

A Mass Sports Disaster— Hillsborough Ten Years on: An Overview of the Legal Processes and Outcomes

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Abstract

This paper aims to provide an overview of the legal processes and outcomes which have followed in the wake of Britain's worst sporting disaster. It begins with a brief outline of the day of the disaster and a summary of the legal processes which have followed over the last ten years. A detailed report follows of the first major legal investigation, the Lord Justice Taylor Public Inquiry, with a focus on the Interim Report of the events and causes of the disaster, locating the material within the first five of the phases of a disaster theorised by Scruton *et al* 1995. This is followed by a report on the outcomes of any criminal liability for statutory duties or reckless manslaughter and an overview of the inquests. The civil claims for death are followed by precedent setting easements for post-traumatic stress disorder from both families of the disaster victims and police officers who had worked at Hillsborough. Other legal processes include the landmark House of Lords judgement which allowed the 96th victim of Hillsborough to be allowed to die, the lack of any disciplinary charges against any police officer, the issues around press and media coverage and the Scrutiny of Evidence related to Hillsborough which reported in 1998. The paper concludes with a summary of the outcomes and issues

raised by such legal process. This material is part of a Socio-legal Phd thesis, analysing the Hillsborough and Marchioness disasters (in sport and leisure) conducted by the researcher, using document analysis and interviews. Within the word limit of this article, it was only possible to briefly report the outcomes of the legal processes of this complex and controversial disaster but reference is made where possible, to sources of critical commentary.

Introduction

On a sunny day on April 15th 1989, thousands of soccer fans made their way to an FA Cup semi-final at Hillsborough Football ground, Sheffield, England [1], regarded as a "perfect venue for all kinds of important matches" [2]. Yet, at this perfect venue, 95 people lost their lives. 88 victims were male, 7 female; 39 were under the age of 20 (the youngest 14); 39 were between the age of 20 and 29 years and only 3 were over 50. In virtually all cases the cause of death was crush asphyxiation [3] (Taylor LJ 1989:18). 730 people were injured and thousands were traumatised, including soccer fans, bereaved families, emergency personnel and police officers.

On the day of the Hillsborough disaster there was a buildup of fans on the narrow Leppings Lane approach road to the ground and serious

congestion between the railings and the turnstiles between 2.00pm and 2.45pm on the day of the disaster (see Appendix 1: Hillsborough stadium West End). The match, due to be kicked-off at 3.00pm was not postponed. In order to relieve the dangerous pressure outside, senior police officers ordered a wide concertina gate C to be opened at 2.54pm and in the next 5 minutes, 2000 fans made their way into pens 3 and 4 behind the goal area (see appendix 2). However, the crowd capacity had not been monitored in these pens and they were already packed beyond capacity well before 2.54pm.

When gate C was opened, officers and club officials were not informed and there were no risk management strategies to divert the fans away from the tunnel, into the nearly empty side pens 5 and 6. The match kicked-off as Liverpool fans were dying or dead, held in an upright position, like a vice, crushed against the small wall and a 14' high perimeter fence. At 3.04pm when a Liverpool player hit the cross bar at the other end of the pitch, a crush barrier at the front of pen 3 collapsed, increasing the pressure and projecting people forwards and downwards. At 3.05pm the match commander ordered dog handlers and operational support to the Leppings Lane end of the pitch, since he still thought he was dealing with an attempted pitch invasion, as fans tried the escape from the crush through the gates and over the fence and were pushed back into the pens, since police orders focused on crowd control at all times [4]. At 3.06pm the game was finally abandoned yet there were delays in calling and communicating with the fire service and the arrival of the major accident vehicle. 90% of those who died were located in pen 3, with a small number in pen 4.

In the ten years since this disaster, the legal response has seen a Public Inquiry conducted by Lord Justice Taylor in 1989, a range of civil compensation cases for physical injury, death, pre-death trauma and post-traumatic stress disorder from 1990-1998 and the longest inquests in English legal history. This was followed, in 1993, by a precedential case related to the withdrawal

of feeding and hydration from Hillsborough's 96th victim, Tony Bland, who had been in a persistent vegetative state since the disaster, and a judicial review application to quash the inquest verdict. In the last two years the Home Secretary ordered an independent scrutiny of evidence relating to the inquests, the Inquiry and the decision of the Director of Public Prosecutions (DPP) that no charges would be brought against any individual or organisation for reckless manslaughter in relation to the Hillsborough disaster. This scrutiny by LJ Stuart-Smith began in 1997 and reported in 1998.

The Public Inquiry by Lord Justice Taylor in 1989

Lord Justice Taylor was appointed in April 1989 to carry out a public inquiry into the Hillsborough disaster. The terms of reference were:

To inquire into the events at Sheffield Wednesday Football Ground on 15 April 1989 and to make recommendations about the needs of crowd control and crowd safety at sports events (Taylor LJ 1989:para 1).

At the start of the investigation by a West Midlands Police team [15], 28 phone lines for members of the public who wished to tender evidence, were open for 6 days, receiving 2,666 calls, followed by 2,776 statements taken and 1550 letters to ministers and 71 hours of video-tape film from SWFC and the BBC. The Interim phase of the inquiry began its oral hearing on May 15th 1989 and was completed on June 29th and heard 174 witnesses, whose evidence was not sworn under oath [6]. Although the terms of reference focused on events on the day of disaster, LJ Taylor took a very revealing, long term view of the causes of the disaster, analysing the involvement of the police, the local authority, Sheffield Wednesday Football Club and its safety consultants, the emergency services and the fans themselves. This report was very illustrative of theoretical and empirical research which conceptualised disasters, not as unforeseeable 'acts

of god', caused by the last person in the chain of circumstances, but as the failure of systems over years of complacency (Turner 1978; Horlick-Jones 1990; Scraton et al 1995; Hartley 1997b).

Long Term History

In January 1979 Hillsborough became a designated ground under the Safety of Sports Grounds Act 1975 [71- Dr Eastwood, the newly appointed club safety consultant, recommended a number of additional crush barriers in the Leppings Lane (West) terraces, since those in place were insufficient to comply with the 1986 Guide to Safety at Sports Grounds, known as the 'Green Guide' (see appendix 2)[8]. In line with their regulatory role, South Yorkshire County Council set up an officer working party (safety advisory group) [9] which granted a general certificate to Sheffield Wednesday FC, identifying 10,100 as the maximum number of people allowed in the Leppings Lane terraces and a maximum packing density of 27-54 persons per square metre. In 1981 Hillsborough hosted an FA Cup semi-final match where the late arrival of fans led to crowd density problems and crushing, resulting in 38 broken limb injuries. The maximum capacity had been exceeded by 400, the police had shut off access to the tunnel and pens and later formally complained, in writing to the club that "the capacity figure for Leppings Lane... was too highthis was not pursued" (Taylor LJ 1989:22,para 124).

In the same year the police requested and were granted radial fencing to divide the terrace into sections whilst a request by Dr Eastwood, to "provide separate access through separate banks of turnstiles enabling each area to be monitored separately, was not adopted" (Taylor LJ 1989:27, pare 126). In 1985 Sheffield Wednesday FC was promoted to the first division and therefore would host larger matches. Dr Eastwood recommended separate access and more turnstiles at Leppings Lane but was refused, as police requests for radial fencing, creating pens 3 and 4 behind the goal, a new perimeter track gate and a

sterile area in pen 5 behind the goal, for reasons of crowd control and segregation of fans, were provided (Taylor LJ 1989:22,see appendix 2)[10]. On May 11th 1985, 56 spectators died when fire broke out in a wooden stand at a match at the Valley Parade ground of Bradford City FC [11] and, in the Public inquiry by Mr J Popplewell which followed, the importance of access and egress was emphasised, with recommendations for normal evacuation in eight minutes and emergency evacuation in two and a half minutes (Popplewell 1986; Hartley 1997b).

Statutory regulation of health and safety depends on those who implement it and the resources provided to support them (Hartley 1997b). In 1986 as a result of the reorganisation of local authority boundaries South Yorkshire County Council handed over the safety certification and inspection to Sheffield City Council. A Mr Bownes took over and assumed that the previous authority had fulfilled their duties adequately, but the Taylor inquiry revealed that there had been problems with certification duties from 1984 onwards [12] and could not get a clear answer from Mr Bownes during questioning as to who was actually chairing the Officer Working Group. LJ Taylor also noted that Mr Bownes already had 32 licensing systems when Hillsborough was added to his burden, with a staff of only five people:

I fully accept that the addition of further statutory responsibilities to the already heavy workload of a local authority with curbs on expenditure creates problems. But it is clear that the attention given to this important licensing function was woefully inadequate (Taylor LJ 1989:27, pare 159).

Soon after the appointment of Mr Bownes, the South Yorkshire Police requested the removal of barrier 144 at the top of pens 3 and 4 near the tunnel at Leppings Lane terraces and this was immediately granted [13]. Each of the alterations to the ground in the 1980s had had a significant effect on health and safety require-

ments of the 1975 Act since the terrace had been “divided into a number of small areas with no means of mechanically monitoring the number of people in any one area, if it was open access” (Taylor LJ 1989:22, para 134).

Furthermore, the capacity of the West terrace, set at 10,100 had not taken account of two further departures from the Green Guide; some 40% of those in pens 3 and 4 were more than 12m away from an exit; there was no gangway and crush barriers had been corroded, repaired at the base with concrete, thus reducing their height [14]. Despite all these changes the maximum capacity remained the same and the safety certificate was never altered and LJ Taylor concluded that “the provisions as to the capacity in the safety certificate should have been reviewed and altered” (Taylor LJ 1989:25, para 149).

In 1988 Hillsborough hosted an FA Cup semi-final match between Liverpool and Nottingham Forest football teams where the police conducted an efficient filtering mechanism on the Leppings Lane approach road. There were warning signs of a compacted queue at ten minutes to three, with uncomfortable overcrowding in pens 3 and 4. The police closed off access to the tunnel and pens 3 and 4 shortly before kick-off (Taylor LJ 1989:31, para 31). In 1989 Hillsborough was chosen as a semifinal venue and tickets for the small end of the ground were allocated to the Liverpool fans, at the request of the South Yorkshire Police, based on the approach roads, segregation of fans and their familiarity with the same arrangements of 1988 [15]

The immediate context: the weeks leading up to the disaster

Chief Superintendent Mole, whose significant expertise was influential in getting Hillsborough re-established as a semifinal venue after the crush of 1981 (Scruton 1999) was replaced as match commander, by CS Duckenfield, only three weeks before the Hillsborough disaster [16]. Unlike his predecessor he had “limited experience of policing foot-

ball matches and would depend heavily on his senior officers” (Scruton et al 1995:111) [17]. Sheffield Wednesday would provide 376 stewards, turnstile operators, supported by various cameras and a club control room; computerised counting at the turnstiles with separate running totals, a warning bleep on the screen when capacity had reached 15% off the 10,100 maximum. However, it could not provide a breakdown of capacity to separate areas within the Leppings Lane terrace (Taylor LJ 1989:7).

Despite disagreements regarding who should be responsible for crowd management and monitoring the terraces (the club and or the police?) [18] LJ Taylor noted that police practice was to avoid both police and stewards entering the terraces themselves, since it was both unsafe and impractical. This meant that all monitoring of crowd safety, density and control, would have to be done from outside the terraces, using police and stewards on the ground and the senior police officers in the control box located at the Leppings Lane end of the ground, directly overlooking pens 3 and 4 with numerous CCTV cameras.

Immediate Circumstances: the day of disaster at Hillsborough

On 15 April 1989 as 54,000 fans were expected at Hillsborough, Superintendent Murray, when asked by a Chief inspector if he should fill the pens in the Leppings Lane end one by one successively, replied that they should be available from the start and fans should ‘find their own level’ (Taylor LJ 1989:9)[19]. By 2.00pm pens 3 and 4 were filling up. Between 1.30pm and 2.20pm a large number of fans arrived, resulting in a very congested crowd build up between the perimeter gates and the seven turnstiles at Leppings Lane (West terrace) [20]. The conditions reached a crucial point between 2.30pm and 2.50pm. The inquiry found that the crisis at the turnstiles developed because a “very large crowd became packed into a confined turnstile area. The density of the crowd hampered passage through the turnstiles. People in that crush had no control over their movements at all,”

and it should have been obvious that a large part of the crowd could not have been admitted until well after 3.00pm (Taylor LJ 1989:34) [21]. At 2.47pm Superintendent Marshall radioed police control to permit the concertina gate C to be opened (see appendix 1). He repeated his request, got no reply, repeated it a third time, adding that if the gate was not opened, someone was going to be killed [22].

A disaster unfolds: the moment of disaster?

Having lost control and rejected options of postponing the kickoff the police were faced with a serious danger of death or injuries. They were left with no choice but to open the gate. Superintendent Marshall was right to ask for it and CS Duckenfield was right to agree. But the possible effects of so dramatic a step required other action. (Taylor LJ 1989:39). The Taylor inquiry found that at around 3.00pm, pens 3 and 4 behind the goal area were 50% over the maximum capacity, 55% over the maximum crowd density, which was exceeded by nearly 100% at the front of the pens. These figures reported were "very high, with the absolute minimum being 10.00 ppsqm for the front row" (personal interview Dr C Nicholson) [23]. LJ Taylor (1989:40) concluded that the tunnel should have been closed off "whether or not gate C was opened. This was a simple exercise which had been completed in the 1988 semi-final". Planning apart:

It should have been clear in the [police] control box, where there was a view of the pens and of the crowd at the turnstiles that the tunnel had to be closed. If [such] orders had been given...*the disaster could still have been avoided. Failure to give that order was a blunder of the first magnitude.*

(Taylor LJ 1989:40, para 231)

When the decision was made to open gate C there was no strategy to deal with the consequences; no warning was given to the club control room, the Chief steward at the Leppings Lane end, nor even the ground commander

Superintendent Greenwood. When gate C was opened 2000 fans "passed through it at a steady fast walk...a large proportion of them headed for the tunnel in front of them" (Taylor 1989:12). Poor signposting, unclear information on the tickets, a high wall blocking the view of alternative routes and the popularity of standing behind the goal area, all contributed to these 2000 fans heading for an already overcrowded pens 3 and 4 and experienced being swept through the tunnel feet off the ground accelerated by a 1 in 6 gradient [24].

People were trapped in pens 3 and 4 like a vice, with none of the normal swaying of a soccer crowd and those who had just arrived could not move backwards. At 2.54pm the teams were announced and came onto the pitch. "Given that both traumatic and crush asphyxia have the potential to take life within minutes this was a critical period which constitutes the moment of the disaster" (Scruton et al 1995:21). At 3.04pm Peter Beardsley, a Liverpool player hit the cross bar with a shot at goal at the other end. The crowd in pens 3 and 4 pressed or leaned forwards and barrier 124a at the front of pen 3 collapsed, projecting people towards the wall and perimeter fence, with those behind involuntarily pressing them down. Dr Nicholson's technical report showed that, despite corrosion, this barrier could take comparable stress loads and could have withstood the normal maximum density allowed in the 1986 Green Guide, "therefore it must have been overloaded" as indicated by the crowd density figures for 3.04pm (Nicholson and Roebuck 1995:251). Dr Nicholson described the collapse of barrier 124a as a "major incident in the event, in that almost all of the dead people were in front of the collapsed barrier" and that "if the barrier had stayed upright it would have prevented a great number of deaths. I really believe that" (Personal Interview Dr Nicholson, 1/9/97).

Rescue and Evacuation: the response to an emergency

Even at this stage the flow continued though the tunnel as cries for help and requests for gates

to be opened were ignored by some police officers whilst others pushed fans back into the pens when perimeter gates in pens 3 and 4 sprung open under the pressure [25]. No-one in the police control room noticed the overcrowding or realised anything was amiss until just after kick-off, when officers in command assumed there was a pitch invasion and, rather than calling for major incident plan status, they called for operational support - and all available officers and dog handlers were instructed to go to the Leppings Lane end of the ground since there was a pitch invasion (Taylor LJ 1989:3). LJ Taylor concluded that:

The combination of no instructions as to overcrowding and a strong prohibition on opening the gates was likely to make police recognition of crushing slow and their response reluctant. Small wonder that the growing pressure and congestion between 2.50pm and 2.59pm went unheeded or certainly unremedied. Even when officers recognised there was a problem, the rule required the consent of a senior officer before the gate could be opened

(Taylor LJ 1989:43, para 247).

Finally, at 3.06pm, Superintendent Greenwood, stopped the match; Superintendent Murray radioed for a fleet of ambulances. Only when CS Duckenfield received the request for the ambulances did he realise "the nature and gravity of the situation and sent messages converting operational support into calls for a major disaster plan" (Taylor LJ 1989:16). Then police and fans who tried to rescue people from pens 3 and 4 found a "truly horrific scene of carnage".."the victims were blue, cyanotic incontinent; their mouths open, vomiting; their eyes staring. A pile of bodies lay and grew outside gate 3" (Taylor LJ 1989:15). Initially, no officer took charge and there was "no effective leadership either from either control or the pitch) to harness and organise rescue efforts" until CS Nesbitt, from traffic arrived (Taylor LJ 1989:44). The first ambulance arrived at 3.12pm and at

3.15pm CS Duckenfield informed Graham Kelly and others from the football club that he thought there were fatalities, the game was likely to be abandoned and "the gate had been forced and there had been an inrush of Liverpool fans" (Taylor LJ 1989:17). CS Duckenfield apologised several weeks after the disaster for misleading Mr Kelly who had gone from the police control box to the world's press and media with that version on the day of the disaster.

LJ Taylor had analysed the disaster giving critical attention to the layout of Leppings Lane end of the ground; the lack of fixed pen capacities; and lack of effective monitoring of the terraces in relation to the problem of overcrowding. He considered the crushing fatalities in relation to the build up at the turnstiles; the blunder on opening the gates; the barriers in pen 3; the crushing not being recognised; the response of the police and the perimeter gates being too small. These themes go beyond police responsibilities to encompass Sheffield Wednesday Football Club and the local authority yet as Bush 1989 points out a focus by the media on police conduct draws attention away from the involvement of other agencies (Hartdey 1997b). Although there were other causes the LJ Taylor Interim Inquiry concluded that the immediate cause of the gross overcrowding and hence the disaster, was "failure, when gate C was opened, to cut off access to central pens which were already overfull" due to the failure to lay down "safe maximum capacities" or to "control entry to individual pens numerically. In addition, there was no effective monitoring of crowd density," and the:

layout of the barriers offered less protection than it should and a barrier collapsed. Again, the lack of vigilant monitoring caused a sluggish reaction and response when the crush occurred. The small size and number of gates to the track retarded rescue efforts. So, in the initial stages, did lack of leadership (Taylor LJ 1989:47).

In August 1990 the LJ Taylor Interim Report

was published, making 43 recommendations including a national football inspectorate- a Football Licensing Authority, conversion of some stadia to all-seater, a safety lens in police planning and several recommendations relating to improvements in the Green Guide. LJ Taylor then consulted with a wide range of individuals and organisations, visited grounds in Europe and in his report, in January 1990, treated the conduct of Sheffield Wednesday FC and the Local Authority, more critically than in the Interim Report, but "returned the debate around ground safety to the issue of hooliganism" and the broader issues of military style policing and decaying stadia, encouraging politicians and the media to focus on the hooligan lens in this higher status Final Report (Coleman et al 1990:65). LJ Taylor extended his Interim recommendations on police planning, including ones to deal with ticketless fans, arrest procedures, kick-off times, strategies for training senior officers and the financial costs of policing. He categorically rejected the national membership scheme incorporated in the 1989 Football Spectators.

Criminal Liability: breaches of statutory duty and reckless manslaughter by individuals or corporate bodies

Since there was no separate statutory investigation by the Health and Safety Executive into any possible breaches of relevant statutory duties, all evidence relevant to any charges was contained in the LJ Taylor public inquiry. However, the HSE only appeared to be used for "technical" aspects of the Taylor Inquiry, conducted by Dr Nicholson. There is no visible legal evaluation of either breaches of the Safety of Sports Grounds Act 1975, possible referrals to the police, for reckless manslaughter (normally the role of HSE). There have never been any charges brought, against any individual or organisation involved at Hillsborough, for any breach of any relevant statute. For example, the Safety of Sports Act 1975, has sections which require crowd capacity in different sections of the ground to be monitored and also places a duty on the

club for any changes to the ground or its management which could affect health and safety, to be notified to the local authority providing the safety certificate. There were serious deviations from the 1986 Green Guide revealed in the public inquiry. However, it is a voluntary code with no approval signature or formal connection to the 1975 Act, although aspects of it can, of course, be required in the safety certificate.

In August 1990 the Director of Public Prosecutions (DPP) ruled that there was "no evidence to prosecute any corporate body and insufficient evidence to prosecute any individual" for reckless manslaughter [26] (Scruton et al 1995:30). The DPP had announced in 1980 that he would only prosecute in cases where he was "satisfied that he had more than a 50% chance of a conviction" (Scruton et al 1995:35), which is considered alongside other criteria such as the presence of corroborating evidence and a public interest need to pursue a case and commit public spending to it. Such decisions are in private, to protect the rights of those who, are in the end, not prosecuted, so there is no access to the evidence used in that decision. However, the mechanics of evidence processing and selection for the inquiry, inquest and DPP decision remains unclear. The Hillsborough disaster resulted in the unusual situation of one investigation team, the West Midlands Police team, servicing all three of these legal processes-with one pool of evidence and set of witness statements. The criteria for selection and directing of evidence to each of these legal processes remains unclear and the problem of the altered police statements discussed later becomes even more significant.

Mass Disaster Inquests: mini and generic inquests and a judicial review

Coroner's Inquests in England and Wales are directed solely at finding out who the deceased persons were and how, when and where they met their deaths. An Inquest is not allowed to indicate or settle any other matter such as criminal liability of a named person or civil liability [27]. Such rules and those of incrimination, which allow

witnesses to claim privilege and refuse to answer any question which might incriminate them, can be in conflict with the duty of the inquest to establish the facts of the death, especially in controversial deaths involving state institutions [28]. In an unprecedented step, the Hillsborough inquests were divided into 'mini' inquests which were resumed [29] on a limited basis, only dealing with factual matters of who and where each person died; blood alcohol levels [30] and the medical evidence on cause of death. 95 mini inquests were held at the rate of 8 per day starting on 18 April 1999. The deaths of most of the victims were caused by crush asphyxiation, with a minority caused by traumatic asphyxiation [31]. The givers of witness statements were not present at the inquest; families and their counsel heard a summary of evidence from a West Midlands Police officer, which like the pathologist's evidence, could not be challenged or cross-examined [32].

The second stage of the inquests-the 'generic' inquests, dealing with the circumstances of how the disaster victims met their deaths was resumed after the decision by the DPP that there would be no prosecutions for reckless manslaughter. The longest inquests in English legal history began in Sheffield Town hall on 19 November 1990 with no legal aid allowed for the families, who had to raise £140,000 to cover the legal costs. The jury returned verdicts of 'accidental death' [33] in April 1991. These inquests have been the subject of intensive research and critical observations around issues including the rules of disclosure and incrimination, the use of summary statements and blood alcohol tests, the treatment of survivors in the witness box, the construction of the events by the police and the relationship or overlap between a public inquiry and an inquest and the status of evidence of the former. (see Scraton et al 1995).

An application was made in 1992 and heard in 1993, for a judicial review to quash the inquest verdicts of accidental death and seek fresh inquests. It was based on several grounds including apparent bias, the use of summary statements

in the mini inquests, the inappropriate introduction of a cut-off point of 3.15pm and failure to consider whether lives could have been saved by calling the emergency services sooner and failure to leave 'lack of care' to the jury, as a possible verdict. With regard to the 3.15pm cut-off, the coroner had taken the view that in "overwhelming pathological evidence available to him, permanent and irrecoverable damage had, by then, been suffered by all of the deceased" (Thomas 1993:1). These applications, made by the relatives of six of the deceased were rejected on all grounds at the hearing in 1993 [34].

Civil Cases

Civil compensation arising out of the Hillsborough disaster was considered in several categories and stages in relation to deaths of loved ones; post-traumatic stress disorder (PTSD) by both the families and some of the South Yorkshire Police officers and pre-death trauma in relation to two of the victims from the same family. Following the disaster a steering committee was formed to co-ordinate litigation and writs were issued in two separate actions [35], initially with two defendants, namely the Chief Constable and the club. Contribution notices issued by the chief constable against the club and Eastwood and Partners and, in October 1990, without admitting liability, these three parties, in a private court hearing in a Manchester court, undertook to compensate the victims [36] (Police Review, 22 June 1990:1259). The major portion was borne by the police and their insurers. This private arrangement meant that there was no judged negligence case, where the issues of the legal status of the 1986 Green Guide and the standard of care of professionals could be tested in an open court [37].

Claims for post-traumatic stress disorder were brought by both the relatives and friends of the deceased and by South Yorkshire Police officers working at the semi-final on 15 April 1989. Sixteen test cases for PTSD were brought by relatives of loved ones, representative of 150 similar claims. At the final stage of these cases in

Alcock [1991] [38], the House of Lords ruled that the requirements for duty of care to be owed would be:

- a) a sufficiently close relationship of love and affection to the primary victim (to make nervous shock reasonably foreseeable)[39]
- b) Proximity to the accident, or its immediate aftermath, was sufficiently close in time and space. Their Lordships all agreed that identifying a deceased relative eight hours after the disaster was not within the immediate aftermath [40]. Liability for nervous shock had been gradually expanding throughout this century was viewed by some as reaching a high water mark in the early 1980s, with *McGloughlin*, followed by a period of retraction, for policy reasons in which *Alcock* is located, although there have been criticisms of the arbitrary nature of the boundaries, challenges to the requirement for geographical proximity, and doubts about the reality of the floodgates fears driving such latent policy decision (Unger 1991; Nasir 1992; Teff 1992).

In 1996 four police officers successfully appealed against the first instance decision by Mr Justice Waller and it was held that they were entitled to damages for their PTSD sustained as a result of their attendance at the 1989 Hillsborough disaster [41]. They were classed as both rescuers and primary victims [42], with a breach of duty established on the part of the Chief Constable to the plaintiffs due to their master and servant relationship. Firefighters had succeeded in claims for suffering physical injury and physical and mental injury [43] were not considered different kinds of injury for this purpose [44]. The successful claims of the police officers, who were seen to be professionals in an emergency service, doing a job in which they were prepared for such shocks, were significantly contrasted to the bereaved relatives who had failed in their claims for PTSD, if they did not meet the *Alcock* criteria. Some officers failed in their claim in the *Frost* appeal if they had "arrived at the ground some time after the incident" or "helped to move bodies or obtain first aid but did not work close at the Leppings Lane end of the

ground" therefore not being at the disaster or its immediate aftermath (Kitson and Allen 1997:7).

In a landmark House of Lords ruling in December 1998 [45], the majority Law Lords laid down restrictive criteria which will limit the rights of emergency service workers, when they overturned the 1996 Court of Appeal judgement in 1996 since none of the four officers were "exposed or thought to be exposed to [the risk of personal danger]" (Dyer and Wainwright, *The Guardian*, 3 December 1998, p.2). The majority ruled that the police officers were bystanders and not rescuers, unlike 14 other officers who dealt with dead and dying fans in the crush in the spectator pens and that in the opinion of Lord Steyn, the "awarding of damages to these police officers sits uneasily with the denial of the claims of bereaved relatives" [46]. The Law Commission of England and Wales in its 1995 consultation paper on Liability for Psychiatric Illness, proposed that the requirement for geographical proximity for those who already have close ties of love and affection, should be removed from the restricting criteria (Law Commission 1995) [47]

Other Legal processes or issues arising out of the Hillsborough Disaster The 96th victim of the Hillsborough disaster, Tony Bland, was left in a persistent vegetative state as a result of brain injuries suffered at the match in 1989. In 1993 in a landmark case, the Law Lords decided that the medical carers of Tony Bland would "not be acting lawfully if they were to discontinue the invasive medical procedures which were necessary to sustain his life" (Herbert 1993, *The Guardian Law Report*, 5 February 1993) [48]. Such action by his hospital doctor, under the law at that time, could constitute manslaughter, if not murder. However a doctor was under no duty to treat such a patient where "a large body of informed and responsible medical opinion was to the effect that no benefit at all would be conferred by its continuance" and this was not overridden by the principle of the sanctity of life, which was not absolute. (Herbert 1993). Lord Browne-Wilkinson considered it imperative that the legal

moral and social issues raised by this case should be considered by Parliament and that in the absence of such considerations each new question of this kind would be considered in a case-by-case judge made law, which in his opinion, was not the best way to proceed [49].

No disciplinary charges have ever been brought against any police officer in connection with the 1989 Hillsborough disaster. In July 1990 the Police Complaints Authority (PCA) directed that charges of neglect of duty be preferred against Chief Superintendent Duckenfield and Superintendent Murray [50]. In November 1990, some eighteen months after the Hillsborough disaster CS Duckenfield retired on the grounds of ill-health. Since disciplinary charges can only be brought against serving police officers, the complaint against him had to be dropped. In October 1991 the PCA announced that it would not pursue the charge against Mr Murray on the grounds that it would be "unfair to pursue what in essence was a joint charge against one officer only" (LJ Stuart-Smith 1998:1) and Mr Duckenfield could not appear as a witness in any charges against another officer.

The promulgation of myths around the Hillsborough disaster by both official sources and the press and media, the behaviour of the press during and after the disaster has been well documented (Coleman et al 1990; Scraton et al 1995)[51]. Intensive research covering several years from the day of the disaster, closely monitored press and media conduct as well as that of police officers, the Prime Minister's press spokesperson, Members of Parliament, Television personalities and football coaches and observed the permeation of myth into academic articles (Scraton et al 1995). In addition, such research resulted in evidence being presented to the House of Commons Select Committee on Privacy and Related Matters (see Scraton et al 1995). However a private member's Bill on Privacy and press regulation failed to get through Parliament and the Calcutt Committee into Privacy and Related Matters in 1995, did not recommend regulation of the press.

In the years since the Hillsborough disaster the Hillsborough Family Support group and the Justice for Hillsborough group have vigorously campaigned for a proper scrutiny of the unanswered questions and kept the lack of legal scrutiny of some issues around the Hillsborough disaster in the public domain [52]. Following a documentary and a drama documentary, highlighting issues around the emergency response and medical treatment, the 3.15pm cut off at the inquest, and questions regarding missing police and club videotapes, from the day of the disaster, the then Home Secretary, Michael Howard announced that if there was new evidence, he was prepared to open re-open new inquiries or investigations into the Hillsborough disaster. In June 1997 the Home Secretary of the recently elected Labour Government, Jack Straw, announced in the House of Commons, that he was appointing LJ Stuart-Smith to ascertain whether "any evidence exists relating to the disaster at the Hillsborough Football Stadium on 15th April 1989, which was not available to" LJ Taylor, The Director of Public Prosecutions or the Attorney General [53], the Chief Officer of South Yorkshire Police [54] or any other evidence which would justify a new public inquiry or may draw attention of the DPP to evidence not previously considered or any other action which should be taken in the public interest [55] (see Hartley 1997a).

LJ Stuart-Smith held a "Scrutiny of evidence relating to the Hillsborough Stadium Football Disaster" in the autumn of 1997, in private [56], considered written applications and held meetings with some of those who wrote to him. The applications raised issues of missing video evidence, the emergency and medical response in the aftermath of the disaster, the 3.15pm cut-off by the coroner, interference with witnesses, altered police statements, criticisms of the inquest, access to police archives, examination by doctors confirming death and the state of the Hillsborough ground (see *Scrutiny of Evidence Relating to the Hillsborough Football Stadium Disaster*, Cm 3878, 1998). His report in February

1998 announced his conclusion that there was no basis for further judicial inquiry (re-opening of LJ Taylor's inquiry); or a renewed application to the Divisional Court for a new inquest; or for any material to be put before the Director of Public Prosecutions or the Police Complaints Authority; or any further inquiry into the performance of the emergency or hospital services. Finally, after considering the circumstances in which alterations were made to self-written statements of South Yorkshire Police officers [571, LJ Stuart-Smith did not consider that there is "any occasion for any further investigation" (Stuart-Smith LJ 1998:103; Scraton 1999).

At the time of writing, there is a private prosecution due to be heard in Leeds Crown Court, brought and financed by the families of the Hillsborough victims, against Chief Superintendent Duckenfield and Superintendent Murray for unlawful killing (equivalent to reckless manslaughter, a charge which has never been brought by the state) and neglect of duty. Another charge for attempting to pervert the course of justice has not been allowed to proceed, following an earlier court hearing. The Police Authority is paying the costs of the case for the two senior police officers, since they were at work when the disaster happened in 1989.

Summary

Ten years after the Hillsborough disaster, procedural justice may have been processed but, in the experiences of the bereaved families, substantive justice appears to be elusive, alongside several unanswered questions as the legal challenges and controversial issues remain on the agenda (see Scraton et al 1995; Scraton 1999). The first public investigation into the Hillsborough disaster, the LJ Taylor inquiry, set the events on the day in an historical context, revealing a catalogue of failures in the previous twelve years leading up to the disaster. Failure to collectively assess the effects of significant changes to the ground on health and safety and an inadequate system of monitoring crowd capacity and density in separate parts of the

ground were aggravated by weaknesses in the Local Authority certification and regulation under the 1975 Act.

The collective creation of risks over the long and short term was further enhanced by the 'hooligan lens' of police planning, where an imbalance between crowd control and crowd safety permeated every level through police planning, operational orders, briefings, emergency responses and construction of events at the inquest (Coleman et al 1990; Scraton et al 1995). The lack of clarity regarding who monitors the crowd capacity on the terraces added to the failure of police practices of visual monitoring and 'find your own level', practices LJ Taylor found to be bad in theory and practice, even though they were presented as standard and tested methods by the police. Re-organisations, restructuring, lack of clarity and changes in key roles, all had adversely influenced the effectiveness of collective risk management in both the Local Authority and the Police [58].

No criminal charges for either breaches of relevant statutory duties or reckless manslaughter, have ever been brought against any individual or organisation in connection with the Hillsborough disaster. This follows the common pattern in other UK disasters, where a very critical public inquiry raises expectations in the minds of the bereaved and survivors that criminal liability will be established. The pooling of evidence in one investigation team feeding all three legal processes -the inquiry, the inquest and the decision of the DPP on reckless manslaughter, lack of clarity regarding the criteria for selecting and directing evidence appear problematic (Scraton et al 1995). The overlap between the inquest and the inquiry, the status of evidence in the latter and its lack of transferability to other legal arenas and the inherent contradictions between the rules governing inquests have repeatedly been raised in academic and policy contexts [59]. Despite serious deviations from the only code of practice for the industry, the 1986 Green Guide, its voluntary status and unclear relationship with the 1975 Act, located in

the wider policy of a very low rate of prosecutions for statutory breaches (Bergman 1994) may present obstacles to charges being brought under the 1975 Act.

The civil claims for PTSD and the decisions of the earlier courts in the similar claims by police officers, created controversy around the contrasting decisions on these two groups of claimants, the necessity for geographical proximity for those with close ties to the primary victims and the empirical grounds for policy decisions based on the fear of floodgates. Both groups of PTSD claimants resulted in precedential cases in the House of Lords, creating controversial criteria which restrict liability for professional rescuers and close relatives. The treatment of the bereaved and survivors by the press and media played a significant role in getting issues of privacy and right to reply on the political agenda [60] and the problems associated with police disciplinary processes and retirement, which reach beyond the Hillsborough disaster were the raised in the House, for the attention of an All Party Committee in 1996 (Hartley 1997a). The issues raised by the altering of police statements and solicitor's roles in advising clients through post disaster inquiries and investigations has yet to be publicly debated and addressed (see Scraton 1999). In mid 1999, ten years after the Hillsborough disaster the outcome of the private prosecution for unlawful killing and neglect of duty against two senior police officers, is awaited.

Hazel J Hardey June 1999.

Endnotes

[1] The Football Association semi-final is held at a neutral ground, where both sets of fans, from Liverpool FC and Nottingham Forest FC are away from home. Hillsborough is the home ground of Sheffield Wednesday Football club. It is an old ground, built in 1965, with terraces for 10,100 people to stand at the Leppings Lane end of the ground, accessed by 7 turnstiles (see

appendix 1).

[2] Mr McGee, Chair of Sheffield Wednesday Football Club stated in the match programme "As you look round Hillsborough today you will appreciate why it has been regarded for so long as the perfect venue for all kinds of important matches" (cited Hartley 1997b).

[3] due to the compression of the chest wall against other bodies or fixed structures so as to prevent inhalation. Six cases were due to traumatic asphyxiation.

[4] It was unprecedented to have fans fighting or causing such disorder between themselves, especially at the beginning of the match and for those who managed to climb over the fence, no-one was running onto the pitch.

[5] Since the South Yorkshire Police were directly involved in policing the match at Hillsborough, another force was allocated to service the inquiry, as is normal practice in the United Kingdom in such circumstances. However it has been considered a matter of concern that the West Midlands Team serviced all three legal processes-the public inquiry, the inquest and the decision of the Director of Public Prosecutions on charges of reckless manslaughter (see Scraton et al 1995)

[6] This means that the evidence presented to this inquiry and its findings are not binding in other legal arenas and in previous disaster cases, any attempt to even make reference to them has been vigorously challenged and successfully stopped in! for example, the criminal case of reckless manslaughter against seven coming to Leppings Lane terraces would only have seven turnstiles to admit 10,100 fans. In the opinion of the South Yorkshire Police, if the ends had been reversed, rival fans would have crossed each other's paths and would therefore frustrate attempts at segregation and create a risk of disorder (Taylor LJ 1989:5). The allocation of both venue and ends remained unchanged.

[16] See Scraton (1999:15) who gives an account of a serious incident in October 1988, in which "a young probationary officer was taken to the grounds of a convent in the Ranmoor district of

Sheffield. Two armed men in military fatigues, faces hidden by balaclavas, dragged him to wasteground. They forced him face down in the mud, hands cuffed behind his back, a gun to his head. His trousers pulled down. He feared the worst. Shaking uncontrollably, expecting to die, he heard a click, saw a flash; not a gun, but a camera...prostrate and terrified on the ground the young officer turned his head to see the armed men removing their balaclavas. They were laughing. Laughing policemen." The young officer underwent stress counselling for what was later described as a prank, some sort of initiation rite common in the armed forces. All the officers involved were based at Sheffield's Hammerton Road police station. Soon after, an unpublished internal disciplinary process, followed by resignations, suspensions, demotions and fines, the head of Hammerton Road police station CS Brian Mole was transferred to Barnsley. "Without disclosure of documentation relating to either disciplinary proceedings or Mole's transfer, a direct and contestable connection cannot be made between them" but what is certain is that "relieving him from his duties at Hammerton Road just 21 days before Hillsborough's semi-final denied the event the services of the most experienced match commander in the force" (Scruton 1999:16).

[17] Superintendent Marshall was i/c of the area outside Leppings Lane and the approaches to it; Superintendent Greenwood was in charge inside the ground, including the area between the turnstiles and the perimeter fence-a reversal of roles from the previous year; Superintendent Murray was to be in the control box with CS Duckenfield. There would also be 801 police officers on duty in the ground, alongside traffic police.

[18] The Interim Report of the Popplewell inquiry into the Bradford Fire seemed to clarify roles, with the police responsible for law and order and the club responsible for safety and crowd management and general housekeeping regarding the health and safety of the facility, yet in the Final Report doubts were raised again

about such a clear division.

[19] 'Finding you own level' is a standard police practice in managing the distribution of fans at soccer matches in the United Kingdom, where fans will move around the terraces, sway with the crowd and will find their own level by moving to another place on the terrace if they are uncomfortable.

[20] In contrast to the 1988 semi-final there was no filtering system set up by police, on the Leppings Lane approach, to filter out fans without tickets.

[21] A police Constable on duty in a police landrover outside Leppings Lane entrance had radioed police control and requested a postponement of the kick-off, a request which was acknowledged and rejected. Dr Nicholson in the HSE technical investigation for the inquiry found that it would have taken 2.25 hours to admit all the spectators (Nicholson and Roebuck 1995:256).

[22] In the police control room LJ Taylor found that CS Duckenfield froze and appeared to be incapable of making a decision, yet in matters which involved any deviation from the police operational order, only he could make such a decision. Superintendent Murray, in the police control box asked CS Duckenfield "are you going to open the gates?,"

[23] The maximum figure allowed by the 1986 Green Guide is 5.40 persons per square metre. Dr C Nicholson is the Deputy Director of the Health and Safety Executive Research and Laboratory Division, located in Sheffield and provided the HSE technical investigation for the LJ Taylor public inquiry, working with Dr A Jones the Director of the HSE laboratories in Sheffield, and liaising with Prof Maunders (technical assessor to the inquiry) and LJ Taylor on a regular basis throughout the inquiry.

[24] The steep gradient was another deviation from the Green Guide. Even after gate C was opened and the police could see the influx on their screens, no order was given to steer fans to the empty wing pens. Mr Duckenfield said "it did not cross his mind to detail officers on the con-

course to shut off the tunnel” (Taylor LJ 1989:40).

[25] The police operational orders and briefings emphasised that these gates must be kept locked and shut at all times.

[26] In Anglo-Welsh law the test for reckless manslaughter is very problematic and has just been reviewed by the Law Commission (1995/6). The principles of reckless manslaughter, both individual and corporate have developed in an ad hoc or piecemeal fashion. Since 1982 it has incorporated Cunningham and Caldwell recklessness (one subjective and the other objective). Reckless manslaughter by corporations is cynically regarded as the ‘perfect’ or ‘invisible’ crime (Bergman 1994) partly due to the lack of prosecutions and convictions for this crime, unlike financial corporate crimes. The law of corporate reckless manslaughter requires the successful prosecution of a person who embodies the ‘mind and will’ of that corporation, who has the *mens rea* and *actus reus* of manslaughter (the mental element related to the serious and obvious risk of death which their conduct created). Even if this is achieved, all the faults and knowledge/awareness of all those who may have contributed to a disaster, (unlike The Netherlands or the United States) cannot be ‘aggregated’ to form the crime of corporate reckless manslaughter (Field and Jorg 1991; Wells 1988, 1993). These restrictions make it almost impossible to prosecute for corporate reckless manslaughter in disaster situations, especially if they are organised by several agencies. In addition the under-resourcing and lack of a manslaughter mindset by the Health and Safety Executive significantly reduces the chances of any referrals by the HSE, for reckless manslaughter charges to the police/Crown Prosecution Service (equivalent to District Attorney).

[27] Rules 36 and 42 of the 1984 Coroner’s Rules.

[28] This means that the breadth and depth of the circumstances of how someone died, which must be answered in the public interest, is often severely restricted by rules 36 and 42. The inher-

ent contradiction between establishing the facts of death without apportioning blame “represents a difficult if not impossible coexistence of objectives and in establishing how a person came by his death the issues concerning liability cannot but arise” (Scruton and Chadwick 1987a:16). See also Scruton 1984; Chadwick 1987b on problems of controversial inquests.

[29] The coroner can decide to resume inquests after the question of criminal liability has been decided by the Director of Public Prosecutions. To do so in advance of the DPP as in this case is an unusual step. The coroner warned that nothing should prejudice criminal proceedings and these stage one ‘mini’ inquests would be limited and non-adversarial.

[30] This was unprecedented. Alcohol levels are often taken from, for example pilots or train drivers involved in accidents or mass disasters, but this was the first time disaster victims have had blood alcohol levels taken—even victims as young as fourteen years old (See Scruton et al 1995)

[31] In the mini inquests Mr Wardrope’s evidence said he had quite a lot of traumatic asphyxiation on the day of the Hillsborough disaster, but in a later article identified the main cause of death was crush asphyxia. Traumatic asphyxia is usually caused by a heavy weight falling on the chest or a violent crush between heavy objects crush asphyxia is caused by a gradually increasing and sustained pressure on the chest” (see Scruton et al 1995:55, for a critique on the mini inquests).

[32] as opposed to a ‘vice’ described by fans, or alcohol levels (even if zero) presented to the jury by the pathologist; such evidence could not be cross-examined or any controversial questions raised. Families were left with unanswered questions about their loved ones which they thought might be answered in the generic inquests to follow (see Scruton et al 1995).

[33] The verdict ‘accidental death’ can encompass a range of meanings from genuine unforeseeable accident to something akin to negligence, although when such a verdict is returned, there is no way of indicating where on that continuum

the jury was locating it's interpretation of events. [34] see *R v HM Coroner for South Yorkshire, ex parte Stringer and others* (1993) 158 JP 453 and Thomas L (1993:1). The case was heard in the High Court before LJ McGowan and Mr Justice Turner in November 1993. .

[35] Writs were issued by Mrs Chapman and Mrs Rimmer, widows of two men who had been killed.

[36] The Queen's Bench Divisional Court "refused the chief constable's application for an order to discontinue proceedings against Sheffield Wednesday FC and Eastwood and Partners (the clubs safety consultants). It was held that, where a case involved complex multi-party litigation, the 'sporting theory of justice' had no place". One party being in control of the litigation ought to, as far as possible be subordinated to case management techniques controlled by the court and there was "no reason why a fair hearing of the issue could not take place (in October or November 1990) " (Police Review, 22 June 1990:1259).

[37] In respect of the fatalities 37 claims were made for loss of financial dependency pursuant to the Fatal Accidents Acts (36 have been settled) although the maximum payout is was £3,500. 53 fatal claims were restricted to damages for funeral expenses and or statutory bereavement payments. (50 have been settled); offers have been made in respect of the other three, but not accepted. 1,473 claims have been made for personal injury were intimated-all claims included a psychiatric element. The great majority were for psychiatric as opposed to physical injury. 1035 have been settled, 19 remain outstanding. In total £13.25 million has been paid in compensation and legal costs, not including compensation to police officers (Stuart-Smith LJ 1998:12).

[38] See *Alcock and Others v Chief Constable South Yorkshire Police* [1991] 4 All ER 907, where ten of the original plaintiffs appealed to the House of Lords and their Lordships unanimously rejected their appeals. There was also a case brought by Mr and Mrs Hicks regarding pre-death trauma of their daughters Sarah and

Victoria (aged 19 and 15) who both died in the Hillsborough disaster. Counsel for the parents submitted that " on the whole of the evidence Mr Justice Hidden ought to have found on the balance of probabilities there was a gradual build-up of pressure on the bodies of the two girls causing increased breathlessness, discomfort and pain from which they suffered for some 20 minutes before the final crushing injury which caused unconsciousness" which should have led to the conclusion that "they sustained injuries which caused considerable pain and suffering while they were still conscious and which should attract a substantial award of damages" (The Guardian Law Report, March 3rd 1992). The House of Lords rejected the appeal by Mr and Mrs Hicks arguing that the case was decided on matters of fact (considered by the High Court and the Court of Appeal); damages could not be awarded for either the anger of the parents or the fear, however terrifying experienced by the victims of fatal injuries, could not "by itself give rise to a cause of action which survived for the benefit of the victim's estate" (The Guardian Law Report, 3 March 1992). Also See Scraton et al 1995 on the issues around medical expert evidence on traumatic and crush asphyxiation at the Hillsborough inquests.

[39] although Lords Ackner, Keith and Oliver were not prepared to rule out even a bystander, where the accident was particularly horrific. In addition rescuers would continue to be owed a duty on policy grounds

[40] This was based on the earlier case of *McGloughlin v O'Brien* [1983] AC 410, in which the plaintiff Mrs McGloughlin arrived at the hospital one hour after a serious road traffic accident in which one daughter had died and her husband and other two children were injured and showing visible signs of the trauma.

[41] See *Frost and Others v The Chief Constable South Yorkshire Police* July 1996 31 October 1996 LJ

Rose, LJ Henry, LJ Judge

[42] See *Alcock v CC South Yorkshire Police* 28 Nov 1991 HOL

[43] see *Ogwo v Taylor* [1988] AC 431.

[44] See *Page v Smith* [1996] 1 AC 155

[45] See *White and Others v Chief Constable of South Yorkshire and others* Dec 3 1998

(Lord Goff, Lord Griffiths, Lord Browne-Wilkinson, Lord Steyn, Lord Hoffman)

[46] Lord Steyn also considered that police officers "who are traumatised by something they encounter in their work have the benefit of statutory schemes which permit them to retire on pension". In addition, Lord Hoffman thought that the ordinary person would consider it wrong that "policemen, even as part of a general class of persons who rendered assistance, should have the right to compensation for psychiatric injury from public funds, while the

bereaved relatives are sent away with nothing" (see Dyer and Wainwright 1998:2)

[47] The Law Commissioners consulted with a wide range of experts from different disciplines and a range of relevant publications as well as receiving responses from the public and legal and medical professionals. The government is considering the proposals.

[48] Tony Bland had been unable to see, hear, feel, communicate because the brain cortex had been starved of oxygen, but the brain stem, controlling breathing, heartbeat and digestion remained in tact. Medical opinion considered that he would never recover from PVS but could remain alive for many years. His parents and doctor considered it

"appropriate to stop artificial feeding and other measures aimed at prolonging his existence". The application by the NHS Trust -Airedale and Wharfedale Hospital, was made and the case was heard in the Family Court, then the Court of Appeal and finally in the House of Lords in February 1993.

[49] Lord Browne-Wilkinson thought that the courts should merely apply present law and not make new law. That was a matter for Parliament. Indeed, following this case, a House of Lords Select Committee considered matters of euthanasia under the brief of 'Medical Ethics'.

[50] Chief Superintendent Duckenfield had been

in charge of police operations on the day and Superintendent Murray was his deputy and was with him in the control box.

[51] Press reporters posed as social workers to gain access to the homes of the bereaved, doorstepped the bereaved families and survivors. One paper published close up photographs of the dead up against the fences in the pens and lies about the conduct of fans claiming that they urinated on police officers who were giving the kiss of life to victims and pick-pocketed the dead claims which were formally dismissed as totally unsubstantiated, alongside others that drunken fans forced open gate C, by LJ Taylor in the 1989 Public Inquiry and led to a case at the Press Complaints Council.

[52] The Hillsborough Family Support Group is also represented in the committee structure of Disaster Action UK launched in October 1991, which represents the bereaved families of nearly 14 major UK disasters and provides advice and counselling support for the bereaved as well an active campaign for greater accountability and responsibility by corporate bodies for health and safety, and has responded to the Royal Commission on Criminal Justice 1991 and the Law Commission Consultation Paper on Involuntary Manslaughter including corporate manslaughter.

[53] who decided in 1990 not to bring any prosecutions for reckless manslaughter against any individual or organisation in connection with the 1989 Hillsborough Stadium Football disaster.

[54] in relation to any decisions regarding disciplinary action against South Yorkshire Police officers

[55] Hillsborough disaster 3.47pm House of Commons Announcement by Jack Straw, Home Secretary, 12 CD 31 pl/4,p.24, June 30th 1997.

[56] although transcripts of statements given to LJ Stuart-Smith in private meetings may be requested.

[57] Scruton's 1999 research (drawing on personal interview with a junior police officer, the LJ Stuart-Smith 1998 Scrutiny and Inquiry statements and police statements located in the

Commons Library, London) reports that, soon after the Hillsborough disaster junior officers were instructed by senior officers to record their recollections of the day, providing "full and detailed accounts including feelings emotions and impressions. These were not usual police statements, bland, factual, written on Criminal Justice Act forms" but were handwritten on blank A4 paper (Scraton 1999:185). Officers thought it was some sort of cathartic counselling process to get it out of their system, and were assured that such information was privileged and not for the public domain of inquiries and investigations. Later, some officers received word processed statements, which had been significantly altered, on the advice of the South Yorkshire Police solicitors; among other things, material on both fact and opinion had been deleted or advised to be deleted, with a tendency to remove any comment which was potentially critical of police conduct on the day of the disaster, yet leave in any critical comments regarding the conduct of Liverpool fans (Scraton 1999 using transcripts of private meetings between LJ Stuart Smith and police witnesses, during the 1998 Scrutiny, not included in the 1998

report- Stuart Smith LJ 1998). Deletions included "Why were the sliding doors at the back of the tunnel not closed at 2.45pm when those sections of the ground were full as at the Manchester United match this season ?"(Scraton 1999:193) "the control room seemed to have been hit by some sort of paralysis"(Scraton 1999:195); "I moved along the fence towards the gate. I then saw another PC begin to open the gates and he was arguing with an inspector who was telling him to close it again. The PC turned away from the inspector and opened the fence gate Once the gate was opened people just poured out" Altered this read simply "I moved along the fence toward a gate, which once open people just poured out" (Scraton 1999:194). It was the altered statements which were fed into the three legal processes- the LJ Taylor Inquiry, the inquest and the DPP decision on reckless manslaughter. By accident, during the LJ Taylor Inquiry, a police officer was

questioned on the original unaltered version and a letter followed to the

Head of the West Midlands Police inquiry team, from the Treasury solicitor, containing advice from the Counsel to the inquiry, Andrew Collins QC, that only the final revised statement was to be used and given to the press (see Stuart-Smith LJ 1998:213 and Scraton 1999, chapter ten 'Sanitising Hillsborough').

[58] See Hartley 1997b which includes a critical analysis of the conduct of the agencies involved using themes of clarity of health and safety roles; management hierarchies and power relations; expertise roles and re-organisation; the enterprise culture and the hooligan lens.

[59] Scraton et al 1995 recommended that the evidence should be taken on oath (sworn) at Public Inquiries. A Home Office Working Group in 1997 The Report of the Disasters and Inquests Working Group HMSO March 1997, made the same recommendation in addition to the transfer of such evidence to a limited resumed inquest. This does not however address the issue of encompassing the criminal case within the inquiry, with sworn evidence.

[60] House of Commons All Party Committee on Privacy (see Scraton et al 1995).

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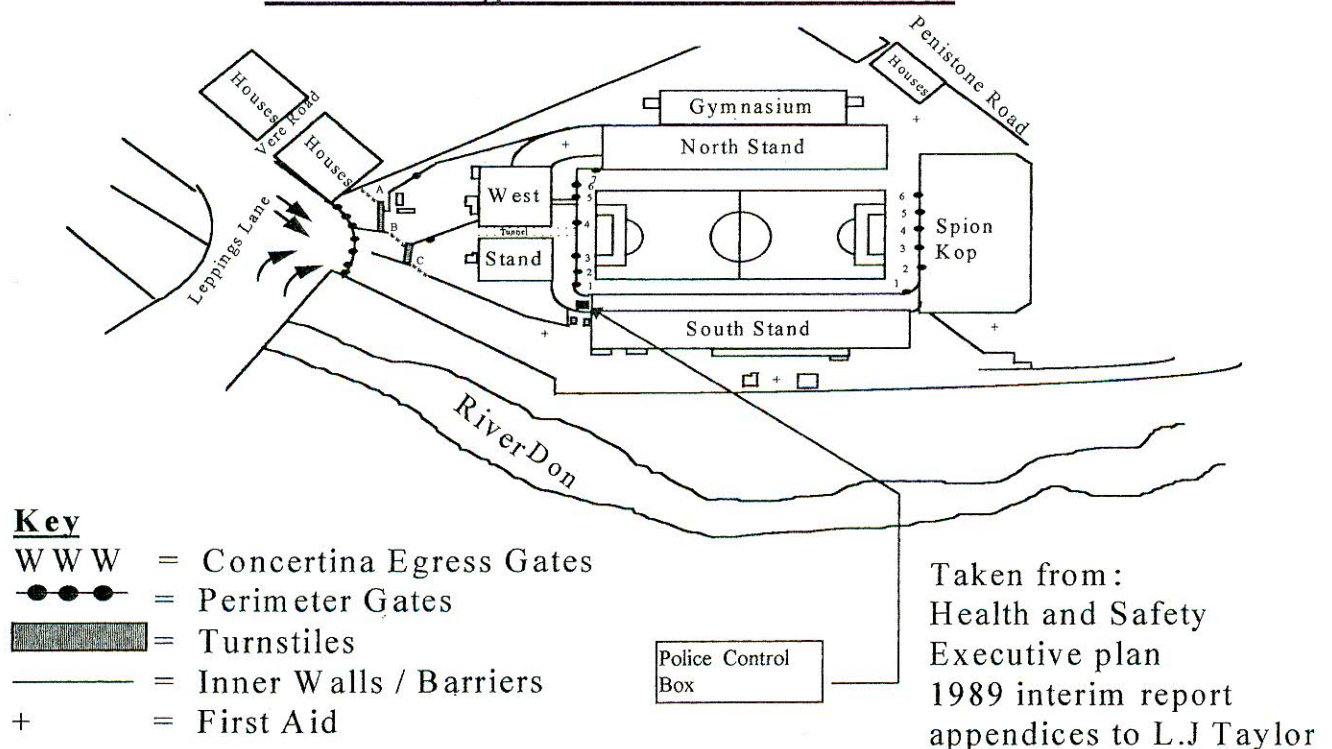
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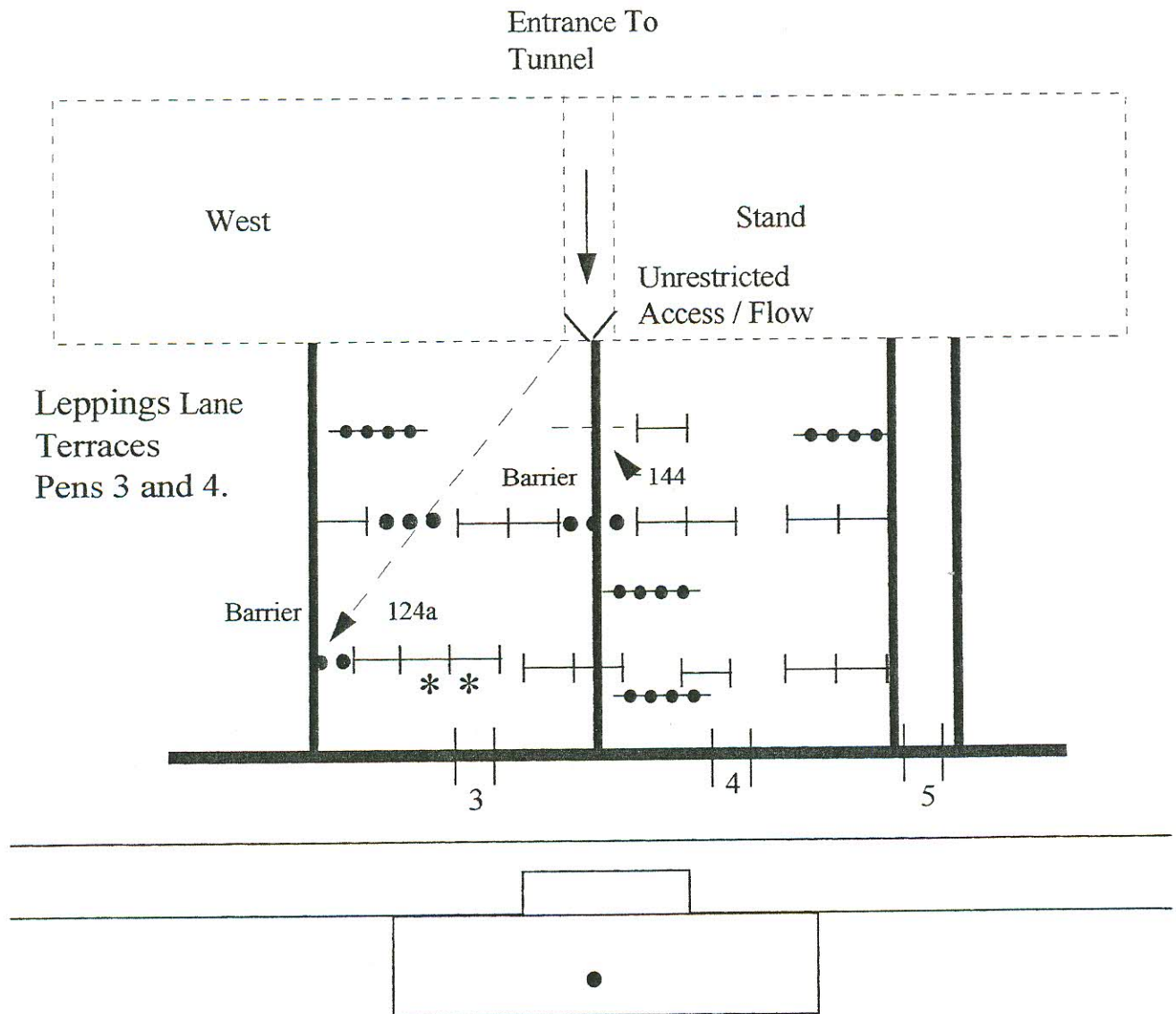
Appendix 1

Hillsborough Stadium: West End.



Appendix 2

Barriers And Access To West (Leppings Lane) Terrace.



Key:

- |— = Barriers : pre 1979
- = Additional Barriers :1979
- = Radial Fences 2m in 1981
- = Radial Fences 2m more in 1985
- = Removal of posts and rails :1985
- = Removal of Barrier 144: 1986

Taken From:
Health and Safety
Executive plan.
Appendices L.J. Taylor
interim report 1990