

Taylor on Hillsborough: What Can We Learn?

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On Saturday 15 April 1989, 95 people were crushed to death and many more injured at the Liverpool versus Nottingham Forest FA Cup Semi-Final. The match was to be played on a fine sunny day, in front of a ticket-only crowd at Hillsborough, one of the largest most modern stadia in the UK, which is well used to staging such matches. How then could this disaster have taken place?

Lord Justice Taylor has gone a long way towards giving us the answers with the publication of his preliminary report on 4 August 1989. The report is extremely critical of the total failure of the South Yorkshire police to control the situation and lays the blame fairly and squarely on their doorstep. However, there are lessons in this document for ALL the emergency services in the UK. Complacency caused the Hillsborough disaster and therefore other services must take heed of the Taylor findings and see how they apply to their own areas in planning for disaster.

The present author has written elsewhere (Walsh, 1989) about the unpredictability of disasters, hence the need to try to anticipate potential incidents whenever possible and to plan ahead. The emergency services in the south west of Scotland and Carlisle area could not have been expected to anticipate the Lockerbie airplane crash, but where a football stadium is regularly housing thousands of excited people, there

could be no excuse for a lack of forward planning.

Advance planning was, however, sadly inadequate at Hillsborough. The Taylor report shows that the police officer in charge, Mr Duckenfield, did not visit the stadium before approving the police plan for the match. The fire brigade computer did not even have the address of the stadium, a fact which has been reported as delaying their response (*The Guardian*, 5 August 1989). There seems to have been a total failure to plan ahead to accommodate the likely late arrival of supporters and ensure areas of terracing did not become overcrowded. There was nothing unpredictable about what happened at Hillsborough.

The first lesson for all of us is, therefore, that a lack of planning, a failure to identify a possible major incident in advance and to plan appropriately, led directly to Hillsborough. The emergency services must all look around their own patches, and carefully consider potential danger spots both now and continually in the future. This applies to everything from major stadia down through smaller venues and on to indoor events such as concerts.

Taylor put his finger on another major factor that contributes to disasters, the 'it will never happen here' syndrome that breeds complacency. Just because previous games at Hillsborough had not led to disaster, it was assumed that the same

arrangements would always work in the future. This is a similar assumption to that made by the owners of the *Herald of Free Enterprise* and how tragically wrong both assumptions proved to be.

No matter how good a plan is, it can always be made better, while on the other hand subtle changes in circumstances can make a weak plan into a recipe for disaster. The plan for closing the doors on the *Herald* was weak and flawed, disaster had to happen eventually as it did. Similarly, the police plan at Hillsborough was weak due to its failure to stop major congestion occurring outside the inadequate turnstiles at the Leppings Lane end of the ground. Roadworks 50 miles away in another county, delaying the arrival of some supporters, was all that was needed for the police plan to collapse.

Lesson number two is, therefore, that just because a plan worked last time, do not assume it will work next. Plans should be continually worked on and revised.

Flexibility and speed of response are fundamental requirements in planning for and responding to disaster (Walsh, 1989). The evidence assembled by Taylor shows that as the disaster developed before the very eyes of senior police officers, both these qualities were sadly lacking. It is to be hoped that emergency services and hospitals will remember the need not to think in stereotyped rigid patterns, as it appears the South Yorkshire police did.

Football matches have become burdened with a hooligan element which can cause trouble out of all proportion to its size. This led the police to think only in terms of a pitch invasion and so they ignored the evidence of their eyes and some escaping fans were actually thrown back into the pens by the police to join the dead and dying. The officer in charge, Mr Duckenfield, did not go down on to the ground to see at first hand what was happening.

The intervention of the Liverpool goal-

keeper, Bruce Grobbelaar, is credited with saving many lives as he persuaded the police to open one of the small gateways in the perimeter fence to allow people to begin escaping. Dogmatic and rigid thought patterns made the disaster worse as the police response was fatally delayed by the assumption that this was just another football riot in the making.

Lesson number three is, therefore, that emergency personnel on the ground and those responsible for planning must be trained to display flexibility of thought and to avoid stereotyped reactions.

Communications failures plague major incidents, recent examples being the Kings Cross fire, the Hungerford massacre and before that the Manchester Airport fire in 1985 (Walsh, 1989). It appears that police communication broke down again at Hillsborough; inadequate radio control was provided, and the picture that appears is of the crush developing outside the ground being reported to central control three times and the messages being ignored. Taylor is absolutely right to recommend that police radio communications on site be greatly enhanced and supplemented by an independent landline system to various key points.

Planners must look at their communication systems again. Are they up to the task in hand? Can they readily talk to other emergency services? This is particularly important in dealing with underground situations where conventional radio will not function. This point applies not only to the London Underground but also the Channel Tunnel. Taylor recommends joint planning between all the services for all major events, a blindingly obvious but still sadly needed recommendation.

Reference was made at the enquiry to verbal abuse and even physical assaults directed against the ambulance service as well as the police once the rescue operation had begun. Those responsible presumably confused ambulance crew with police because of the similarity in uniform, a point

that has been discussed elsewhere (Walsh, 1989). Unfortunately, ambulance crews will have to face this possibility as long as their uniform is so similar to that of the police.

In major incidents involving civil unrest, ambulance crews try very hard to maintain neutrality and are usually successful in avoiding becoming the targets for angry crowds. In riots, the wearing of distinctive clothing and a policy of having a casualty collection centre on the periphery of the conflict area, have prevented ambulance crew casualties, e.g. in the Tottenham riots. It is also a fact that most casualties in riots are police officers, the opposite of the case at Hillsborough.

The lesson here is that ambulance crews may find themselves under attack, probably as a result of being mistaken for police. In attending major crowd incidents, therefore, they should be clearly distinguishable from the police.

The medical facilities at Hillsborough were exposed as totally inadequate. It is impossible to say how many of the dead might have been saved by better equipment and more expert trained medical assistance. Taylor recommends one doctor should be on duty at football matches.

There is nothing new in this proposal. Last season Bristol Rovers began a Third Division match without their club doctor in attendance as he should have been, and early in the game a player was knocked unconscious, inhaling a dental plate in the process. Only immediate intervention by the club physiotherapist saved the player's life. The point is that this is already a requirement, but games can still kick off without the doctor present. The requirement should be that an appropriately trained doctor will be present at the ground before the turnstiles are opened. It is crucial that the doctor involved should have experience of, and be up to date in, resuscitation techniques.

However there is little one doctor can do for a single casualty without equipment,

and nothing s/he can do for many scores of casualties. Grounds must have resuscitation equipment able to deal with cardiopulmonary arrest, a not uncommon event in single members of the crowd. The former manager of Everton, Harry Catterick, died in such a way after a cup tie at Goodison Park, while a member of the pipe band providing entertainment before Nottingham Forest's Littlewoods cup semi-final against Bristol City died in the same way only weeks before Hillsborough.

The deployment of one ambulance per match if a crowd in excess of 5,000 is expected is a welcome recommendation, along with further ambulances for bigger crowds. It is an arbitrary limit. It would have been better to insist on an ambulance for any football league fixture, and to have included other sports and leagues that were likely to attract crowds of say, 1,000 minimum, such as cricket and rugby league. It is essential that such ambulances should be crewed by trained staff able to perform advanced resuscitation.

There has been controversy about the role of voluntary first aiders at major events and their limitations were revealed at Hillsborough. To be proficient at resuscitation and the treatment of major casualties, a person has to have continual and up to date experience. They therefore have to be either working in the emergency ambulance service or hospital A&E units/ITU/Resuscitation teams. If such staff are regularly available on a voluntary basis they should be utilised. However, to provide the degree of expert, experienced assistance that would be required in the event of an incident, the services of the professional NHS ambulance service are needed in line with the Taylor recommendations.

Voluntary helpers from one of the first aid societies have a useful role to play provided they are properly trained for that role, regularly assessed as to their competence and, crucially, provided everyone recognises their limitations. They are not a

cheap alternative to expert medical and paramedical care

Perhaps the saddest lesson of all from Hillsborough is that we do not seem to learn lessons. In 1946, overcrowding at a football match at Burnden Park, Bolton, led to the collapse of a wall and 33 deaths. In 1971, 66 people were crushed to death at Ibrox Park, Glasgow, during a Rangers match. The writing has been on the wall all that time, and yet the Hillsborough disaster still happened because the police in South Yorkshire failed to learn the lessons which appear to have been learnt by other forces about crowd control.

There is a need for a national body that can quickly summarise an incident and circulate the lessons learned around all the emergency services. It should also have the power to follow up such a report and see what has been done to act on its recommendations. Planning for major disaster should be coordinated on a national scale by such a body, instead of the present ad hoc local arrangements. Perhaps then we may have some definitive research into why disasters happen and what is the best way

to respond to them, avoiding the duplications and omissions, along with the communications foul ups that plague UK disaster responses today.

When disasters happen, government is quick to heap praise on heroes, and the press to heap blame on individuals, such as the unfortunate Mr Duckenfield. But need it always be like this? How vigorously are we pursuing accident prevention and safety? Do we have to continue to rely on local heroics rather than a coordinated national response? Is it my imagination or has Britain become a much more dangerous place to live in these last few years?

References

Walsh, M (1989) *Disasters, Current Planning and Recent Experience*. London, Edward Arnold.

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