that produces it, about what formation and human infrastructure would need to look like to begin to change it. Those arguments stand, and they matter.

But sometimes the argument should stop, and the fact should simply be named.

Daisy's mother had to justify why she was traumatised and was still refused the support she needed.

Her daughter survived a mass stabbing at a dance class. Three of her daughter's companions did not.

There is nothing in that sentence that requires a framework to process. There is only a person, a loss, and a system that looked at her grief and said: twelve sessions.

That is the bill. That is what this language costs, in the end – not in billions, not in inquiry fees, not in the accumulated expense of forty years of findings that changed nothing – but in a parent sitting in a counsellor's office, counting the sessions she has left, saving some back for when the institution will need her to perform her loss in a form it can use.

The Hillsborough Law, passed this week, is a real answer to part of this. A duty of candour will make it harder for officials to lie to the bereaved, and that matters. But it legislates honesty; it cannot legislate the change in culture the families themselves asked for. And it arrives, as these things do, after the harm – a rule for the next inquiry, not a change in the disposition that keeps producing them.

The Southport Inquiry chair said this culture has to end. He is right. But it will not end while a system can spend decades and millions understanding failure without the people it failed ever entering the account as anything but a cost to be contained. Until the human layer is itself the primary site of intervention – resourced and governed, not just investigated once the harm is done – the culture will not end. It will produce the next inquiry. And that inquiry will do what Burnham warned the state does to the bereaved: re-traumatise them – requiring

them to relive their worst days on its own timetable, rationing their grief to stay functional at the moments the process demands.

And somewhere, another parent will be counting the counselling sessions she has left.

Victoria Ferrier is the CEO of WILD Learning Sciences CIC. This essay was inspired by Josh Halliday's reporting of the Southport attacks in The Guardian, particularly this article on the 22nd of May 2026: https://www.theguardian.com/uk-news/2026/may/22/victim-commissioner-southport-attack-parents-support The opening and closing sections draw on The Guardian's reporting of the passage of the Hillsborough Law on the 14th of July 2026: https://www.theguardian.com/football/2026/jul/14/burnham-hails-hillsborough-law-rewiring-state-mps-approve-bill

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of the 11,759 claims lodged had resulted in a payment. The average successful award was approximately £32,100 (NAO).

A Note on WILD Learning Sciences

WILD Learning Sciences CIC is a community interest company founded on Professor Ruth Deakin Crick's twenty-six years of peer-reviewed research into Learning Power, adaptive capacity and dispositional development. Learning Power is defined as the collection of psychological dispositions – involving thinking, feeling and doing – that enable a person to engage effectively with uncertainty, challenge and change: the measurable interior capacity that determines whether people and systems can learn their way forward when no prior model applies. Its mission: WILD restores humanity to systems that have forgotten it.

CLARA (Crick Learning for Resilient Agency) is WILD's primary psychometric instrument, measuring Learning Power across eight dimensions. The primary validation study is Deakin Crick, Huang, Ahmed-Shafi and Goldspink (2015), with structural equation modelling fit statistic RMSEA = 0.035. The instrument has been deployed across more than 100,000 participants in approximately 200 organisations across six countries.

The intellectual property underlying CLARA and the Learning Power framework is held permanently by WILD Learning Sciences CIC under a statutory asset lock, ensuring it remains in community ownership and cannot be extracted for private benefit. This structure is intentional: it protects the long-term integrity of the research and ensures that commercial applications of the framework remain accountable to its founding purpose.

Researchers and journalists seeking access to the full evidence base, unpublished longitudinal datasets, or the current research programme should contact WILD Learning Sciences CIC directly via wildlearn.co.