Report summary

Introduction

On 15 April 1989 over 50,000 men, women and children travelled by train, coach and car to Hillsborough Stadium, home of Sheffield Wednesday Football Club, to watch an FA Cup Semi-Final between Liverpool and Nottingham Forest. It was a sunny, warm, spring day and one of the high points of the English football season.

Hillsborough was a neutral venue, like so many stadia of its time a mix of seated areas and modified standing terraces. As the match started, amid the roar of the crowd it became apparent that in the central area of the Leppings Lane terrace, already visibly overcrowded before kick-off, Liverpool fans were in considerable distress.

In fact, the small area in which the crush occurred comprised two pens. Fans had entered down a tunnel under the West Stand into the central pens 3 and 4. Each pen was segregated by lateral fences and a high, overhanging fence between the terrace and the perimeter track around the pitch. There was a small locked gate at the front of each pen.

The crush became unbearable and fans collapsed underfoot. To the front of pen 3 a safety barrier broke, creating a pile of people struggling for breath. Despite CCTV cameras transmitting images of distress in the crowd to the Ground Control Room and to the Police Control Box, and the presence of officers on duty on the perimeter track, it was a while before the seriousness of what was happening was realised and rescue attempts were made.

As the match was stopped and fans were pulled from the terrace through the narrow gates onto the pitch, the enormity of the tragedy became evident. Fans tore down advertising hoardings and used them to carry the dead and dying the full length of the pitch to the stadium gymnasium.

Ninety-six women, men and children died as a consequence of the crush, while hundreds more were injured and thousands traumatised. In the immediate aftermath there was a rush to judgement concerning the cause of the disaster and culpability. In a climate of allegation and counter-allegation, the Government appointed Lord Justice Taylor to lead a judicial inquiry.

What followed, over an 11-year period, were various different modes and levels of scrutiny, including LJ Taylor's Interim and Final Reports, civil litigation, criminal and disciplinary investigations, the inquests into the deaths of the victims, judicial reviews, a judicial scrutiny

of new evidence conducted by Lord Justice Stuart-Smith, and the private prosecution of the two most senior police officers in command on the day.

Despite this range of inquiry and investigation, many bereaved families and survivors considered that the true context, circumstances and aftermath of Hillsborough had not been adequately made public. They were also profoundly concerned that following unsubstantiated allegations made by senior police officers and politicians and reported widely in the press, it had become widely assumed that Liverpool fans' behaviour had contributed to, if not caused, the disaster.

In 2009, at the 20th anniversary of the disaster, Andy Burnham, Secretary of State for Culture, Media and Sport, announced the Government's intention to effectively waive the 30-year rule withholding public records to enable disclosure of all documents relating to the disaster.

In July 2009 the Hillsborough Family Support Group, supported by a group of Merseyside MPs, presented to the Home Secretary a case for disclosure based on increasing public awareness of the circumstances of the disaster and the appropriateness of the investigations and inquiries that followed.

The Home Secretary met with representatives of the Hillsborough Family Support Group and in January 2010 the Hillsborough Independent Panel, chaired by James Jones, Bishop of Liverpool, was appointed.

The remit of the Hillsborough Independent Panel

The remit of the Hillsborough Independent Panel as set out in its terms of reference was to:

- oversee full public disclosure of relevant government and local information within the limited constraints set out in the Panel's disclosure protocol
- consult with the Hillsborough families to ensure that the views of those most affected by the tragedy are taken into account
- manage the process of public disclosure, ensuring that it takes place initially to the Hillsborough families and other involved parties, in an agreed manner and within a reasonable timescale, before information is made more widely available
- in line with established practice, work with the Keeper of Public Records in preparing options for establishing an archive of Hillsborough documentation, including a catalogue of all central Governmental and local public agency information and a commentary on any information withheld for the benefit of the families or on legal or other grounds
- produce a report explaining the work of the panel. The panel's report will also illustrate how the information disclosed adds to public understanding of the tragedy and its aftermath.

The structure of the Panel's Report

The Hillsborough Independent Panel's Report is in three parts.

The first part provides an overview of 'what was known', what was already in the public domain, at the time of the Hillsborough Panel's inaugural meeting in February 2010.

The second part is a detailed account, in 12 substantial chapters, of what the disclosed documents and other material 'adds to public understanding' of the context, circumstances and aftermath of the disaster.

The third part provides the Panel's review of options for establishing and maintaining an archive of the documents made available by over 80 contributing organisations in hard copy, many of which have been digitised and are now available online.

Finally, the Report includes a set of appendices: the Panel's full terms of reference; how the Panel has consulted with bereaved families and their representatives and how it responded to well-publicised events during its work; the process of disclosure; and the research methodology adopted in analysing the documents.

The Report summary: scope and content

In accessing and researching the mass of documents and other material disclosed by organisations and individuals, the Panel was guided in its work by its regular consultation with, and the priorities of, Hillsborough families and their representatives.

Part 2 of the Report comprises 12 chapters that respond to the bereaved families' priorities in establishing the scope of the Panel's research into the documents. They also demonstrate the depth of the research conducted and the profound issues raised by this unique process of disclosure.

In analysing the disclosed documents it has been necessary within the 12 chapters to include contextual material already in the public domain. What follows summarises each of the detailed 12 chapters, providing an overview of how the documents disclosed to the Panel add to public understanding.

Brief background

Hillsborough Stadium, home of Sheffield Wednesday Football Club (SWFC), was opened in 1899. Like many such city stadia it was located in a built-up residential area no longer suited to modern transport or the access necessary for 54,000 spectators on big match days.

The stadium underwent significant structural modification in preparation for staging the 1966 World Cup. Both ends of the stadium, the Spion Kop and the Leppings Lane terrace (beneath the West Stand), were standing terraces.

Hillsborough was hired regularly by the Football Association (FA) to host FA Cup semi-finals, the most prestigious knock-out tournament in English soccer. These matches usually drew capacity crowds. Both teams' supporters, travelling to Sheffield, were unfamiliar with the city, with access to Hillsborough and with the layout of the stadium.

In 1981 before the FA Cup Semi-Final between Tottenham Hotspur and Wolverhampton Wanderers there was serious congestion at the Leppings Lane turnstiles and crushing on the confined outer concourse. This led directly to severe compression on the Leppings Lane terrace and injuries to fans. Hillsborough was not used again for an FA Cup semi-final until 1987, and then again in 1988.

Chapter 1. 1981–1989: unheeded warnings, the seeds of disaster

Based on documents disclosed to the Panel, this chapter assesses the impact of the 1981 crush on crowd safety at Hillsborough. It considers the decisions taken between 1981 and 1989 by SWFC, its safety consultants, the local authority (Sheffield City Council) and the

South Yorkshire Police (SYP) regarding modifications to the Leppings Lane terrace and their consequences for the safe management of the crowd.

It is evident from the documents disclosed to the Panel that the safety of the crowd admitted to the terrace was compromised at every level: access to the turnstiles from the public highway; the condition and adequacy of the turnstiles; the management of the crowd by SYP and the SWFC stewards; alterations to the terrace, particularly the construction of pens; the condition and placement of crush barriers; access to the central pens via a tunnel descending at a 1 in 6 gradient; emergency egress from the pens via small gates in the perimeter fence; and lack of precise monitoring of crowd capacity within the pens.

These deficiencies were well known and further overcrowding problems at the turnstiles in 1987 and on the terrace in 1988 were additional indications of the inherent dangers to crowd safety. The risks were known and the crush in 1989 was foreseeable.

1. In 1981 before the FA Cup Semi-Final between Tottenham Hotspur and Wolverhampton Wanderers there was serious congestion at the Leppings Lane turnstiles and crushing on the confined outer concourse. It resulted in the opening of exit Gate C to relieve the crush. The disclosed documents indicate that entry into the stadium was managed by South Yorkshire Police (SYP) officers on duty and Sheffield Wednesday Football Club (SWFC) stewards.

2. What followed was a serious crush on the terraces in which many people were injured and fatalities narrowly avoided. At that time lateral fences did not divide the Leppings Lane terrace into pens, and fans were able to move sideways along the full length of the terrace; others escaped onto the perimeter track through the narrow gates in the perimeter fence.

3. The disclosed documents show that police officers located on the inner concourse, between the turnstiles and the rear of the terrace, restricted access to the central tunnel under the West Stand, diverting fans to the side access points to the terrace, thus relieving pressure at the centre. Crowd density figures available to the Panel demonstrate that the maximum capacity for the terrace was significantly exceeded.

4. The disclosed documents demonstrate that, following the 1981 incident, there was a breakdown in the relationship between SWFC and SYP. SWFC refused to accept the seriousness of the incident and held SYP responsible for the mismanagement of the crowd. SYP considered that the maximum capacity for the Leppings Lane terrace, set at 10,100, was too high, a view strongly contested by SWFC.

5. On the recommendation of SYP the construction of lateral fences in 1981 created three pens, with movement between pens limited to a small gate at the head of each lateral fence. According to SYP these gates were used to manage segregation at league matches but were not ‘stewarded’ by the police.

6. From the earliest safety assessments made by safety engineers commissioned in 1978 by SWFC, it was apparent that the stadium failed to meet minimum standards under the Safety of Sports Grounds Act 1975 and established in the *Guide to Safety at Sports Grounds* (known as the ‘Green Guide’), 1976. Documents released to the Panel confirm that the local Advisory Group for Safety at Sports Grounds carried out inadequate and poorly recorded inspections. There is clear evidence that SWFC’s primary consideration was cost and, to an extent, this was shared by its primary safety consultants, Eastwood & Partners.

7. Following the near tragedy in 1981, Hillsborough was not used for FA Cup semi-finals until 1987. During this period the Leppings Lane terrace underwent a series of significant modifications and alterations, none of which led to a revised safety certificate. The introduction of further lateral fences created two central pens accessed via the tunnel beneath the West Stand. Recommendations to feed fans directly from designated turnstiles into each pen, thus monitoring precisely the distribution of fans between the pens, were not acted on because of anticipated costs to SWFC.

8. Consequently, the turnstile counters were rendered irrelevant. Although they provided a check on the overall numbers entering the terrace, there was no information regarding crowd distribution between pens, each of which had an established maximum capacity.

9. It is evident from the disclosed documents that SYP were preoccupied with crowd management, segregation and regulation to prevent potential disorder. SWFC's primary concern was to limit costs. The Fire Service, however, raised concerns about provision for emergency evacuation of the terraces. As the only means of escaping forwards was onto the pitch, concern was raised specifically about the width of the perimeter fence gates which was well below the standard recommended by the Green Guide. The gradient of the tunnel under the West Stand leading down onto the terrace also significantly breached the Green Guide's recommendation.

10. While modifications were made inside the stadium, the issue of congested access to the turnstiles outside the stadium remained unresolved. As Lord Justice Taylor's Interim Report noted, of the stadium's 54,000 capacity, over 24,000 fans were channelled through 23 turnstiles feeding the North Stand, the West Stand and the Leppings Lane terrace.

11. Following alterations, the safety of the existing maximum capacity for the Leppings Lane terrace was questioned repeatedly yet the decision was taken by the Club and the safety engineers not to revise the figure.

12. From the documents disclosed to the Panel, key issues – positioning of safety barriers, elevation of the tunnel, adequacy of the perimeter fence gates – were not discussed or recorded at the annual safety inspections. Following the delayed kick-off at the 1987 FA Cup Semi-Final and the crushing at the 1988 FA Cup Semi-Final, it is evident that debriefings held by all parties were inadequate. Crucial information arising from these events was not shared within SYP, nor was it exchanged between SYP and other agencies. There is no record provided by SWFC of debriefings held between Club stewards and their managers. The Club denied knowledge of any crowd-related concerns arising from the 1987 or 1988 FA Cup Semi-Finals.

Chapter 2. The 'moment' of 1989

The challenges and responsibilities of policing and managing capacity crowds at Hillsborough were evident following the events of 1981 and the subsequent difficult relations between SYP and SWFC. In this context, the decision by SYP senior management to replace an experienced match commander just 21 days before the match is without explanation in the disclosed documents.

The documents disclosed to the Panel, however, reveal that the flaws in responding to the emerging crisis on the day were rooted in institutional tension within and between organisations.

This was reflected in: a policing and stewarding mindset predominantly concerned with crowd disorder; the failure to realise the consequences of opening exit gates to relieve congestion at the turnstiles; the failure to manage the crowd's entry and allocation between the pens; the failure to anticipate the consequences within the central pens of not sealing the tunnel; the delay in realising that the crisis in the central pens was a consequence of overcrowding rather than crowd disorder.

13. The SYP decision to replace the experienced match commander, Chief Superintendent Brian Mole, and appoint Chief Superintendent David Duckenfield who had minimal experience of policing at Hillsborough, just weeks before an FA Cup semi-final, has been previously criticised. None of the documents disclosed to the Panel indicated the rationale behind this decision.

14. A planning meeting attended by both senior officers was held less than a month before the match. The documents disclosed to the Panel give no explanation for the non-attendance of the South Yorkshire Metropolitan Ambulance Service and the Fire Service at this meeting.

15. Chief Superintendent Duckenfield held a briefing for senior officers on the day before the match. At that meeting he emphasised the importance of crowd safety. Briefings held by other senior officers, however, focused on potential crowd disorder, alcohol consumption, ticketless fans and the difficulties of managing Liverpool supporters. From the documents disclosed to the Panel, it is apparent that the collective policing mindset prioritised crowd control over crowd safety.

16. This mindset, directed particularly towards Liverpool fans, was clearly evident in SYP's submission to the Taylor Inquiry.

17. As previously known, the SYP 1989 Operational Order was derived, with a few alterations, from the 1988 Order and gave no indication of the crowd management problems experienced in 1988.

18. The SYP Operational Order concentrated primarily on the control and regulation of the crowd with no appropriate reference to crowd safety, crushing or evacuation of the stands/terraces.

19. From the documents disclosed to the Panel, the management roles and responsibilities of senior SYP officers were unclear, particularly the lines of communication, decision-making and information exchange between those responsible for policing outside the stadium and the ground commander inside the stadium.

20. There was clear evidence in the build-up to the match, both inside and outside the stadium, that turnstiles serving the Leppings Lane terrace could not process the required number of fans in time for the kick-off. Yet the growing danger was ignored. When the request to delay the kick-off eventually was made, it was considered too late as the teams were on the pitch.

21. For a considerable period inside the Police Control Box it was clear from the near view of the central pens below, and the CCTV coverage of the turnstiles

and pens, that serious problems of overcrowding were occurring at the turnstiles and in the pens. Senior police officers' decision-making was hampered by poor communications, a malfunctioning radio system and the design of the Control Box.

22. Superintendent Roger Marshall was responsible for policing outside the stadium at the Leppings Lane end. As the crush at the turnstiles became severe he requested the opening of exit gates to allow fans into the stadium and relieve crowd pressure. He had no knowledge of the uneven distribution of fans on the Leppings Lane terrace. Similarly, the ground commander inside the stadium, Chief Superintendent Roger Greenwood, had no knowledge of the extreme situation developing outside the stadium.

23. The overview of both sites was the Control Box, with CCTV monitors and a near view of the central pens. Chief Superintendent Duckenfield acceded to Superintendent Marshall's request and authorised the opening of Gate C. Despite a clear view from the Control Box and CCTV monitors, neither Chief Superintendent Duckenfield nor his assistant, the experienced Superintendent Bernard Murray, anticipated the impact on the already packed central pens of fans descending the tunnel directly opposite Gate C.

24. On opening Gate C there was no instruction given to the SYP officers inside the stadium to manage the flow and direction of the incoming crowd.

25. From the documents provided to the Panel it is clear that the crush at the Leppings Lane turnstiles outside the stadium was not caused by fans arriving 'late' for the kick-off. The turnstiles were inadequate to process the crowd safely, and the rate of entry insufficient to prevent a dangerous build-up of people outside the ground.

Chapter 3. Custom, practice, roles, responsibilities

The spectators at an FA Cup semi-final do not comprise the large, mostly local, home-based crowd with limited away support usual at regular league matches. Rather, there are two sets of fans, approximately equal in number and unfamiliar with the stadium.

The supporters allocated to the Leppings Lane end, in this case Liverpool, were allocated the entire terrace and the West Stand above it. This intensified the problems of access that were already inbuilt into the restricted approaches, inadequate provision of turnstiles and subdivision of the terrace into separate pens.

Over preceding years, police custom and practice had evolved in response to crowd management issues unique to FA Cup semi-finals, particularly filtering access to the concourse through ticket-checking on the approaches, directing incoming spectators away from the central pens when they were estimated to be near capacity, and closing the tunnel when capacity was estimated to have been reached.

None of these practices appear to have been recorded and none formed part of the Operational Order or the police briefings before the 1989 Semi-Final.

Throughout the 1980s there was considerable ambiguity about SYP's and SWFC's crowd management responsibilities within the stadium. The management of the crowd was viewed exclusively through a lens of potential crowd disorder, and this ambiguity was not resolved despite problems at previous semi-finals. SWFC and SYP were unprepared for the disaster that unfolded on the terraces on 15 April 1989.

26. Based on the established policy of maintaining segregation of fans within the stadium and its approaches, particularly at FA Cup semi-finals, the documents disclosed to the Panel demonstrate that SYP determined the allocation of the stadium's stands and terraces to each club's fans. The tickets allocated to Nottingham Forest fans significantly exceeded those allocated to Liverpool fans, an issue raised by Liverpool Football Club and the Football Association.

27. The confined outer concourse area serving the Leppings Lane turnstiles accommodated the entire Liverpool crowd, heading towards three discrete areas within the stadium (North Stand; West Stand; Leppings Lane terrace). It was a well-documented bottleneck and at matches with capacity attendance presented a predictable and foreseeable risk of crushing and injury.

28. From statements provided to the Panel, at previous FA Cup semi-finals SYP managed congestion in the outer concourse area and its approaches by filtering the crowd and checking tickets on the roads leading to the ground. This did not happen in 1989. The former SYP match commander, Chief Superintendent Brian Mole, denied that filtering the crowd's approach to the turnstiles had been previously adopted as police practice.

29. SYP proposed that preventing ticketless fans from approaching the turnstiles was not possible because no offence had been committed. This was contested and criticised by Counsel to the Taylor Inquiry.

30. In their 1989 statements some SYP officers referred to crushing in the outer concourse area at the 1988 FA Cup Semi-Final. They were asked by the SYP solicitors, Hammond Suddards, to reconsider and qualify their statements.

31. Concerning the distribution of the crowd on the standing terraces inside the stadium, Chief Superintendent Mole stated that officers on the perimeter track and in the Control Box estimated when full capacity of each pen was reached 'based on experience'.

32. SYP officers with extensive experience of policing Hillsborough, including Chief Superintendent Mole, stated that the fans' distribution between the Leppings Lane terrace pens was based on an informal practice that allowed fans to 'find their own level'. In the aftermath of the 1989 disaster, SYP claimed that 'find their own level' was a flawed practice 'devised' by the safety engineers and SWFC.

33. From the SYP statements disclosed to the Panel it is evident that SWFC stewards and SYP officers with experience of managing the crowd on the Leppings Lane terrace had adopted the practice of redirecting fans to side pens when the central pens were estimated to be full. At semi-final matches in 1987 and in 1988 the gates at the entrance to the tunnel opposite the turnstiles and leading into the central pens were closed temporarily by police officers who redirected fans to the side pens. In 1988 many fans in the central pens experienced crushing and minor injuries. Neither the gate closures nor the crushing were recorded in debriefing notes.

34. Although an established practice, the use of the tunnel entrance gates as a means of regulating access to the central pens was not included in the Operational Order for capacity crowd matches.

35. The disclosed documents reveal persistent ambiguity throughout the 1980s about SYP's and SWFC's responsibilities for crowd management. The SYP position, exemplified by Chief Superintendent Mole's statements, was that while safety was a concern for SYP the 'prevention of hooliganism' and 'public disorder' was the main priority. The custom and practice that had evolved within SYP for packing the pens was concerned primarily with controlling the crowd.

36. In the view of Chief Superintendent Mole's successor, Chief Superintendent David Duckenfield, crowd distribution between the Leppings Lane terrace pens was the responsibility of SWFC stewards but police officers, particularly those on the perimeter track, were expected to react to overcrowding in the pens.

37. In its post-disaster assessment the West Midlands Police investigators concluded that the failure to anticipate that unregulated entry of fans through exit Gate C and down the tunnel would lead to a sustained crush in already full central pens had a 'direct bearing on the disaster'.

38. SYP officers with experience of the inner concourse and terrace access stated that previously they had controlled access to the tunnel once the central pens appeared to be full, particularly in 1988. The disclosed documents reveal that this information was deleted from some officers' statements. Several officers declined a further invitation by SYP solicitors to reconsider their statements regarding SYP responsibility for monitoring the pens.

39. Senior SYP officers denied knowledge of tunnel closures at previous semi-finals, particularly 1988. They placed responsibility for that information not being given at debriefings on the officers responsible for the closures. Yet SYP officers responsible for closing the tunnel access in 1988 claimed that they had acted under instructions from senior officers.

40. Whatever their personal knowledge of the 1988 tunnel closure, both Chief Superintendent Mole and Chief Superintendent Duckenfield admitted their awareness of the practice of occasionally restricting access to the tunnel to prevent overcrowding in the central pens.

Chapter 4. Emergency response and aftermath: 'routinely requested to attend'

The immediate aftermath of a major disaster is by its nature chaotic, and presents unique challenges to first responders. To implement effective rescue and recovery, it is important that the disaster is recognised and the major incident plan activated by all emergency services. The disclosed documents reveal important flaws at each stage.

Not only was there delay in recognising that there were mass casualties, the major incident plan was not correctly activated and only limited parts were then put into effect. As a result, rescue and recovery efforts were affected by lack of leadership, coordination, prioritisation of casualties and equipment.

The emergency response to the Hillsborough disaster has not previously been fully examined, because of the assumption that the outcome for those who died was irretrievably fixed long before they could have been helped.

41. Disclosed documents show that police officers, particularly senior officers, interpreted crowd unrest in the Leppings Lane terrace central pens as a sign of potential disorder, and consequently were slow to realise that spectators were being crushed, injured and killed.

42. Ambulance control room transcripts show that Ambulance Service officers, present specifically to respond to a major incident rather than have any crowd control brief, were slower than police to identify and realise the severity of the crush despite being close to the central pens.

43. Neither SYP nor the South Yorkshire Metropolitan Ambulance Service (SYMAS) fully activated the major incident procedure. Communications between all emergency services were imprecise and inappropriately worded, leading to delay, misunderstanding and a failure to deploy officers to take control and coordinate the emergency response.

44. Only the two major Sheffield hospitals correctly activated their major incident procedures, relying on staff judgement and information received from an ambulance crew member about radio traffic he had overheard.

45. Lack of correct activation of the major incident procedure significantly constrained effective and appropriate response. Senior ambulance officers were not deployed to specified command and control roles and an emergency foot team with essential medical equipment was not mustered. Site medical teams were not called until it was too late for them to be used to effect.

46. The disclosed documents show clear and repeated evidence of failures in leadership and emergency response coordination. While this is understandable in the immediate moments of an overwhelming disaster, it was a situation that persisted for at least 45 minutes after injured spectators were released from the pens.

47. Despite lack of direction, many junior ambulance staff and police officers attempted to resuscitate casualties and transfer them to the designated casualty reception point in the gymnasium. They were aided by the efforts of many fans, some of whom were injured. Doctors and nurses among the fans made a contribution to resuscitation.

48. There was no systematic assessment of priorities for treatment or removal to hospital (triage). Individuals including ambulance staff and two doctors among the crowd attempted to compensate for the lack of an appropriate system, with varying results.

49. There was a lack of basic necessary equipment where it was most needed, including airways, suction and swabs. While this equipment was provided on front-line ambulances, it remained in vehicles outside the stadium as crews were unaware of what was required on the pitch.

50. The absence of leadership, coordination, systematic triage and basic equipment was also evident in the gymnasium, the designated casualty reception point. Statements and ambulance control transcripts reveal that opportunities for senior officers to exercise control were missed for almost an hour, and conditions remained chaotic.

51. Doctors and nurses attending the match as spectators were uniquely placed to weigh the emergency services' response against their professional experience. Their documented accounts confirm that a large majority were critical of the lack of leadership, coordination, triage and equipment.

52. SYMAS responded vigorously to any criticism expressed publicly. Its attempts to portray criticism as the views of ill-informed and impulsive doctors caught up in the emotions of the disaster are revealed as factually incorrect. Although given wide credence, the SYMAS responses were misleading.

53. Control room transcripts show that radio communication problems clearly hindered SYMAS's response more than the Service was prepared to admit, but the lack of appropriate activation of the major incident procedure was more significant.

54. Viewed entirely as an operation to deploy ambulances to the stadium, and to transport casualties as quickly as possible to hospital, the SYMAS response was rapid and efficient. Yet this ignores a significant component of the response to a major disaster set out in the SYMAS major incident plan: the provision of appropriate assessment, prioritisation and treatment on site.

55. Disclosed records show that both main Sheffield hospitals provided prompt and effective treatment for survivors taken there, aided by the activation of their major incident procedures. This was enhanced significantly by the spontaneous attendance of a general physician at the Northern General Hospital who was well placed to manage the effects on the brain of shortage of oxygen, the principal cause of life-threatening injury.

56. The gymnasium at the ground was used as a temporary mortuary pending identification of the bodies. Neither that environment nor the preliminary identification process using Polaroid photographs were ideal, and were constrained by available facilities. It appears from the Coroner's notes that the identification process was intended to ease distress, but it was poorly executed. No reason is given for the decision to use the gymnasium.

57. Large numbers of friends and relatives remained for a prolonged period in poor surroundings in the Boys' Club opposite the divisional police station while the identification process was established. They had minimal information, if any, due in part to the casualty bureau telephone lines being swamped and limited access to public telephones.

58. Immediately following identification, the intrusive questioning of bereaved relatives about the social and drinking habits of their loved ones was perceived as insensitive and irrelevant, and added to their distress.

59. Previously, the emergency services' response has been considered in the context of the Taylor Inquiry and the inquests. Medical evidence to both maintained that all who died were irreversibly and fatally injured in the initial crush, and no response could have changed the outcome. As shown in Chapter 5, the disclosed documents demonstrate that this evidence was flawed and some, partially asphyxiated, survived for a significant period.

60. It is not possible to establish whether a more effective emergency response would have saved the life of any one individual who died. Given the evidence disclosed to the Panel of more prolonged survival of some people with partial asphyxiation,

however, a swifter, more appropriate, better focused and properly equipped response had the potential to save more lives.

Chapter 5. Medical evidence: the testimony of the dead

The medical evidence from pathologists who had conducted post mortem examinations on the deceased was central in establishing the picture of an unvarying pattern of death within a few minutes of crushing. This evidence was the basis for the assertion by the Coroner and others that the outcome was predetermined from an early stage for all who died.

This underpinned the imposition of the 3.15pm cut-off on the generic inquest and the repeated assumption that the emergency services' response could not have helped. The Panel's access to all of the relevant records has confirmed that the notion of a single, unvarying and rapid pattern of death in all cases is unsustainable. Some of those who died did so after a significant period of unconsciousness during which they might have been able to be resuscitated, or conversely may have succumbed to a new event such as inappropriate positioning.

The idea that alcohol contributed to the disaster was raised at an early stage, and has proved remarkably durable despite being dismissed by the Taylor Report. The disclosed documents confirm the repeated attempts that were made to find supporting evidence for this.

They also show that available evidence was significantly misinterpreted, including an attempt to establish a link between later arrival and drunkenness that was fundamentally flawed.

The weight placed on alcohol in the face of objective evidence of a pattern of consumption modest for a leisure event was inappropriate. It has since fuelled persistent and unsustainable assertions about drunken fan behaviour.

61. In the great majority of cases, the cause of death given after post mortem examination was either traumatic asphyxia or crush asphyxia, each regarded as synonymous terms. The disclosed documents show that this corresponded to an assumption made by the Coroner and formed before the post mortems were conducted.

62. The detailed review of all post mortem reports casts significant doubt on the single unvarying pattern, described consistently during the 'mini-inquests', of traumatic asphyxia causing unconsciousness within seconds, followed inevitably by death within a few minutes.

63. There was clear evidence from the post mortem reports that 28 of those who died did not have traumatic asphyxia with obstruction of the blood circulation, and asphyxia may have taken significantly longer to be fatal. There was separate evidence that in 31 the heart and lungs had continued to function after the crush, and in 16 of these this was for a prolonged period. (These numbers cannot be added to the 28 as some featured in both groups.)

64. It was asserted repeatedly, by the Coroner, by the High Court in the Judicial Review proceedings and by the Stuart-Smith Scrutiny, that the effects of asphyxia were irreversible by the time each of those who died was removed from the pens. Yet individuals in each of the groups now identified could have had potentially

reversible asphyxia. Resuscitation of an unconscious person with a heartbeat is much more likely to be successful than if cardiac arrest has already occurred, as was previously assumed. While they remained unconscious, these individuals were vulnerable to a new event, particularly further airway obstruction from inappropriate positioning.

65. It is not possible to establish with certainty that any one individual would or could have survived under different circumstances. It is clear, however, that some people who were partially asphyxiated survived, while others did not. It is highly likely that what happened to these individuals after 3.15pm was significant in determining that outcome. On the basis of this disclosed evidence, it cannot be concluded that life or death was inevitably determined by events prior to 3.15pm, or that no new fatal event could have occurred after that time.

66. Disclosed documents provide no rationale for the Coroner's exceptional decision to take samples for blood alcohol measurement from all of the deceased.

67. The implicit and explicit use of a blood alcohol level of 80mg/100ml as a marker was unjustified. This level has relevance to the rapid response times of individuals in charge of motor vehicles, but none to people attending a leisure event.

68. Analysis of the data demonstrates that the attempt to draw statistical correlation between the time of arrival and alcohol level was fundamentally flawed in six respects, and no such link could be deduced.

69. The weight placed on alcohol levels, particularly in the Coroner's summing up at the inquests, was inappropriate and misleading. The pattern of alcohol consumption among those who died was unremarkable and not exceptional for a social or leisure occasion.

70. A document disclosed to the Panel has revealed that an attempt was made to impugn the reputations of the deceased by carrying out Police National Computer checks on those with a non-zero alcohol level.

71. The disclosed documents show that blood alcohol levels were tested in some survivors who attended hospital, as well as in all those who died. There is no record of these tests or their results in the medical notes of survivors, and in some there was no apparent medical reason for the test. The extent of this testing remains unknown.

72. There was no evidence to support the proposition that alcohol played any part in the genesis of the disaster and it is regrettable that those in positions of responsibility created and promoted a portrayal of drunkenness as contributing to the occurrence of the disaster and the ensuing loss of life without substantiating evidence.

Chapter 6. Parallel investigations

Following a disaster that claimed so many lives, inevitably the investigation and inquiry into its circumstances and causes were complex. Because there were fatalities the Coroner was involved immediately. Within SYP an internal investigation was established, including a process of information gathering involving 'self-taken' statements written by police officers.

Lord Justice Taylor was appointed to conduct a judicial inquiry. The Chief Constable of West Midlands Police (WMP) was invited to establish a full investigation carried out by a WMP team. The WMP team served the criminal investigation, the Taylor Inquiry and the Coroner's inquiry and inquest.

Thus multiple investigations proceeded in parallel. It is evident from the disclosed documents that from the outset SYP sought to establish a case emphasising exceptional levels of drunkenness and aggression among Liverpool fans, alleging that many arrived at the stadium late, without tickets and determined to force entry.

A less well-known investigation was conducted by the Health and Safety Executive (HSE), and found that restricted access, poor condition and inadequate means of escape rendered the Leppings Lane terrace – particularly its central pens – structurally unsafe. This risk was known.

73. Documents disclosed to the Panel by SYP show that on the morning after the disaster senior officers discussed privately the 'animalistic behaviour' of 'drunken marauding fans', but agreed not to make this a public issue in case they were perceived as avoiding responsibility.

74. No contemporaneous documents have been disclosed concerning the briefing given to the Prime Minister and the Home Secretary by SYP when they visited Sheffield on 16 April 1989. The Prime Minister's Press Secretary later revealed, however, that he had been informed on the day that drunkenness and violent crowd behaviour were significant causes of the disaster.

75. The disclosed documents show that in the immediate aftermath of the disaster SYP prioritised an internal investigation and the collection of self-taken, handwritten statements in preparation for the imminent external inquiries and investigations. SYP Counsel advised that the police should approach its information-gathering exercise by considering themselves 'the accused'.

76. A subsequent internal report ('the Wain Report') informed the SYP submission to the Taylor Inquiry. Key elements of the SYP submission emphasised exceptional, aggressive and unanticipated crowd behaviour: large numbers of ticketless, drunk and obstinate fans involved in a concerted action, even 'conspiracy', to enter the stadium.

77. The SYP submission also noted structural deficiencies within the stadium and its management by SWFC. This line of argument was further developed in advice from a senior police officer from another force commissioned by SYP in support of civil proceedings. In contrast, the SWFC submission specified serious failures in policing in monitoring the pens, processing the crowd and opening Gate C without preparing for the consequences.

78. Reports commissioned by SYP and SWFC from two experienced senior police officers reveal how, when confronted with consistent information from two distinct and potentially culpable institutional interests, significantly different conclusions were drawn.

79. The submission by Counsel to the Taylor Inquiry focused on the build-up of fans outside the stadium, insufficiency of turnstiles and lack of control of the numbers distributed between the pens.

80. An initial investigation into the condition of the Leppings Lane terrace and its approaches was conducted by Sheffield City Council. It found deficiencies in the placement of safety barriers and in the width of the perimeter fence gates.

81. In its more detailed investigation, the Health and Safety Executive (HSE) established that the safe maximum capacity of the pens had been set too high and that the crowd density in pen 3, where most of the deaths occurred, was substantially higher than the Green Guide maximum.

82. The HSE established not only that the maximum capacity of the terrace and the central pens had been significantly over-calculated, but that alterations to the terrace had not been considered in establishing safe capacity. It concluded that the terrace safety barriers were considerably below the recommended height and that this deficiency should have reduced further the maximum safe capacity.

83. The restricted approach to the Leppings Lane end and the comparatively low number of turnstiles resulted in inevitable congestion and delays in entering the stadium at capacity matches. The HSE noted that the number of fans that had to pass through each of the Leppings Lane turnstiles was between 2.9 and 3.5 times higher than at turnstiles serving other parts of the stadium. The calculated rate of admission shows that the crowd could not have completed entering the ground until approximately 40 minutes after the kick-off.

84. Many of these issues were also raised in Professor Leonard Maunder's advice as one of the assessors to the Taylor Inquiry. The advice from the police assessor, Chief Constable of Lancashire Brian Johnson, criticised SYP's failure to review the 1988 Police Operational Order to identify 'shortcomings'; poor communications between senior officers; and the consequent failure to divert the crowd away from the tunnel once Gate C had been opened.

85. It is evident from the Salmon letters issued to SYP, SWFC, Sheffield City Council and Eastwood & Partners (disclosed to the Panel) that there was an understanding within the Home Office of the central issues of responsibility to be examined by the Taylor Inquiry.

86. In documents disclosed to the Panel it is evident that the primary concern of the Government at the time was the potential impact (positive or negative) on the Parliamentary passage of the planned Football Spectators Bill.

87. Following the publication of the Taylor Report, the Prime Minister was briefed that 'the defensive – and at times close to deceitful – behaviour by the senior officers in South Yorkshire sounds depressingly familiar'. The Government did not seek to protect the SYP Chief Constable and it was considered inevitable that he would resign. His resignation, however, was rejected by South Yorkshire Police Authority.

88. Access to Cabinet documents reveals that in an exchange about her Government 'welcoming the Report' the Prime Minister, Margaret Thatcher, expressed her concern that the 'broad thrust' of the Taylor Report constituted a 'devastating criticism of the police'.

89. In reaching a decision on criminal prosecutions, the Director of Public Prosecutions was advised that responsibility for the disaster lay with SWFC, Eastwood & Partners engineers, Sheffield City Council and SYP. While the most significant proportion of responsibility was attributed to SYP, it was considered that the legal case for manslaughter or any other criminal offence could not be established.

90. Disciplinary proceedings against Chief Superintendent David Duckenfield and Superintendent Bernard Murray were brought only following a direction from the Police Complaints Authority (PCA). Responding to legal advice, SYP had decided that disciplinary charges should not be brought. The PCA was concerned that subsequent delays in bringing disciplinary proceedings were 'tactical'. A significant cause of the delay was the impact of the 'review and alteration' of SYP statements and their evidential unreliability.

Chapter 7. Civil litigation

The documents disclosed to the Panel show that SYP sought to avoid any admission of liability in the settlement of compensation claims and in contribution proceedings against other organisations. SYP officers who claimed compensation were pressured within the Force to withdraw their claims.

91. The decision by SYP to settle certain categories of compensation claims from the injured and bereaved in November 1989 was sudden and taken for legal and tactical reasons. It was made deliberately without any admission of liability so as not to prejudice the position of any police officers subsequently under criminal investigation.

92. Following legal action by SYP, other organisations agreed to contribute to the payment of compensation to the injured and bereaved as follows:

    - Sheffield Wednesday Football Club – £1.5 million
    - the Club's engineers Eastwood & Partners – £1.5 million
    - Sheffield City Council – £1 million.

93. It was estimated that total compensation to the injured and bereaved might reach £12 million, suggesting that SYP would have accepted two-thirds of the liability and the other organisations one-third. Ultimately the cost of compensation rose to £19.8 million. SYP's public liability insurance cover was limited to £8.5 million. The remainder of the total was paid from the Police Authority's financial reserves and through special payments from the Home Office.

94. Compensation claims from SYP officers caused considerable tension within the Force. Senior officers viewed the claims with 'great concern' and junior officers felt 'immense pressure' from the Force to withdraw them. SYP accepted internally that they had 'no defence' in relation to a category of claims in late 1992, but did not agree to make payments until mid-1995. This was a strategic decision to deter 'copy-cat' claims. Those claims not settled were successfully defended in court. £1.5 million was ultimately paid out by SYP to 16 officers. The costs were met from the Force's employers' insurance cover.

Chapter 8. The Coroner's inquiry: from the immediate aftermath to the preliminary hearings

The most striking feature of the Coroner's inquiry was the decision to hold the inquest in two separate parts. The initial phase was a series of preliminary hearings or 'mini-inquests', one for each death, followed later by a single generic inquest to consider the circumstances of the disaster. The decision to hold separate preliminary hearings had far-reaching consequences.

Each preliminary hearing before a jury heard a pathologist give evidence on cause of death, preceded by the contentious reading of the deceased's blood alcohol level. This

was followed by an account by a WMP officer, summarising what was known concerning the deceased's prior movements, location in the pens and events after evacuation from the pens. Because the account was given by a WMP investigating officer, this evidence could not be questioned during the inquest.

The disclosed documents show that while the families' lawyers welcomed the Coroner's unusual decision to hold individual, preliminary hearings, many families were dissatisfied with the denial of an opportunity to enquire into the precise circumstances in which their loved ones died.

95. In public statements the Coroner explained that his decision to hold preliminary hearings on a limited basis (mini-inquests) was in response to representations from families' lawyers. The disclosed documents show that the Coroner took Counsel's advice before deciding to hold mini-inquests, a decision initially rejected by the WMP investigation team.

96. The procedures adopted for the presentation of evidence to the jury, particularly WMP investigating officers reading witnesses' summarised statements, prevented examination of the evidence. This undermined its reliability and this became a serious issue of concern regarding 'sufficiency' of inquiry.

97. This process, while agreed by the bereaved families' legal representatives, was accepted on the assumption that questions and inconsistencies within summaries would be fully examined at the generic stage of the inquests. This occurred only in a limited number of cases.

98. Following the mini-inquests, the families' legal representatives conveyed their clients' satisfaction with the process to the Coroner. Yet families' correspondence demonstrates serious concerns regarding what they considered to be a flawed process which left many questions unanswered.

Chapter 9. The generic hearing, Judicial Review and continuing controversies

The second stage of the inquests was the generic hearings held after the decision had been taken by the Director of Public Prosecutions not to pursue criminal prosecutions.

The documents disclosed to the Panel show that there were concerns raised in discussions between the Coroner and the WMP investigators about the status and ownership of information gathered and statements made for the Taylor Inquiry and the criminal investigation.

It is clear from the documents that SYP considered that the generic hearings provided an opportunity to use the court to respond to criticisms levelled against the Force and its senior officers by Lord Justice Taylor's Interim Report. Consequently the nature of the generic hearing was adversarial rather than inquisitorial.

While the High Court in the Judicial Review proceedings considered that the inquests had been unorthodox, it did not consider that the process had been insufficient in establishing how the deceased came by their deaths.

99. The Coroner decided against relying on the Taylor Inquiry to meet the requirements of the generic stage of the inquests. As the disclosed documents show, the

hearings became adversarial as SYP attempted to use the proceedings to respond to criticisms in Lord Justice Taylor's Interim Report.

100. The Coroner anticipated that SYP would attribute responsibility for the disaster to 'drunkenness and disobedience' and 'ticketless' fans while also proposing that failings by SWFC and its safety engineers and the 'nepotism' of Sheffield City Council were relevant factors.

101. The Coroner's file notes also indicate his acceptance, regardless of Lord Justice Taylor's findings, that the relationship between alcohol consumption, late arrivals and crowd behaviour could have contributed to the disaster. The reason for this assumption is not evident from the disclosed documents.

102. Exchanges between the lead investigating officer, Chief Constable Leslie Sharp, and the Coroner demonstrate strong differences of opinion regarding the status of the information gathered for the criminal investigation and the access to the information granted to SYP prior to completion of the inquests.

103. These differences were settled by Chief Constable Sharp's decision to release documents to SYP and the Force's agreement that they would be used only for disciplinary purposes and not in preparation for the inquests.

104. Confusion and controversy about the status and ownership of documents and statements gathered by the WMP investigation team reveal the problems associated with sharing evidence between interested parties and the privilege enjoyed by SYP in preparation for the generic stage of the inquests.

105. It is also evident that, in order to fulfil an expectation that the Coroner had all documents 'available' to him, he arranged for their delivery to his home for a few days even though he would not have the capacity to consider them thoroughly.

106. It is clear from the disclosed documents that the Coroner considered the mini-inquests had answered issues of relevance to each of the bereaved. The task of the generic hearing was to establish 'how' the 95 had died.

107. Having invited all interested parties to identify who they wanted to be called as witnesses at the generic stage, in the disclosed documents there is no explanation for the Coroner's final selection.

108. There is a substantial amount of documentary evidence concerning the inadequacy of the inquest process. In subsequent Judicial Review proceedings the High Court recognised that the inquests were 'unorthodox' and failed to comply with the Coroners Rules. Yet the High Court rejected claims that there had been insufficiency of process.

109. Lord Justice Stuart-Smith raised concerns with the Coroner that families had been misled into believing that questions that remained unanswered at the mini-inquests would be addressed at the generic stage. The Coroner reassured him that, wherever relevant, this was achieved, although subsequent correspondence from families suggests otherwise.

110. While Lord Justice Stuart-Smith recognised the complexities and difficulties facing the Coroner, he considered that the generic hearing became 'out of control'. He suggested that it might have been more appropriate to have adopted the findings of the Taylor Inquiry than to have conducted a generic hearing.

Chapter 10. The 3.15pm cut-off

The Coroner's decision to limit evidence to events before 3.15pm was based on pathologists' evidence, then uncontested and accepted as incontrovertible, that all who died were by that time beyond recovery. It remains one of the most significant causes of concern for bereaved families because it eliminated examination of the adequacy of the emergency response and rescue.

111. The disclosed documents establish that 'evidence gathering' by SYP in the immediate aftermath of the disaster focused on the 'incident itself', specifying a cut-off at 3.15pm or 3.30pm.

112. From the disclosed documents it is clear that, prior to the mini-inquests, the Coroner understandably was concerned about his capacity to control the scope of the inquests – a concern reflected in the advice he received from other coroners. 'Response' and 'rescue' attempts were considered to be 'post-incident' and would not be addressed at the inquests.

113. Prior to the generic stage of the inquests, the WMP investigation team (acting as coroner's officers) advised that its scope should be restricted to the period 2.20pm to 3.05pm.

114. The rationale presented by the Coroner for selecting 3.15pm as the cut-off, acknowledged as appropriate by the High Court in the Judicial Review proceedings and the Stuart-Smith Scrutiny, was that all who died had suffered fatal and irreversible injuries by that time.

115. 3.15pm was chosen because it was an undisputed and recorded time when an ambulance arrived on the pitch. This served as a 'marker' and the Coroner rounded the time to the nearest quarter-hour.

116. The pathologists' medical opinion underpinned the Coroner's final decision. It concluded that all who died suffered irretrievable, fatal injury and there could be no recovery regardless of whether the deceased lived beyond 3.15pm. This opinion neglected the significance of the particular circumstances in which each individual died, including the absence of appropriate medical or treatment intervention.

117. The acceptance of the pathologists' medical opinion as incontrovertible is evident from the Coroner's notes, in his affidavit to the High Court in the Judicial Review proceedings (in which he described the 'expert' pathological evidence as 'overwhelming') and in his evidence to the Stuart-Smith Scrutiny.

118. Records of meetings between the Coroner and the families' legal representatives reveal that the representatives accepted the 3.15pm cut-off and portrayed families' concerns about the mini-inquests as 'minimal'.

119. As the extent of the correspondence from families demonstrates, this assumption was mistaken. The Coroner dismissed the families' requests to extend the cut-off beyond 3.15pm to incorporate the period of rescue and evacuation because he believed they misunderstood the role and function of the inquests.

120. The disclosed documents show that the Coroner formed the view that the case for extending the generic stage of the inquests beyond 3.15pm would require evidence of a new causal act that resulted in any one death (*novus actus interveniens*). He

concluded that there was no evidence of such acts or interventions, a conclusion supported by the High Court in the Judicial Review proceedings and by the Stuart-Smith Scrutiny.

121. The families accepted that the primary cause of injuries was crushing but, supported by further medical opinion, they challenged the certainty that all who died had suffered irretrievable fatal injury by 3.15pm. Thus they sought further inquiry into the emergency response, rescue and treatment.

122. In his evidence to the Stuart-Smith Scrutiny, the barrister who had represented the families at the generic stage of the inquests informed Lord Justice Stuart-Smith that he had advised the families there was no new causal act beyond 3.15pm.

123. In the Coroner's summing up he accepted that had resuscitation been administered correctly, and before the onset of 'irretrievable brain damage', some of those who died might have survived. Taken literally, this comment raises concerns about the sufficiency of inquiry into the period of rescue and resuscitation.

124. In the well-documented case of Kevin Williams and successive submissions by his family to the Attorney General, the initial pathologist's opinion appeared definitive, but further authoritative opinions raised significant doubts about the accuracy of that initial opinion.

125. The documents disclosed show that, considered alongside the restrictions placed by the Coroner on the examination of the evidence presented to the mini-inquests and the presentation of the pathologists' medical opinion as incontrovertible, the imposition of the 3.15pm cut-off severely limited examination of the rescue, evacuation and treatment of those who died. This raised profound concerns regarding sufficiency of inquiry and examination of evidence.

Chapter 11. Review and alteration of statements

Eight years after the disaster it was revealed publicly for the first time that statements made by SYP officers were initially handwritten as 'recollections', then subjected to a process of 'review and alteration' involving SYP solicitors and a team of SYP officers. In a number of cases police officers were asked to reconsider and amend their initial statements before they were forwarded to the Taylor Inquiry.

The documents disclosed to the Panel show that there was confusion concerning the status of the recollections, the rationale behind their review and alteration, the extent of the amendments and officers' acceptance of the process. While Lord Justice Stuart-Smith raised concerns about the appropriateness of the process, he considered there was no malpractice involved.

Other disclosed documents show that the practice of review and alteration extended to the South Yorkshire Ambulance Service.

126. From the documents disclosed to the Panel it is apparent that the decision to gather self-taken recollections from SYP officers, rather than following the standard procedure of contemporaneous pocket-book entries as the foundation for formal Criminal Justice Act statements, originated in the immediate aftermath of the disaster on 16 and 17 April. The initial justification was to provide SYP and the Force solicitors with candid, 'warts-and-all' accounts from officers that would be used to inform SYP's submission to the Taylor Inquiry.

127. What followed, however, was an extensive process of review and alteration of the recollections and their transition to multi-purpose statements. The disclosed documents reveal confusion about the purpose of recollections, initially taken for SYP 'internal' purposes, and their subsequent use by the WMP investigation. It was brought into stark relief in the confusion surrounding the status of statements presented to the Taylor Inquiry and the Inquiry's acceptance of the 'final versions' of the reviewed and altered statements.

128. It was the Taylor Inquiry's understanding that the 'final versions' of SYP statements differed from the initial 'recollections' only with regard to the removal of officers' opinions. The Inquiry team considered there to be 'absolutely no reason' why opinion should be removed, but did not consider the process improper and did not raise any objection.

129. The process of transition from self-taken recollections to formal Criminal Justice Act statements was presented as removing 'conjecture' and 'opinion' from the former, leaving only matters of 'fact' within the latter. Disclosed correspondence between SYP and the Force solicitors reveals that comments within officers' statements 'unhelpful to the Force's case' were altered, deleted or qualified (rewritten by the SYP team).

130. A significant number of SYP officers were uncomfortable with the methodology adopted in reviewing and altering their initial accounts and with the role of the SYP solicitors in this process. Senior SYP officers, including the Chief Constable, were aware of these concerns and the disclosed 'Hillsborough updates' demonstrate their attempts to assuage these concerns. An SYP inquiry liaison team was available to provide junior officers with 'necessary information and assistance' prior to giving evidence to the Taylor Inquiry.

131. Examination of officers' statements shows that officers were discouraged from making criticisms of senior officers' responses, their management and deficiencies in the SYP operational response: 'key' words and descriptions such as 'chaotic' were counselled against and, if included, were deleted.

132. Some 116 of the 164 statements identified for substantive amendment were amended to remove or alter comments unfavourable to SYP.

133. Lord Justice Stuart-Smith raised concerns about the derivation and operation of the process of review and alteration with SYP's Chief Superintendent Donald Denton and Peter Metcalf (Hammond Suddards, SYP solicitors).

134. Lord Justice Stuart-Smith also wrote directly to a number of officers to investigate the extent to which they were 'pressurised' into making alterations to original statements.

135. One officer stated he had accepted the changes only because he was suffering from depression and post-traumatic stress. He considered it an 'injustice for statements to have been "doctored" to suit the management of South Yorkshire Police'. Another officer had accepted the process, but had not realised how much of his statement had been removed.

136. Detective Chief Superintendent Nick Foster of the WMP investigation team informed the Stuart-Smith Scrutiny that in five out of a sample of six amended statements material should not have been removed. In one case he 'question[ed]

the objectivity … of the person vetting'. He considered that the investigation had not been affected by the deletions made.

137. The disclosed documents demonstrate that the role played by the Force solicitors was more significant and directive than was understood by Lord Justice Stuart-Smith.

138. Lord Justice Stuart-Smith accepted that SYP edited those statements that were 'unhelpful to the police case' but 'at worst this was an error of judgement' as there were only a few examples 'where matters of fact were excluded'. The process reflected an 'understandable desire' to protect the interests of a Force on the 'defensive'. Yet Lord Justice Stuart-Smith found no 'irregularity or malpractice'. There had been no negative consequences for the Taylor Inquiry, the criminal investigations, the disciplinary proceedings or the coronial inquiry.

139. The documents disclosed to the Panel show that the review and alteration of statements extended to the South Yorkshire Metropolitan Ambulance Service (SYMAS) and its solicitors. While there is variation in the amendments, in a number of cases they deflected criticisms and emphasised the efficiency of the SYMAS response.

Chapter 12. Behind the headlines: the origins, promotion and reproduction of unsubstantiated allegations

In the days after the disaster the media, particularly the press, published allegations and counter-allegations apportioning blame. This came to a head on 19 April when a number of newspapers, *The Sun* being the most prominent, reported serious allegations about the behaviour of Liverpool fans before and during the unfolding tragedy.

The documents disclosed to the Panel show that the origin of these serious allegations was a local Sheffield press agency informed by several SYP officers, an SYP Police Federation spokesperson and a local MP.

They also demonstrate how the SYP Police Federation, supported informally by the SYP Chief Constable, sought to develop and publicise a version of events that focused on several police officers' allegations of drunkenness, ticketlessness and violence among a large number of Liverpool fans. This extended beyond the media to Parliament.

Yet, from the mass of documents, television and CCTV coverage disclosed to the Panel there is no evidence to support these allegations other than a few isolated examples of aggressive or verbally abusive behaviour clearly reflecting frustration and desperation.

140. As the severity of the disaster was becoming apparent, SYP Match Commander, Chief Superintendent David Duckenfield, told a falsehood to senior officials that Liverpool fans had broken into the stadium and caused an inrush into the central pens thus causing the fatal crush. While later discredited, this unfounded allegation was broadcast internationally and was the first explanation of the cause of the disaster to enter the public domain.

141. Within days, further serious allegations emerged from unnamed sources, a Police Federation spokesperson and a local Conservative MP, Irvine Patnick. These were that Liverpool fans had conspired to arrive late, many were without tickets, were exceptionally drunk and aggressive and determined to force entry into the stadium.

142. On 19 April, four days after the disaster, *The Sun* newspaper published a front-page story under the banner headline, 'THE TRUTH', alleging that Liverpool fans had assaulted and urinated on police officers resuscitating the dying, stolen from the dead and verbally sexually abused an unconscious young woman. Although less prominently, and often with a lesser degree of certainty, other regional and national newspapers published similar allegations.

143. In a letter revealed to the Panel, within days of *The Sun*'s article its Managing Editor wrote to people, including bereaved families, who had complained about the allegations. While regretting the presentation of the article, he refused to apologise for its 'substance', claiming it was factually accurate. Subsequently the coverage was condemned by the Press Council.

144. Given the broader press reporting of the allegations, the Panel sought to establish their origins. Documents disclosed to the Panel show that the allegations were filed by White's News Agency, a Sheffield-based company. They were based on meetings over three days between agency staff and several police officers, together with interviews with Irvine Patnick MP and the South Yorkshire Police Federation Secretary, Paul Middup.

145. From the documents, it is clear that Mr Patnick based his comments on a conversation with police officers on the evening of the disaster while the officers were in considerable distress. Mr Patnick submitted a detailed account of this meeting and his overall involvement that evening to the Taylor Inquiry.

146. Months after the disaster White's News Agency confirmed to the London *Evening Standard* that its filed stories originated from 'unsolicited' allegations made by 'high ranking' SYP officers to agency 'partners'. There were four separate police sources plus the interview with Mr Patnick. Together these sources were considered sufficient verification for the story to be considered factually accurate and it was distributed accordingly.

147. A document disclosed to the Panel shows that while the Taylor Inquiry was in session White's News Agency received copies of several SYP officers' sworn statements alleging drunken and violent behaviour by Liverpool fans. The agency forwarded the statements to Mr Patnick.

148. A further document records a meeting in Sheffield of Police Federation members on the morning of the publication of the controversial story in *The Sun*. The Police Federation Secretary, Mr Middup, confirmed that 'putting our side of the story over to the press and media' had been his priority. He told the meeting that the Chief Constable had stated that 'the truth could not come from him' but he had given the Police Federation a 'free hand' and his support.

149. At the meeting police officers repeated many of the allegations published in the media. The Chief Constable joined the meeting and advised that the SYP case had to be pulled together and given to the Inquiry. A 'defence' had to be prepared and a 'rock solid story' presented. He believed that the Force would be 'exonerated' by the Taylor Inquiry and considered that 'blame' should be directed towards 'drunken ticketless individuals'.

150. Lord Justice Taylor's Interim Report condemned the evidence and testimony of senior police officers and rejected as exaggerated the allegations made against