IOPC Independent Office for Police Conduct

The Hillsborough Disaster

The report of the IOPC and Operation Resolve investigations

December 2025

The names of those who were unlawfully killed

Adam Edward Spearritt, 14 years old
Alan Johnston, 29
Alan McGlone, 28
Andrew Devine, 55
(22 at the time of the disaster)
Anthony David Bland, 22
(18 at the time of the disaster)
Anthony Peter Kelly, 29
Arthur Horrocks, 41
Barry Glover, 27
Barry Sidney Bennett, 26
Brian Christopher Matthews, 38
Carl Brown, 18
Carl Darren Hewitt, 17
Carl David Lewis, 18
Carl William Rimmer, 21
Christine Anne Jones, 27
Christopher Barry Devonside, 18
Christopher Edwards, 29
Christopher James Traynor, 26
Colin Andrew Hugh William Sefton, 23
Colin Mark Ashcroft, 19
Colin Wafer, 19
David George Rimmer, 38
David Hawley, 39
David John Benson, 22
David Leonard Thomas, 23
David Steven Brown, 25
David William Birtle, 22
David William Mather, 19
Derrick George Godwin, 24
Eric George Hughes, 42
Eric Hankin, 33
Francis Joseph McAllister, 27
Gary Christopher Church, 19
Gary Collins, 22
Gary Harrison, 27
Gary Philip Jones, 18
Gerard Bernard Patrick Baron, 67
Gordon Rodney Horn, 20
Graham John Roberts, 24
Graham John Wright, 17
Henry Charles Rogers, 17
Ian David Whelan, 19
Ian Thomas Glover, 20
Inger Shah, 38
James Gary Aspinall, 18
James Philip Delaney, 19
James Robert Hennessy, 29
John Alfred Anderson, 62
John McBrien, 18
Jonathon Owens, 18
Jon-Paul Gilhooley, 10
Joseph Clark, 29
Joseph Daniel McCarthy, 21
Keith McGrath, 17
Kester Roger Marcus Ball, 16
Kevin Daniel Williams, 15
Kevin Tyrrell, 15
Lee Nicol, 14
Marian Hazel McCabe, 21
Martin Kenneth Wild, 29
Martin Kevin Traynor, 16
Michael David Kelly, 38
Nicholas Michael Hewitt, 16
Nicholas Peter Joynes, 27
Patrick John Thompson, 35
Paul Anthony Hewitson, 26
Paul Brian Murray, 14
Paul Clark, 18
Paul David Brady, 21
Paul William Carlile, 19
Paula Ann Smith, 26
Peter Andrew Burkett, 24
Peter Andrew Harrison, 15
Peter Francis Tootle, 21
Peter McDonnell, 21
Peter Reuben Thompson, 30
Philip Hammond, 14
Philip John Steele, 15
Raymond Thomas Chapman, 50
Richard Jones, 25
Roy Harry Hamilton, 34
Sarah Louise Hicks, 19
Simon Bell, 17
Stephen Francis Harrison, 31
Stephen Francis O'Neill, 17
Stephen Paul Copoc, 20
Steven Joseph Robinson, 17
Stuart Paul William Thompson, 17
Thomas Anthony Howard, 14
Thomas Howard, 39
Thomas Steven Fox, 21
Tracey Elizabeth Cox, 23
Victoria Jane Hicks, 15
Vincent Michael Fitzsimmons, 34
William Roy Pemberton, 23

At the request of family members, some names have not been included in this list.

This report includes witness accounts, images and descriptions of scenes that may be distressing.

Images of a sensitive nature may include blurring or pixelation. Where necessary, we have done this to avoid showing distressing material or where individuals may have been identifiable. Some images may have been digitally enhanced to ensure they are of the best possible quality, despite the passage of time.

Contents

Executive summary 6
Summary of outcomes 22
1. Introduction 23
2. The safety of Hillsborough Stadium 31
3. Police planning for the 1989 FA Cup Semi-Final 47
4. The events of 15 April 1989 63
5. The emergency response 97
6. The treatment of families and friends of those who died 131
7. SYP's interaction with the media after the disaster 161
8. SYP's engagement with MPs after the disaster 177
9. SYP's collection of evidence 187
10. SYP's presentation of evidence to the Taylor Inquiry 215
11. SYP's presentation of evidence to the Popper Inquests and contribution proceedings 233
12. The checking of blood alcohol levels of those who died 245
13. Police National Computer checks carried out on those who died 251
14. WMP's work for the Taylor Inquiry 257
15. WMP's criminal investigation into the Hillsborough disaster 281
16. WMP's investigation of complaints made against SYP officers 297
17. WMP's work for the Popper Inquests 307
18. The disappearance of video tapes from the stadium 317
19. Alleged surveillance of family members of those who died 323
20. Norman Bettison's appointment as Chief Constable of Merseyside Police 329
21. The allegation that SYP and WMP sought to deflect blame for the disaster away from the police 337
Glossary 348
Appendix A: Terms of reference 354
Appendix B: Police Discipline Code 1985 359
Appendix C: The role of the IOPC 362
Timeline of the IOPC's investigations 363

Executive summary

1. This is the report of the Independent Office for Police Conduct (IOPC) and Operation Resolve investigations into the role of the police in the Hillsborough disaster and the actions of the police in the aftermath. It concludes the IOPC's and Operation Resolve's work, which began in 2012, following the publication of the Hillsborough Independent Panel (HIP) Report. This work involved securing evidence for new inquests into the deaths that resulted from the events at Hillsborough Stadium on 15 April 1989, conducting criminal investigations that led to a series of trials, and investigating 352 complaints and conduct matters related to police actions before, during and after the disaster.
2. The report is structured in line with the investigations' terms of reference and focuses on the actions of the police forces and officers involved. It summarises the outcomes of the complaint and conduct investigations as well as the key evidence that led to those outcomes.
3. Using new evidence obtained by the investigations, as well as existing material, it re-examines a number of issues which have been scrutinised extensively by previous investigations and inquiries, showing how this new evidence adds further insight into what took place. It also explains why, after obtaining and examining more evidence relating to the disaster than any previous investigation, the IOPC and Operation Resolve have found nothing to change or challenge the core public understanding of the disaster that was established by the HIP Report and findings of the new inquests led by Lord Justice Sir John Goldring (the Goldring Inquests).
4. The report also covers the evidence gathered around aspects of the disaster and its aftermath that have not previously been investigated.

From the Hillsborough disaster to the new investigations

5. The Hillsborough disaster refers to the events at the 1989 FA Cup Semi-Final football match between Liverpool and Nottingham Forest at Hillsborough Stadium in Sheffield. An extreme crush developed in the terraces at the Leppings Lane end of the stadium, resulting in the deaths of 97 Liverpool supporters. In addition, hundreds were injured and thousands left traumatised.
6. A public inquiry led by Lord Justice Peter Taylor (the Taylor Inquiry) was set up to investigate the causes of the disaster and to prevent similar events occurring. On 4 August 1989, Lord Justice Taylor published his Interim Report, setting out his findings on the causes of the disaster. The Interim Report was highly critical of the police operation and of some of the senior officers in the force responsible for the policing of the match, South Yorkshire Police (SYP). It concluded that "the main reason for the disaster was the failure of police control."
7. Lord Justice Taylor also addressed allegations about supporter behaviour that had appeared in some early media coverage, making it clear that in his view, the actions of supporters played no part in the disaster.
8. Despite this, and a series of further inquiries into aspects of the disaster, until the publication of the HIP Report in 2012, there was a widespread public perception that supporters were in some way to blame for what happened.

9. The HIP Report transformed such perceptions, setting out documentary evidence that undermined the allegations about supporter behaviour and drawing attention to how the police acted in the aftermath of the disaster. It also raised important new questions about whether the disaster could have been prevented, and whether a more effective emergency response could have saved more lives.

10. Its impact was immediate. It led to decisions to quash the verdicts of the original inquests into the deaths and to start new inquests, and to launch two substantial new investigations:

    - a police-led investigation, known as Operation Resolve, into the disaster and its causes
    - an investigation by the IOPC into police actions in the aftermath of the disaster

About the investigations

11. The role of the HIP had been to oversee maximum disclosure of existing information about the Hillsborough disaster and explain how this information added to public understanding of the disaster and its aftermath. The IOPC and Operation Resolve by contrast were criminal investigations, which could (and did) result in people facing criminal charges. As well as revisiting all the material the HIP had considered, they had the authority to secure new evidence, by interviewing witnesses and suspects, taking statements and conducting or requesting searches.

12. Both investigations were also police disciplinary investigations, addressing:

    - complaints made about the actions of the police in relation to the disaster and its aftermath
    - conduct matters identified by investigators, where police officers may have committed a criminal offence or behaved in a manner which would justify disciplinary proceedings, but there had not been a complaint about the matter

13. In addressing this extensive remit, the two investigations examined more material about the disaster and its aftermath than any previous investigation or inquiry.

14. Having considered all of this material, the IOPC and Operation Resolve found evidence of fundamental failures by SYP in both the planning for the match and the policing of it, as well as in its response to the disaster.

15. While some of these failures had already been highlighted in previous investigations and inquiries, these investigations found additional evidence that has resulted in a more detailed understanding of what happened on the day and in the aftermath.

16. The evidence examined by Operation Resolve demonstrated persistent failings in police command and coordination on the day of the disaster.

17. The IOPC found considerable evidence that SYP adopted a defensive approach to the investigations and inquiries that followed, and sought to control the material submitted to the Taylor Inquiry in an attempt to deflect the blame away from the police. It also found deficiencies and potential evidence of bias in the work of West Midlands Police (WMP), the police force which undertook the original investigations into the disaster and supported the Taylor Inquiry.

18. Like the HIP Report and the new inquests, the IOPC found no evidence to support police accounts which suggested that the behaviour of supporters caused or in any way contributed to the disaster.

The new inquests

19. As well as addressing their terms of reference, both investigations supported the Goldring Inquests and conducted enquiries for them. The Goldring Inquests hearings ran for 308 days, spread over two years, and heard evidence from more than 1,000 individuals. The IOPC and Operation Resolve provided the inquests with more than one million pages of investigative material, such as witness statements and documents, together with hundreds of hours of audio-visual (AV) material.

20. The original inquests had returned a verdict of accidental death. At the Goldring Inquests, the jury concluded that those who died in the Hillsborough disaster were unlawfully killed—a momentous change.

21. The jury at the Goldring Inquests was also asked to respond to a series of questions about the disaster. One of these was: "Was there any behaviour on the part of football supporters which caused or contributed to the dangerous situation at the Leppings Lane turnstiles?" The jury responded "no". The jury was then asked if there was any such behaviour which **may** have caused or contributed to the dangerous situation; again, the answer was "no". By contrast, the jury answered "yes" to a series of questions about whether there were errors or omissions by police officers in the planning, preparation, decision making and emergency response that caused or contributed to the situation that developed.

Outcomes of the investigations

22. The investigations led to criminal trials of three former SYP officers and two civilians. The police officers were:

    - Chief Superintendent David Duckenfield (Ch Supt Duckenfield), the SYP match commander on the day
    - Chief Superintendent Donald Denton (Ch Supt Denton), who was involved in the way SYP prepared evidence for the Taylor Inquiry and oversaw the amendment of fellow officers' accounts
    - Detective Chief Inspector Alan Foster (DCI Foster), who was directly involved in the amendment of fellow officers' accounts

23. The civilians who faced trial were:

    - Graham Mackrell, the Secretary of Sheffield Wednesday Football Club (SWFC), which owned Hillsborough Stadium
    - Peter Metcalf, a solicitor with the firm Hammond Suddards, who advised SYP in the aftermath of the disaster and suggested amendments to officers' accounts

24. None of the police officers was convicted, as explained further in the report, but the Operation Resolve investigation did lead to the conviction of Mr Mackrell for failing to discharge a duty under the Health and Safety at Work etc. Act 1974 (HSWA 1974).

25. In addition, the IOPC and Operation Resolve investigations examined a vast range of issues, including 260 complaints and 92 conduct matters, involving 137 identified former officers and a further 41 who had not been identified. These included officers from SYP and from West Midlands Police (WMP), the police force which undertook the original investigations into the disaster and supported the Taylor Inquiry.

26. These complaints and conduct matters have been addressed in 161 separate investigation reports; some conduct reports covered multiple conduct matters, for example where several officers were under investigation for the same issue. Complainants and the officers under investigation have been informed of the outcomes, as have those identified as 'interested persons' in any of the individual investigations.

27. The IOPC had the responsibility, under the Police Reform Act 2002, to make the final decisions about these complaints and conduct matters, including those investigated by Operation Resolve.

28. However, none of the officers investigated could face disciplinary proceedings, because they had retired before the investigations began. Legislation has now been changed so that retired officers can be subject to disciplinary proceedings.

29. The IOPC found that 12 officers (10 from SYP, 2 from WMP) would have had a case to answer for gross misconduct in relation to the disaster and/or its aftermath, if they had still been serving. That means that if a disciplinary panel found the allegations proven, they could have been dismissed. Most of these officers were senior officers and would have had a case to answer on multiple counts: for example, Ch Supt Duckenfield would have faced a case to answer for ten alleged breaches of the Police Disciplinary Code. SYP Chief Constable Peter Wright (CC Wright) would also have faced a case to answer on ten alleged breaches, regarding his actions in the aftermath of the disaster.

30. In addition, the IOPC upheld, or found a case to answer for misconduct in, 92 complaints about police actions.

31. The IOPC can only uphold complaints or reach a view that the officer would have had a case to answer for misconduct where the available evidence meets the legal thresholds it must apply. This report includes more details on the outcomes of the complaints and conduct matters investigated.

Permanent preservation of investigative material

32. Both investigations will transfer all the individual investigation reports, plus the new investigative material that is suitable for permanent preservation to The National Archives, following sensitivity checks. This material will be added to the full, digital copy of the historic Hillsborough archive created by the IOPC to provide a permanent record for future public access.

The Operation Resolve investigation

33. Operation Resolve investigated the lead-up to the disaster, in terms of the suitability and safety of the stadium and police planning for the match, what happened on the day itself and how the police responded. The Operation Resolve investigation is summarised in chapters 2–6 of this report.

An unsafe stadium

34. In relation to safety matters, Operation Resolve drew on expert analysis from John Cutlack, a Chartered Structural Engineer, which showed that Hillsborough Stadium failed on several counts to meet the safety standards of the day. These failings were particularly evident on the West Terrace. There were not enough turnstiles to allow people in safely, emergency exits were inadequate for the number of people permitted in the centre pens and some crush barriers, intended as safety measures, were the wrong height or too far apart.

35. All of these factors meant that by 1989 the permitted capacity of the West Terrace as a whole, and the centre pens in particular, was much higher than it should have been.

36. This capacity had been determined in 1979, as part of SWFC's application for a Safety Certificate. The original assessment of 7,200 was already higher than it should have been, when compared to the requirements set out in the official Guide to Safety at Sports Grounds (the Green Guide). Then, over the following decade, there were numerous structural changes to the West Terrace, most notably the installation of fences to divide the terrace into separate pens. These are detailed in chapter 2. Each of these changes should have resulted in the Safety Certificate being formally reviewed by SWFC, as the certificate holder, and the safe capacity reassessed. This did not happen.

37. Applying a strict interpretation of the safety standards of the day, Mr Cutlack found that the safe capacity of the West Terrace on the day of the disaster should have been 3,089: less than half the number of supporters stated on the Safety Certificate. Yet some 7,200 tickets were sold for the terrace. In short, the risk of dangerous overcrowding on the West Terrace was extremely high, if not managed properly.

38. SYP had some involvement in safety matters; it was the driving force behind SWFC's initial application for a Safety Certificate and the installation of fences to create pens. However, it did not have the final say: that lay with SWFC, as ground owners, and the local council, which issued the Safety Certificate and was responsible for monitoring compliance.

39. The evidence indicates that SYP's primary focus appears to have been how the stadium layout affected its ability to police matches effectively. In line with that, in 1985 officers had put forward a plan for a comprehensive redesign of the Leppings Lane entrance, clearly aligning banks of turnstiles with different areas and pens. The plan was considered but ultimately rejected for cost reasons, with SWFC prioritising investment in fire safety following a fatal fire at Bradford City's stadium. Mr Cutlack's view was that if the redesign had been implemented, the disaster could have potentially been averted; at the very least the consequences of the events would have been less severe.

40. Despite officers' awareness of the difficulties at the Leppings Lane entrance and knowledge of previous crushing incidents on the West Terrace, Operation Resolve has found no indication that SYP's planning for the 1989 Semi-Final took these factors into account.

Complacency in police planning

41. The 1989 FA Cup Semi-Final was a repeat of the previous year's match, involving the same teams and the same venue. SYP, SWFC and the FA perceived the 1988 Semi-Final to have been a success, so SYP insisted that the same arrangements should apply for 1989. This included segmenting the stadium geographically, with the north and west sides allocated to Liverpool supporters and south and east sides to Nottingham Forest supporters. The purpose was to keep opposing supporters separate.

42. Following the disaster, SYP officers insisted that its planning for the 1989 fixture had been strongly based on the 1988 operation. However, there were several important differences, including a reduction in the number of officers on duty, particularly in the areas allocated to Liverpool supporters, and changes in the command team for the match. Because Ch Supt Duckenfield was about to take up the role of divisional commander for the area where Hillsborough Stadium was located, he was appointed as the match commander—the officer in overall charge of the police operation—even though he had no previous experience of commanding major football matches.

43. While evidence indicates his promotion was made in line with standard procedures, there was minimal time for him to familiarise himself with the stadium and he received little support or knowledge transfer. This was one of several factors in the police planning that had clear consequences on the day of the disaster.

44. Another was that there had been a change in turnstile arrangements, which meant that all 10,100 Liverpool supporters who had standing tickets had to enter through just seven turnstiles, equating to 1,443 supporters per turnstile. Because each turnstile could admit a maximum of 750 people per hour, the minimum time needed to get all the supporters in would have been almost two hours of constant operation.

45. By contrast, there were 42 turnstiles for Nottingham Forest supporters with standing tickets, equating to 500 supporters per turnstile. This change was authorised by Mr Mackrell and was the basis for his conviction, as the consequences of it should have been foreseeable.

46. As examined in chapter 3, the Operational Orders did not adequately address several issues that had occurred at previous matches. For example, though there had been crowd crushes on the West Terrace at previous semi-finals, no officer was instructed to monitor the safety of the crowd. There were also no instructions about how officers should manage the crowd outside the Leppings Lane turnstiles, even though this was a known bottleneck.

47. Together, these factors indicate a degree of complacency in the police planning, encapsulated in the remarks of Assistant Chief Constable Walter Jackson (ACC Jackson), who was responsible for approving the plans. He told the original inquests led by Dr Stefan Popper (the Popper Inquests) it was “inevitable” that when the plan was complete, it would be right. His confidence was to prove tragically misplaced.

48. The IOPC was of the opinion that ACC Jackson would have had a case to answer for gross misconduct for failing to plan adequately for the match. As the senior officer with overall responsibility for the planning process and approving the plans, he failed to, among other things, ensure that learning from previous matches was properly gathered and applied. Superintendent Bernard Murray (Supt Murray) drew up the plans; the IOPC view was that he too would have had a case to answer for gross misconduct for failing to plan adequately.

The failure of police control

49. On the day of the 1989 Semi-Final, there were initially no signs of concern ahead of the 3pm kick-off. Supporters were enjoying the fine weather and generally described as being in good spirits. There were no police reports of any significant trouble.

50. From around 2.15pm, however, the situation at the Leppings Lane entrance began to change. A crowd began to build, with supporters arriving in greater numbers than could enter the ground through the limited number of turnstiles available.

51. The number of supporters in the area was sufficiently high that Superintendent Roger Marshall (Supt Marshall), the officer in charge at this end, asked officers in the Police Control Box (PCB) at the stadium to arrange for Leppings Lane to be closed to traffic. But there were no control measures in police plans for managing a crowd in this area. The situation worsened and a serious crush developed outside the turnstiles. By around 2.45pm, supporters entering the stadium were visibly distressed, while those crushed outside were increasingly scared and, in some cases, struggling to breathe.

52. Officers outside the stadium recognised they had lost control of the situation. However, they did not know that inside the stadium, some of the areas allocated to Liverpool supporters—the side pens of the West Terrace—were still largely empty, indicating there was space for Liverpool supporters once they were able to enter the ground. This was identified by numerous witnesses, including police officers, who commented on the fullness of the areas allocated to Nottingham Forest supporters, compared to those for Liverpool supporters.

53. Officers in the PCB, including Ch Supt Duckenfield, were in the optimal position to ensure colleagues inside and outside the stadium were aware of this difference, which could have informed policing decisions. The PCB was situated directly in line with the West Terrace and officers there could have seen through the windows that the side pens were particularly empty, while the centre pens appeared full. They also had CCTV showing the situation outside the ground. Despite having the complete picture of what was happening inside and outside the stadium, no one in the PCB shared this with their fellow officers.

54. With the crush at the Leppings Lane entrance showing no signs of reducing, Supt Marshall spoke to Inspector Robert Purdy (Insp Purdy), an experienced colleague on duty outside the turnstiles. They were both of the view that one or more exit gates should be opened to relieve the crush but have different recollections of what action they agreed to take. Supt Marshall has insisted he told Insp Purdy that they would need Ch Supt Duckenfield's agreement to open the exit gates and allow supporters into the stadium in greater numbers. He therefore radioed to ask Ch Supt Duckenfield for his approval but received no response. Believing he was not getting through, Supt Marshall tried again.

55. At 2.48pm, Gate C opened. It appears that this was intended to allow a supporter out. However, an estimated 130–180 supporters entered. Because the numbers were small, officers were able to close the gate again within 30 seconds.

56. In the PCB, this 2.48pm opening of Gate C was seen on CCTV and greeted with surprise. Supt Marshall, who was not close to Gate C, radioed again, this time more urgently, that unless the gates were opened, someone could be killed. It is not clear whether he knew that Gate C had opened.

57. This message was heard in the PCB; other officers around the ground have stated they recalled it. It led to a discussion in the PCB and ultimately an instruction from Ch Supt Duckenfield to "open the gates". It is not clear exactly when this instruction was issued or how many officers heard it; Operation Resolve has not identified any officer who has said they acted in response to Ch Supt Duckenfield's instruction.

58. The fact that the 2.48pm opening of Gate C had appeared to help reduce the crush led some officers close to the gate to consider opening it again, in a controlled way, for a similar short duration. Insp Purdy has stated that following his conversation with Supt Marshall, he believed he had the authority to do so. Police Sergeant John Morgan (PS Morgan) guided a small group of supporters to Gate C with this intention.

59. At 2.52pm, stewards opened Gate C again. Despite comprehensive analysis of CCTV, officer accounts and radio transcripts, Operation Resolve has not been able to establish whether this was on the instruction of PS Morgan or any other officer, or whether the stewards did so themselves. The stewards' accounts have been contradictory.

60. It is, however, certain that this time, the number of supporters entering was far higher and the police were unable to control the situation. The gate remained open for several minutes and while estimates vary, the commonly accepted figure is that more than 2,000 supporters entered through Gate C at this point.

61. Crucially, the police did not prepare for this second opening of the gate in any way, and no measures were taken to control or guide the incoming supporters. These supporters therefore followed the most visible and direct route to watch the match, which for those with terrace tickets was along a tunnel into the centre pens of the West Terrace. When they entered the tunnel, supporters could not see how full those pens were.

62. The failures in decision making and communication were at the heart of why the IOPC reached the view that Ch Supt Duckenfield would have had a case to answer for gross misconduct in relation to managing the build-up to the game. Supt Murray was in the PCB alongside him and failed to advise him correctly; the IOPC also found he would have had a case to answer for gross misconduct, as would Supt Marshall in relation to failures in controlling the situation outside the Leppings Lane entrance.

The emergency response: continued failures in police control and communication

63. The rapid influx of supporters into the already full centre pens led to a sudden and devastating change in the situation. With large numbers of supporters entering through the tunnel at once, the pressure of the crowd increased to the extent that at 2.57pm, one of the gates in the perimeter fence at the front of Pen 3 burst open. Officers on the track in front of the pens assumed it was a pitch invasion and sought to close the gate. Supporters who had been thrust through were made to go back in. Almost immediately, the gate burst open again.

64. This time, some of the police officers on the track began to recognise that this was not a pitch invasion and started to respond, by deliberately opening the other gates to allow supporters through and onto the pitch side. This was against the written instructions officers had been given. By 2.59pm, all of the perimeter gates at the West Terrace were open. Other supporters were climbing over the perimeter fence, to get out of the centre pens. Some officers on the track attempted to guide supporters into the side pens, while other supporters sat or stood at the side of the pitch, in some cases exhibiting clear signs of distress or discomfort.

65. When those in the PCB saw that supporters were on the pitch, one officer was sent to the perimeter track to see what was going on, but it appears he gathered little information. Ch Supt Duckenfield has said he radioed Superintendent Roger Greenwood (Supt Greenwood), the senior officer on duty on the pitch side, to try to establish what was happening, but there is no record of this.

66. At 3pm, Supt Greenwood had been at the halfway line. Having seen supporters on the pitch, he had gone to the West Terrace, arriving by 3.02pm. He has said he instantly recognised that supporters were being crushed and at first tried to urge the crowd to go back. Realising this was not working, he then made a gesture to the PCB that the match should be stopped. This was at 3.04pm. He then ran onto the pitch to instruct the referee to stop the game, reaching him at 3.05pm. Following that, he returned to the pens to attempt to free supporters from the crush.

67. The PCB issued requests for officers to assist but gave no explanation of what had happened or why assistance was needed. After asking officers at the stadium to attend, a request was made to the SYP Force Control Room for Operation Support. This meant all available officers from across the force area were required to come to the stadium. However, Operation Support was designed and understood to be a response to public disorder.

68. As chapter 5 demonstrates, the lack of clarity about the situation became an increasing problem as attempts were then made to contact the South Yorkshire Metropolitan Ambulance Service (SYMAS). With no understanding of what had happened, SYMAS provided a holding response, rather than dispatching the "fleet of ambulances" requested. There was a protocol for ensuring a rapid response from the emergency services: declaring a major incident. SYP failed to do this.

69. Though officers on the pitch, aided by St John Ambulance (SJA) volunteers and some supporters, began to engage in frantic rescue efforts, there was no coordination and people were getting in each other's way. SYP's Major Incident Manual clearly stated that "the overall control and co-ordination of the effort of all the services involved in dealing with a major incident is a POLICE responsibility." [Emphasis in the original.]

70. Evidence clearly shows that the senior officers in the PCB failed to take control of the situation or coordinate the response. The importance of such coordination was demonstrated when Chief Superintendent John Nesbit (Ch Supt Nesbit) arrived and organised officers into chains at each gate. This helped free supporters in a more orderly way.

71. But freeing supporters from the pens was only the first step; there was then a need for coordination of medical treatment. Again, the police did not provide any guidance to support this. When ambulances first arrived at the stadium, police officers at the entrances had no idea why. When the fire service arrived, they faced similarly confused responses. In the absence of police instructions, both SYMAS and the fire service attempted to coordinate the medical response themselves.

72. It is clear that Ch Supt Duckenfield froze in the crisis—a fact that his lack of experience in controlling football matches undoubtedly contributed to. However, no one took over or filled the void. ACC Jackson was at the stadium and could have done but did not. Both failed to give coherent instructions that could have helped accelerate the rescue effort.

73. These failings were at the heart of the IOPC opinion that both officers would have had a case to answer for gross misconduct in relation to several aspects of the way they responded to the disaster. The IOPC was also of the view that Supt Murray would also have had a case to answer for gross misconduct in failing to respond effectively, and Supt Greenwood would have had a case to answer for misconduct.

Chaos and a lack of compassion

74. Clear control and communication were still lacking in the hours that followed, as families and friends of those injured or missing sought information. The accounts of families, a small selection of which are included in chapter 6, paint a devastating picture of a chaotic response, where there was no effective information flow between the stadium, hospitals and locations set up to assist them. At the hospitals, police teams seem to have been largely invisible.

75. A Casualty Bureau—essentially a telephone contact centre intended to be the hub of information flow to supporters' families and between police forces and the other emergency services—was overwhelmed. It had insufficient telephone lines and resources. It later emerged that SYP had only ever set one up once before, for a much smaller incident.

76. From around 9.30pm, a formal identification process began. The process prioritised consistency of protocol over compassion. All those who died had been returned to the gymnasium at the stadium. After a protracted wait and with little explanation, each family

or group of friends was taken through individually and asked to identify their loved one from distressing photographs on boards. They were confronted by the horror of seeing all those yet to be identified, with the police making no attempt to pre-select relevant images (such as the right age group or gender) or to use personal property as the basis for provisional identification.

77. Once they had found a photograph of their loved one, families and friends were then required to carry out a physical identification. Some reported being prevented from holding or touching their loved one, on the basis that they were now "the property of the Coroner".

78. They then had to give an identification statement. Many have reported that during this process they were asked questions about their, or their loved one's, alcohol consumption. These questions and answers were not recorded in the statements, yet the accounts of those who experienced or witnessed the questioning are strikingly consistent. There would have been no legitimate reason to ask this as part of an identification statement.

79. Many have subsequently suggested this was the first indication that supporters' alcohol consumption would be cited as a contributory factor in the disaster. This allegation was categorically rejected by the Taylor Inquiry, and again by the Goldring Inquests, as well as in the subsequent criminal and disciplinary proceedings detailed in this report.

80. Throughout the night, no senior SYP officer assumed overall responsibility for coordinating the many strands of activity or ensuring effective communication across the different sites. At each location, individual officers, many of whom were themselves exhausted and deeply affected, remained focused only on their immediate tasks. The police relied heavily on volunteers, who provided organisational as well as emotional and practical support, often with great empathy. Many of these volunteers, along with individual officers, went far beyond what could reasonably have been expected. Yet it was the failure of senior police leadership, and the absence of effective command, that left the overall response fragmented, inconsistent and impersonal, compounding an already devastating experience for families, friends and all those affected by the disaster.

The IOPC investigation

81. The IOPC investigated the actions of SYP in the aftermath of the disaster, from its involvement in the immediate response and media coverage, through to the way it engaged with the Taylor Inquiry, the Popper Inquests and civil litigation that resulted from the disaster. It also examined the work of West Midlands Police (WMP), which had not previously been scrutinised, as well as some other issues that resulted from the disaster. The IOPC investigation is covered in chapters 7–21 of this report.

Behind the media coverage

82. The tone and content of the media coverage around the disaster has caused enormous distress, primarily due to recurring allegations that the disaster had in some way been caused by the actions of Liverpool supporters. Like the Taylor Inquiry had done 25 years previously, the Goldring Inquests wholly refuted this; the IOPC has found no evidence to challenge or change that central finding. The focus of the IOPC investigation into media coverage was to try to establish the sources of this coverage—in particular, what role SYP officers played in it.

83. The first reports blaming Liverpool supporters came in TV and radio coverage on the afternoon of the disaster, where it was stated that supporters had forced entry to the ground. These reports were based on comments made by Ch Supt Duckenfield to FA

and SWFC officials, which he has since acknowledged were lies. They were corrected the same evening by CC Wright during a press conference but still featured in newspaper articles the next day. At the Goldring Inquests in 2015, Ch Supt Duckenfield said he apologised unreservedly to the families of those who died for the lies. However, the damage his comments caused was immense and enduring.

84. Even more damaging and distressing reports were to come, culminating in a notorious article in *The Sun* which included a number of allegations about the actions of supporters. As set out in chapter 7 of this report, the IOPC examined what evidence existed around each of these allegations and can confirm that there was little or none. There is no evidence that there were large numbers of supporters present without tickets. While some officers were jostled in the rescue efforts, or faced with angry and upset supporters, there is very little evidence to indicate that any supporters attacked or struck police officers. The IOPC found no evidence to support the most lurid allegations published in *The Sun* about supporter behaviour.

85. The article in *The Sun* was based on material that had been published by news outlets in South Yorkshire before it was picked up by the national media. The local coverage included quotes from several police officers. This is part of the evidence that indicates that, in the days that followed, numerous police officers spoke to the media about the disaster and, in several instances, about the behaviour of supporters. However, for the most part they did so anonymously. The IOPC contacted more than 200 journalists but was unable to establish the identity of any of the officers quoted anonymously. None of the officers interviewed said they spoke to journalists in this way. Based on a comparison with the words he has used in other accounts, and the description of the officer included in the media report, the IOPC has identified that Chief Inspector David Sumner (Ch Insp Sumner) was the most likely source of one published comment, that "excessive drinking was a major contributory factor" in the disaster.

86. Two individuals who spoke to the media gave their names: Police Constable Paul Middup (PC Middup), who was the SYP Police Federation representative, and Irvine Patnick, then MP for Sheffield Hallam. The strong impression is that in a bid to defend police officers, both repeated stories they had been told, without checking them. At an internal meeting, CC Wright indicated his support for PC Middup's actions; however, the IOPC did not find evidence that he was directed by SYP or that he acted as part of a coordinated effort by the force. In fact, forcewide directions were issued twice, expressly instructing officers not to speak to the media without the express permission of the Chief Constable.

87. CC Wright's own interactions with the media were also subject to scrutiny, in relation to allegations that he abused his position by commenting publicly on matters that were still under investigation and that he attempted to promote a false narrative, blaming supporters. Having examined all of his interactions with the media, from the day of the disaster to the day of his retirement, the IOPC view was that he would have had a case to answer for gross misconduct, as his actions were insensitive and could have prejudiced the ongoing investigations, contrary to force Standing Orders.

SYP's attempt to deflect blame for the disaster away from the police

88. While there was no evidence of coordination behind the media coverage, the IOPC did find consistent patterns in the way SYP responded to the Taylor Inquiry and then prepared for the Popper Inquests.

89. This evidence is set out across several chapters of this report. It shows how a group of senior officers within SYP, with the assistance of the legal team appointed by the force's insurers, presented a case that the disaster was not caused by failings on the part of SYP corporately, or on the part of individual officers.

90. Having collected a range of evidence, including written accounts from officers who had been on duty, SYP sought to:

- minimise potential criticisms of leadership on the day
- downplay the significance of changes in the police operation for the 1989 Semi-Final compared with the 1988 game
- deny that SYP had any responsibility for monitoring safety in the pens
- refute that there was any official police tactic to close the tunnel to the centre pens of the West Terrace, once they were full

91. In support of this, SYP and its legal team reviewed every officer's account before it was submitted to WMP and the Taylor Inquiry and amended almost 1 in 4 of them. Through its comprehensive investigation with access to all accounts, the IOPC established that 327 SYP officers' accounts were amended: 133 more than identified in the HIP Report.

92. Further analysis of the 327 amended accounts showed that there were 63 accounts from which criticisms of senior officers and/or police command and control were removed or reworded, although the IOPC also identified 49 accounts where such criticisms were not changed. Comments about aspects of police planning and tactics, including pre-match briefings, an apparent shortage of officers and a lack of coordination in the rescue effort were amended in 31 accounts, but left unchanged in 13.

93. Every reference to monitoring the pens or tunnel closure was removed from the accounts. That was despite senior officers demonstrating their knowledge of such tactics in meetings after the disaster, and SYP having successfully argued in a court case a few years previously that its officers' role involved maintaining safety on the terraces.

94. Some officers objected to their accounts being amended. They were then pressured to accept the proposed changes. One of the officers involved in making the amendments was DCI Foster. He also engaged with some of the officers who resisted amending their accounts; the IOPC found he would have had a case to answer for gross misconduct, for directly or indirectly pressuring them to accept the changes.

95. However, neither DCI Foster nor Ch Supt Denton, who has accepted overall responsibility for the amendment process, would have had a case to answer in relation to the amendment of accounts itself. This was because, as long as the amendments did not actively mislead, SYP was under no obligation to put forward evidence that might undermine the version of events the force and its legal team wanted to portray, unless that evidence was specifically requested.

96. The same patterns, of removing information that could suggest SYP was responsible for monitoring the pens or had previously closed the tunnel, can be seen in the 120+ page document known as a 'proof of evidence' the force submitted to the Taylor Inquiry, and in particular how the content related to such issues was removed or edited by the legal team in the production of the final version. There is some evidence to suggest that several SYP officers, including CC Wright, did have knowledge of previous police actions or available contingencies to close the tunnel. However, even though this material was removed from the written submission, the Taylor Inquiry heard about these actions from some SYP officers who gave evidence.

97. Before they gave evidence to the Taylor Inquiry, senior officers met with the legal team and agreed some appropriate answers to potential questions they may be asked or criticisms the force could face. In some cases, the answers they then gave could not have been based on their personal experience.

98. After the Taylor Inquiry hearings, SYP, like other parties was invited to make a closing submission. SYP's was produced by the appointed Counsel and included numerous references to alleged drunken or disruptive behaviour by supporters, which had not been mentioned in the proof of evidence. It also asserted that no "reasonable relevant criticism can be levelled at police planning for this event." The evidence available to SYP did not support this assertion. CC Wright and Deputy Chief Constable Peter Hayes (DCC Hayes) were reported to be "very pleased". This indicates they were aware of its content and tone.

99. After SYP had agreed to settle claims for compensation relating to the disaster, it started legal proceedings against other parties involved—including SWFC and Sheffield City Council (SCC)—to request that they contributed to the costs.

100. SYP and its legal team again sought to minimise the available evidence about its responsibility for monitoring the pens and its previous actions to close the tunnel. At the suggestion of Mr Metcalf, four officers were asked to review the evidence they had given to the Taylor Inquiry about these issues, to see if they felt it had given the wrong impression: all refused.

101. Ahead of the Popper Inquests, SYP also sought to identify witnesses who could give evidence about alleged drunken behaviour by supporters, in keeping with what their solicitor described as a strategy "to bring out the issue of drink-related hooliganism."

102. As detailed in the final chapter of this report, the consistency of these actions and of the case SYP advanced led the IOPC to the view that this was a deliberate attempt to deflect the blame. However, SYP was legally entitled to do this. As long as they did not actively mislead the courts or the Taylor Inquiry, neither the force nor individual officers were obliged, unless specifically requested, to put forward any information which might undermine the case SYP was seeking to present.

103. However, acting in this way was not in keeping with the aims of the Taylor Inquiry, to prevent such events recurring. The IOPC's analysis found that SYP adopted a highly defensive approach and was selective in what it put forward as evidence. That was despite officers, including CC Wright, knowing from an early stage that the police bore at least some responsibility for the disaster, including for the events around the opening of Gate C.

104. As he was the officer with overall responsibility for his force's approach, the IOPC was of the view that CC Wright could be deemed to have breached the Disciplinary Code for discreditable conduct. If he was still serving, he would have had a case to answer for gross misconduct in relation to this, particularly given his stated approval of SYP's closing submission to the Taylor Inquiry.

Flaws in the work of WMP

105. As the police force tasked in 1989 with investigating the disaster, WMP was best placed to have gathered and presented evidence to offer a different version of events to that presented by SYP, or at least to question it.

106. WMP took on a series of responsibilities, starting with gathering evidence for the Taylor Inquiry. The force then conducted a criminal investigation focused on potential manslaughter, a police disciplinary investigation into complaints relating to the disaster and also supported the Popper Inquests.

107. WMP's work has not previously been subject to scrutiny. The IOPC examined what WMP did, against the standards of the day, to establish whether the force demonstrated bias or in any way inappropriately influenced the outcomes of the various inquiries and investigations. The findings are summarised in chapters 14–17 of this report.

108. The first step in the IOPC's investigation of WMP was a major witness appeal, asking those who had contact with the force in the aftermath of the disaster to share their experiences. This led to 118 complaints about the actions of WMP officers, predominantly around the way they interviewed supporters in the aftermath of the disaster. In total, 41 complaints about WMP were upheld, or the IOPC found that the officers would have had a case to answer.

109. Further investigation of these complaints found that, while there were several occasions where WMP officers did not show sufficient compassion for traumatised and vulnerable witnesses—leading to complaints being upheld—most officers did attempt to conduct this challenging task with professionalism and sensitivity. Though the evidence indicates that there were instances where WMP officers introduced significant inaccuracies when writing up some witness accounts, again leading to some complaints being upheld, the IOPC did not find that this was a recurring or widespread issue.

110. Many supporters interviewed by WMP recalled being questioned extensively about their alcohol consumption on the day, and about whether others were drinking. However, the questionnaires and statements WMP completed with supporters included very few responses or comments about alcohol consumption. When supporters either found their accounts on the HIP website or were shown them by the IOPC, they were surprised not to see such information in them.

111. Senior WMP officers have stated to the IOPC that they believe it was appropriate to ask questions about alcohol consumption in the questionnaire. It was identified early as a necessary line of enquiry, particularly given the media coverage.

112. The IOPC fundamentally accepts that, in a set of circumstances where alcohol consumption had been publicly and widely identified within days of the disaster as a potential causative factor, it was necessary to ask supporters about this. The fact that it has since been established that the reports of alcohol consumption were exaggerated and that it had no bearing on the events does not change this.

113. Even though the line of enquiry was relevant, this would not have justified asking supporters aggressively or insistently about the subject. Further, the questions included on the questionnaire appear of limited value in addressing the issue. They offered no insight into whether any alcohol consumption that was witnessed was different from normal. In short, WMP investigated this important topic ineffectively.

114. WMP also did not interview SYP officers at all. Instead, it chose to rely on the amended accounts submitted by SYP. While this may have been a matter of necessity due to the tight timings of the Taylor Inquiry, when WMP senior officers were alerted to the fact that SYP officers' accounts were being amended before SYP submitted them, they took no action to check the process or stop it. Instead, Assistant Chief Constable Mervyn Jones (ACC Jones) of WMP, who was leading the work for the Taylor Inquiry, wrote to CC Wright to inform him that officers had expressed concerns about the process.

115. Further, WMP then continued to rely on these accounts as primary evidence in the criminal investigation, even though in the case file submitted to the Director of Public Prosecutions (DPP), WMP made clear that such accounts were not admissible as evidence for a prosecution.

116. This was one of several areas identified by the IOPC where WMP's criminal investigation appeared inexplicably narrow. Between August 1989 and March 1990, it completed just 76 additional actions, beyond the work already undertaken for the Taylor Inquiry, related to lines of enquiry for the criminal investigation. This was an astonishingly limited number for a manslaughter investigation of this size. WMP also delayed interviewing the suspects until after it submitted the file of evidence, and when it did, belatedly, interview the suspects, the interviews were conducted poorly, when measured against the expected professional standards of the day.

117. The IOPC has further established that the file WMP submitted to the DPP did not accurately reflect the totality of the underlying evidence that WMP had at its disposal. In the section of the file where Detective Chief Superintendent Michael Foster (D Ch Supt Foster) analysed the evidence submitted, he included repeated references to the behaviour of supporters and how much alcohol had been consumed. Unlike other investigations, including the Taylor Inquiry and the Goldring Inquests, he indicated that supporters' behaviour had affected the events and cited it as a mitigating factor against prosecutions.

118. Further evidence identified by the IOPC, in the form of a memo he sent to ACC Jones after Counsel to the Taylor Inquiry had made his closing submission in July 1989, indicate that by that stage D Ch Supt Foster had already concluded that alcohol was a key factor in the disaster, and that the Taylor Inquiry did not consider it sufficiently. It appears that he then approached the criminal investigation with this fixed view of the evidence.

119. The IOPC reached the view that both ACC Jones and D Ch Supt Foster would have had a case to answer for gross misconduct, for failing to investigate SYP effectively and for not intervening in SYP's account amendment process. Further, D Ch Supt Foster would have had a case to answer for not submitting all relevant evidence to the DPP and for failing to investigate the competence of SYP's match commander.

120. Importantly, the IOPC did not find any evidence of an instruction from SYP or any external party to WMP to focus on alcohol consumption or the behaviour of supporters, or to deflect blame from the police. There was no evidence that indicated the flaws in WMP's investigations were the result of a wider 'establishment' cover-up.

The need for a change in the law

121. The public, understandably, expects that the police will act in an open, honest and transparent way, including when police officers and forces face inquiries and investigations into their actions. The basic assumption is that they should assist the search for the truth in every way and not conceal or omit relevant documents and facts, even if such facts paint the police or individual officers in a bad light.

122. The aftermath of the Hillsborough disaster shows the consequences when this does not happen. It served as the catalyst for a longstanding campaign for justice, involving families of those who died, survivors of the disaster and others, who correctly recognised that the whole truth had not emerged. This in turn led to a series of investigations and re-examinations of the events, prolonging the trauma and distress for decades, for

the families of those who died, for individuals under investigation and for all those who attended the match in any capacity. Public confidence in the police and the justice system has been damaged and the costs to the public purse have been substantial.

123. It is in this context that the IOPC has supported proposals to introduce a stronger duty of candour for all public servants, including police officers. The Public Office (Accountability) Bill, introduced to Parliament in 2025, includes a positive duty for all public officials, including police officers, to engage with candour, transparency and frankness in their dealings with investigations and inquiries. If they do not, they risk criminal sanctions. This is in addition to the duty to cooperate with investigations and inquiries set out in Schedule 1 to the Police (Conduct) Regulations 2020 and the duty of candour for police chief officers introduced in December 2023 as part of a new Code of Practice for Ethical Policing.

124. If this stronger duty had been in force in 1989, it may have helped bring the full facts of what occurred to light far sooner. The years and costs of multiple investigations could have been avoided, and most importantly the families of those who were unlawfully killed in the Hillsborough disaster would have experienced a far less traumatic fight for answers about what happened to their loved ones.

Summary of outcomes

352 complaints and conduct matters investigated*

138 Total number of officers under investigation**

98 Total number of complainants

* Several complaints or conduct matters may be addressed within the same investigation report
** Identified officers. An additional 40 are unidentified by IOPC and/or Operation Resolve

260 Complaints



92 (35.4%) upheld/case to answer

168 (64.6%) not upheld/no case to answer

92 Conduct matters



18 (19.6%) found a case to answer †

74 (64.6%) found no case to answer

352 Total investigated



110 (31.25%) upheld/case to answer ††

242 (68.75%) not upheld/no case to answer

Of the 98 complainants

31 made more than one complaint

51 had a complaint upheld or the IOPC found one or more of the officers under investigation would have had a case to answer

Who investigated what?

The IOPC investigated 178 complaints

(58 upheld/CTA) + 81 conduct (16 found a case to answer)

Operation Resolve investigated 82 complaints

(34 upheld/CTA) + 9 conduct (2 CTA)

Which forces were complained about?

133 South Yorkshire Police (50 upheld/CTA)

118 West Midlands Police (41 upheld/CTA)

7 Others (1 upheld)

Operation Resolve complaints



27 of the 82 complaints investigated by Operation Resolve were about match commanders



In **19** of these, the IOPC found a case to answer

What would officers have had a case to answer for? ❖

27 falsehood and prevarication

16 discreditable conduct

19 abuse of authority

30 neglect of duty

1. Introduction

1.1 This report provides an overview of the evidence gathered by two linked investigations into the Hillsborough disaster and its aftermath:

- a police-led investigation, known as Operation Resolve, into the disaster itself
- an investigation by the IOPC into police conduct in the aftermath of the disaster

1.2 The report aims to add to public understanding of the disaster and its aftermath, specifically in relation to the actions of the police forces involved. By setting out the evidence gathered, it aims to help answer allegations of potential police misconduct.

The Hillsborough disaster

1.3 The Hillsborough disaster refers to events at the FA Cup Semi-Final football match between Liverpool and Nottingham Forest at Hillsborough Stadium on 15 April 1989. A devastating crush developed on the West Terrace at the Leppings Lane end of the stadium, which resulted in the deaths of 97 Liverpool supporters. In addition, hundreds were injured and many more left traumatised by the events.

1.4 SYP was responsible for the police operation at the Semi-Final. The actions of the force, and its officers, in relation to the disaster have been examined in several previous investigations.

Previous investigations

1.5 The Taylor Inquiry was promptly set up to investigate the causes of the disaster and to seek to prevent similar events occurring. It was followed by inquests and a criminal investigation.

1.6 However, the families of those who died in the disaster, survivors and other campaigners have long maintained that these previous investigations were unsatisfactory and that the truth about what happened that day had not yet emerged. Their campaign led to several appeals, reviews and other judicial processes, including a private prosecution, in which one of the officers on trial for manslaughter and misconduct in public office (Supt Murray) was acquitted and the jury was unable to reach a verdict on the same charges against Ch Supt Duckenfield.

1.7 The campaign continued and in 2010 led to the formation of the Hillsborough Independent Panel (HIP), to oversee maximum possible public disclosure of information related to the disaster. In 2012, the HIP published a report to explain how the information that had been disclosed through its work added to public understanding of the tragedy and its aftermath. The HIP Report identified material that had not been considered by previous investigations and inquiries into the disaster. This material raised new questions about how people died, whether the disaster could have been prevented and how the police acted in the aftermath of the disaster.

The decision to start two new investigations

1.8 The HIP Report, and the questions it raised, led to a decision to open new inquests into the disaster and separate decisions to start two new investigations.

- The investigation into the disaster itself was given the name Operation Resolve. Operation Resolve was a police-led investigation, set up specifically to examine the events leading up to and including the disaster. It was launched in December 2012 at the direction of the then Home Secretary, Theresa May MP, and a dedicated team was recruited to undertake it. To ensure independent oversight and scrutiny, the elements of the Operation Resolve investigation relating to the police were managed by the IOPC.
- The investigation into the actions of police officers and police forces in the aftermath of the disaster was started in October 2012 by the Independent Police Complaints Commission (IPCC). It was subsequently taken forward by the IOPC, the organisation that oversees the police complaints system in England and Wales. The IOPC was established in January 2018 as a successor to the IPCC. It investigates the most serious matters involving the police, including deaths following police contact, and sets the standards by which the police should handle complaints.

What has been investigated?

1.9 The Operation Resolve investigation examined the planning for the 1989 Semi-Final, the events of the day leading up to the disaster, the emergency response and aspects of the immediate aftermath of the disaster—notably the way that the families and friends of those who died were treated by the police and other authorities. In investigating these issues, Operation Resolve looked at the roles and responsibilities of organisations that were involved in staging the match, including (listed alphabetically):

- Eastwood & Partners, the engineering firm that advised the stadium owners, SWFC, on ground structure and layout
- the FA, which selected Hillsborough Stadium as the venue for the match
- SCC, the local authority that, under the Safety at Sports Grounds Act 1975 (SSGA 1975), was responsible for overseeing the safety of professional sports grounds in Sheffield
- SWFC, which owned Hillsborough Stadium
- SYCFS, which assisted in the emergency response to the disaster
- SYMAS, which also took part in the emergency response to the disaster
- SYP, the force responsible for policing on the day

1.10 Operation Resolve also investigated the actions of individuals who worked for these organisations and whether any of them may have committed criminal offences.

1.11 The IOPC investigation focused on key aspects of the aftermath of the disaster—in particular, the allegations that police officers may have deliberately altered or suppressed evidence about the disaster and may have sought to deflect blame away from the police by focusing on the alleged behaviour of some of the Liverpool supporters.

1.12 The IOPC examined the actions of SYP officers in preserving, gathering and presenting evidence to the various investigations that followed the disaster, including the Taylor Inquiry and the Popper Inquests. It also examined the work of WMP, the force appointed in the days after the disaster to support these investigations and inquiries and to gather evidence for them.

The full terms of reference for both investigations are included at Appendix A.

Status of the investigations

1.13 The two investigations were both criminal investigations, meaning they could result in people facing criminal charges—and both did. They were also police disciplinary investigations, which examined whether police officers acted in line with the professional standards of the time (see Appendix B), in planning for the event, on the day of the disaster and in its aftermath.

1.14 The two investigations responded to 260 complaints about the actions of the police in relation to the disaster. These ranged from complaints that SYP officers at the stadium failed to respond effectively to the situation that led to the disaster, to complaints about the way WMP officers interviewed supporters in the weeks that followed. Some complaints were discontinued after initial investigative steps were taken. In addition, the investigations identified 92 conduct matters for investigation, some of which involved multiple officers. These were matters where police officers may have committed a criminal offence or behaved in a manner which would justify disciplinary proceedings, but there had not been a complaint about the matter.

1.15 Some of the complaints investigated were first made in 1989. Material cited in the HIP Report raised questions about whether these had been investigated properly, in line with the requirements at the time. The IOPC wanted to reopen these complaints, but legislation did not allow it to reinvestigate matters which had been previously investigated under the oversight of the Police Complaints Authority (PCA), the national body that oversaw complaints against police officers in 1989. The IOPC sought an amendment to the Police Reform Act 2002 (PRA) to make reinvestigation possible. The Police (Complaints and Conduct) Act 2012 added a new section, 28A, to the PRA, giving the IOPC discretionary power in exceptional circumstances to reopen complaints that had been investigated by the PCA.

1.16 Each complaint and conduct matter has been investigated in its own right and an individual report has been produced, as part of the statutory process for making decisions relating to alleged misconduct by police officers. (See Appendix C for more details of this process and the role of the IOPC in it.) Complainants and the officers under investigation have been informed of the outcomes, as have those identified as interested persons in any of the individual investigations.

1.17 In total, the IOPC upheld or found an officer would have had a case to answer (so would have been expected to face disciplinary proceedings) in respect of 92 complaints in relation to police actions before and during the disaster, and in its aftermath. Similarly, it found that in 18 conduct matters, officers would have had a case to answer. In total, the IOPC found that 12 officers would have had a case to answer for gross misconduct, if they had still been serving. That means that if a disciplinary panel agreed, they could have faced dismissal. In a further four complaints, the IOPC found that officers would have had a case for gross misconduct, but it was not possible to identify who the officers involved were.

1.18 From the outset, it was understood that no officer would face disciplinary proceedings as a result of the IOPC and Operation Resolve investigations, even if it was found they had a case to answer. This was because they were subject to the legislation in force when the investigations commenced; at that time, officers who were no longer serving with a police force could not be subject to disciplinary proceedings.

1.19 Similarly, complaints had to be assessed against the police professional standards at the time of the disaster. These were very different to the standards in place today.

1.20 The IOPC can only uphold complaints or find a case to answer for misconduct where the available evidence meets the legal thresholds it must apply.

- To be able to uphold a complaint, the IOPC must conclude that, on the balance of probabilities, the force or officer did not deliver the service to a standard that was expected of them.
- To give an opinion that there would be a case to answer for a complaint or conduct matter, the IOPC must be of the opinion that there is sufficient evidence upon which a reasonable misconduct panel could conclude there has been a breach of the professional standards that amounts to misconduct.

1.21 Reflecting this, the IOPC could not uphold complaints where there was insufficient, contradictory or missing supporting evidence, or where the complaint was made about a decision taken elsewhere. For example, complaints about individual WMP officers using questionnaires to gather information from witnesses could not be upheld, because the decision to gather information in this way was made by others.

1.22 The fact that a complaint is not upheld does not challenge the account of the complainant.

Criminal trials that resulted from the investigations

1.23 As a result of their investigations, both the IOPC and Operation Resolve referred a number of individuals to the Crown Prosecution Service (CPS) for it to decide whether anyone should face criminal charges in relation to the disaster or its aftermath. In June 2017, six individuals were charged with criminal offences.

- Ch Supt Duckenfield was the SYP match commander on the day: in other words, he was the officer in charge of the police operation. He was charged with manslaughter by gross negligence. He went on trial in January 2019, and the jury was unable to reach a unanimous or a majority verdict. He then faced a retrial in October 2019, at which the jury found him not guilty.
- Mr Mackrell was the SWFC Secretary and designated safety officer at the time of the disaster. He was charged with two offences under the SSGA 1975 and one offence under the HSWA 1974 relating to the turnstile arrangements. He went on trial at the same time as Ch Supt Duckenfield. He was found guilty of the offence under the HSWA 1974 and fined £6,500.
- Norman Bettison, a former chief inspector and superintendent with SYP and subsequently Chief Constable of Merseyside and of West Yorkshire. He was charged with four offences of misconduct in public office in relation to the allegation that he lied about his involvement in the aftermath of the Hillsborough disaster and about the culpability of Liverpool supporters. This prosecution was discontinued by the CPS on 22 August 2018, following a review of the evidence. This is examined further in chapter 20.

- SYP officers Ch Supt Denton and DCI Foster were charged with perverting the course of justice for their involvement in amending fellow SYP officers' accounts before they were submitted to the Taylor Inquiry. Peter Metcalf, a solicitor from a firm called Hammond Suddards, which was acting for SYP in 1989–1990, was also charged with the same offence, for his role in the amendment process, including suggesting specific changes to officers' accounts.

1.24 These latter three went on trial in April 2021. On 26 May 2021, the judge ruled that the defendants had no case to answer. This was because the offence they were charged with was perverting the course of justice in relation to the amendment of officer accounts presented to the Taylor Inquiry. As the Taylor Inquiry was a non-statutory departmental inquiry, it was not a course of justice, so the case required the prosecution to demonstrate that the amendment of these accounts was also intended to affect the Popper Inquests or the subsequent criminal investigation conducted by WMP—both of which were courses of public justice. The judge concluded that the prosecution had failed to demonstrate this.

1.25 This report includes more details of the evidence provided by Operation Resolve and the IOPC that led to these charges and the trials that followed.

The Goldring Inquests

1.26 In 2012, following the publication of the HIP Report, the then Attorney General applied to the High Court to have the Popper Inquests' verdicts, of accidental death, quashed. The application was successful, and the Goldring Inquests began in 2013.

1.27 The IOPC and Operation Resolve conducted enquiries for the Goldring Inquests and provided more than one million pages of investigative material, such as witness statements and documents, together with hundreds of hours of AV material. Operation Resolve also produced a comprehensive timeline of the movements of each of those who died, built from AV material and witness statements, and its senior investigating officer presented detailed background evidence about the disaster.

1.28 The Goldring Inquests hearings ran for 308 days, spread over two years, and heard evidence from more than 1,000 individuals. Having heard the evidence, the jury concluded that all of those who died in the Hillsborough disaster were unlawfully killed—a profound and momentous change from the conclusion of the original inquests.

1.29 As part of its conclusions, the jury was also asked to answer a series of questions. One of these was, "Was there any behaviour on the part of football supporters which caused or contributed to the dangerous situation at the Leppings Lane turnstiles?" The jury responded "no". They were then asked if there was any such behaviour which **may** have caused or contributed to the dangerous situation; again, the answer was "no".

The evidence examined

1.30 The Hillsborough investigations gathered and reviewed a vast quantity of evidence. The IOPC and Operation Resolve re-examined the documents disclosed to the HIP, having brought them back together in a single location from archives around the UK. The investigation teams also obtained, and restored, the HOLMES databases (specialist IT systems used to support large police investigations) used by the previous investigations into the disaster. In addition, the teams reviewed 2,700 individual pieces of AV material from broadcasters, CCTV and audio recording systems, as well as approximately 23,000 still images.

1.31 The material disclosed to the HIP included minutes and notes from a large number of meetings involving police officers and other parties. These included meetings after the disaster between SYP officers and its appointed legal team. While these would have been conducted under legal professional privilege, because the meeting minutes were disclosed to the HIP, the documents entered the public domain and could be used as evidence.

New evidence

1.32 Both investigations gathered a wealth of new evidence. As well as taking witness statements from thousands of those who had been at the match—including police officers, supporters, media, SWFC staff and volunteers—the investigations recovered documents that were assumed to have been lost or destroyed. This included more than 8,000 pocket notebooks belonging to SYP officers and the policy books of the officer that led the WMP investigation, providing a major insight into the way WMP conducted its work. In addition, video material from the day was obtained from various sources, and recordings of radio messages and communications between the PCB and the Force Control Room (made using a system manufactured by Racal) were secured and examined.

1.33 Both investigations also:

- used witness appeals to attempt to reach people who had not previously given their account
- conducted searches of key locations that resulted in new evidence being found
- applied to the courts to gain access to video material that had not previously been provided
- made use of the evidence of expert witnesses in specific topics. Some of these were appointed by the investigations—for example, a health and safety inspector from the Health & Safety Executive (HSE) was seconded to work as part of the Operation Resolve team—while others were instructed as expert witnesses to the Goldring Inquests

1.34 Despite this comprehensive approach, there remain some gaps in the information related to the disaster.

- Some potentially significant documents have not been found, such as minutes of debriefs of previous matches at Hillsborough Stadium; others have been damaged and are no longer fully legible.
- Some material has, wholly legitimately, been destroyed or disposed of over time.
- Some witnesses, who may have been able to provide additional insight, could not be interviewed. In part, this is because the investigations began more than 23 years after the disaster; some witnesses had died, while others were in poor health.
- This length of time also meant that many individuals could not recall all matters accurately or in detail.
- A small number of potential witnesses declined to engage with the investigations, as is their right; some of these explained that they had already given one or more accounts and had nothing further to add.

1.35 Nonetheless, the two investigations had access to more material about the disaster and its aftermath than any previous investigation or inquiry.

The vast quantity of new material gathered by the investigations has been assessed and, where appropriate and where the original owners give their consent, will be transferred to The National Archives for long-term preservation.

About this report

1.36 The IOPC is required by law to produce an investigation report for each complaint or conduct matter it investigates. These reports are designed to allow the IOPC decision maker to reach a view on appropriate outcomes and, with the decision maker's additional input, to inform the relevant police force or police and crime commissioner of the IOPC opinions and decisions In the Hillsborough investigations, there are 161 such reports; several conduct reports covered multiple conduct matters, for example where a group of officers were under investigation for the same issue. Complainants and the officers under investigation have been informed of the outcomes, as have those identified as interested persons in any of the individual investigations.

1.37 However, none of these reports, on its own, can address the wider scope of the IOPC and Operation Resolve investigations, or respond to the full terms of reference for these investigations. This report therefore fills this gap. As well as explaining the outcomes of complaints and conduct matters, it summarises what the investigations found in relation to unresolved queries around the disaster. It also gives an overview of topics related to police conduct that have not been addressed by previous inquiries or investigations, such as the work of WMP in the aftermath of the disaster.

Notes on language and terminology

- **All statements and accounts are cited verbatim in this report. In some cases, they include spelling or typographical errors, which are reflected in the quotations.**
- **A glossary of terms is at pages 348–353 of this report.**
- **Unless specifically stated, all police officers are referred to by the rank they held at the time of the disaster. Similarly, if an officer's name has subsequently changed, they are referred to by the name they used at the time of the disaster.**
- **During the course of this investigation, the IOPC was established, replacing the IPCC. The IOPC took on responsibility for any ongoing IPCC investigations. For clarity, throughout this report, all references to the independent investigation into police conduct in the aftermath of the disaster refer to the actions of the IOPC rather than the IPCC, even where those actions took place before the IOPC was established.**

The Operation Resolve investigation

2. The safety of Hillsborough Stadium

What was investigated?

Under the terms of reference for the managed investigation, Operation Resolve investigated:

Issues relating to the stadium, including any role played by the police in:

a) suitability and choice of the stadium to host the event

b) the planning and decision making in relation to the ground's design, alterations and final layout, including the siting and condition of barriers, fences, and gates within the fences

c) the design and layout of the pens

What was found?

- **The Safety Certificate issued to Hillsborough Stadium in 1979 was based on incorrect calculations about the safe capacity of each area of the stadium.** This meant that more people were permitted in some areas of the ground than should have been. On the West Terrace, the permitted capacity was 7,200 but the engineering expert appointed to the Goldring Inquests calculated that, applying a strict interpretation of the guidance at the time, it should have been no more than 4,518 when first set in 1979—and possibly as low as 3,089.
- **When changes were made which further reduced the amount of space for spectators on the West Terrace, no steps were taken to reassess the safe capacity of the terrace,** either by SWFC or SCC which issued the Safety Certificate for Hillsborough Stadium. Nor was capacity formally reviewed in response to changes in safety requirements for sports grounds during the 1980s.
- **Following crushing incidents at previous FA Cup semi-finals at Hillsborough Stadium in the early 1980s, SYP officers proposed changes should be made to the layout of the West Terrace.** These were implemented, splitting it into separate pens, which would also allow home and away supporters to share the terrace at relevant SWFC matches.
- **SYP officers subsequently proposed significant changes to the Leppings Lane entrance to the stadium, to help segregate rival supporters at that end.** The proposed changes were rejected as too expensive; though some changes were eventually made to this area of the stadium as an indirect result, these were very different from what SYP had suggested. This demonstrates an awareness among the police and other organisations that some aspects of the stadium layout presented potential risks to supporters.

- **Despite this awareness, recognised risks were not managed with due care. For example, SYP officers requested that a crush barrier near the main entrance of the centre pens of the West Terrace should be removed, so that supporters did not congregate there. Engineering experts raised concerns that this could affect barriers lower down the terrace, but the barrier was removed, on the condition that SYP would keep the area near the entrance clear of spectators. However, there was no mention of this in police planning for the 1988 or 1989 Semi-Finals.**

Significant new evidence

The most significant new evidence in relation to stadium safety was the three reports produced by Mr Cutlack, who was instructed as an independent civil engineering expert to the Goldring Inquests.

These showed, among other matters, that the capacity calculations used when SWFC first applied for a Safety Certificate were too high. They also included detailed analysis of key issues such as the causes of a crush barrier breaking on the day of the disaster.

The third report was commissioned by Operation Resolve to address issues that had arisen during its investigation and had not been considered in Mr Cutlack's first two reports.

About Hillsborough Stadium

2.1 In 1989, Hillsborough Stadium was one of the largest football grounds in England. It hosted World Cup matches in 1966 and had been used several times during the 1980s for major games such as FA Cup semi-finals, including in 1987 and 1988. The 1988 Semi-Final was between Liverpool and Nottingham Forest; SYP, the FA and SWFC all perceived it to have been a success.

2.2 Like most football stadia in 1989, Hillsborough Stadium had a mix of seated areas (called stands) and standing areas (known as terraces). Tickets for terraces were generally cheaper. At the east end of the ground, known as the Penistone Road end, there was a large terrace named the Spion Kop. This was the 'home' end, normally used by SWFC supporters. At the opposite end of the ground, known as the Leppings Lane end, there was a smaller terrace, referred to as the West Terrace, below the West Stand.

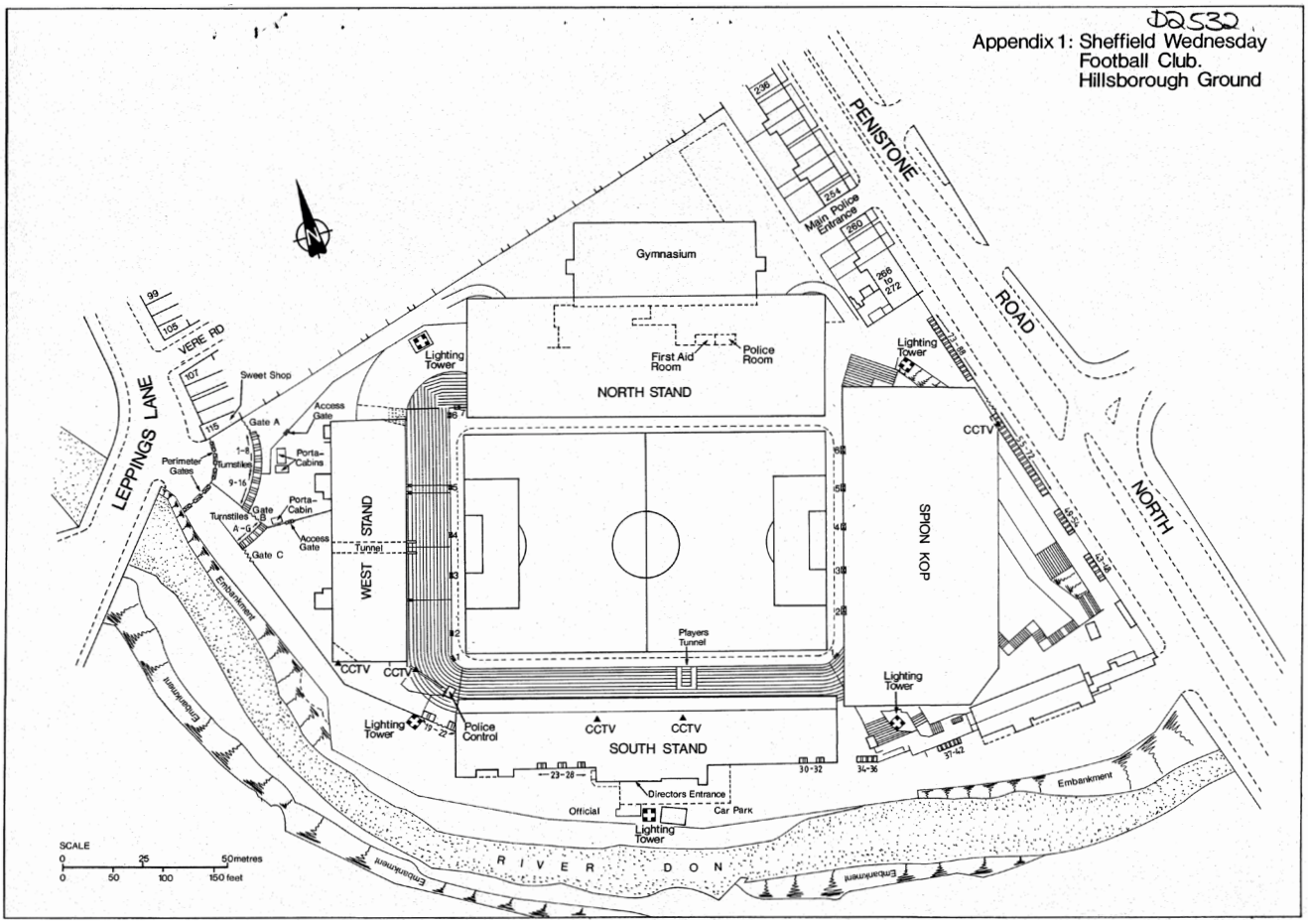


Figure 2A: Map of Hillsborough Stadium as it was in 1989 (Source: SYP Archive)

2.3 Despite its pre-eminent status, there had been various safety incidents at the ground, with supporters experiencing crushing at the Leppings Lane entrance and on the West Terrace. The most severe of these incidents had been at the 1981 FA Cup Semi-Final, where a crush on the West Terrace resulted in numerous injuries and several supporters receiving hospital treatment. However, in the aftermath of the Hillsborough disaster, supporters of different clubs described (including in evidence to the Taylor Inquiry) having experienced uncomfortable overcrowding in the pens of the West Terrace on other occasions, including at both the 1987 and 1988 FA Cup Semi-Finals.

2.4 Together, these incidents raise questions about the suitability of Hillsborough Stadium to host major matches and whether it met the safety standards of the day.

2.5 Operation Resolve investigated these issues, with a particular focus on what role the police played in any discussions and decisions about the stadium layout.

Stadium safety standards in 1989

2.6 In 1989, stadium safety was based on the SSGA 1975 and the Guide to Safety at Sports Grounds, an official government publication widely known as the 'Green Guide' due to its green cover. Both had been introduced following the 1971 disaster at Ibrox Park, the stadium of Glasgow Rangers, in which 66 spectators were killed. The report into the disaster recommended a new process of certifying and inspecting football grounds. It also set out some proposed standards for clubs and licensing authorities to follow.

2.7 The Green Guide was first published in 1973. It provided detailed guidance on numerous aspects of stadium design and layout, such as how many exits were needed for each area, the use of crush barriers, particularly on terraces, and the construction of stairways. It also explained how to calculate the safe capacity of each area of the ground. It was, and remains, guidance and there is no legal requirement to adhere to it.

2.8 In 1976, and again in 1986, the Green Guide was updated, to include additional guidance and clarification. The 1986 version was produced soon after the publication of 'The Final Report of the Committee of Inquiry into Crowd Safety and Control at Sports Grounds 1985'. This inquiry had been set up following two incidents at football matches on the same day, 11 May 1985: a fatal fire at Bradford City's stadium, in which 56 people died, and a riot at a match between Birmingham City and Leeds United, in which a 15-year-old boy died. Following the two incidents, Justice Oliver Popplewell, a senior judge, was appointed by the then Home Secretary to undertake an inquiry into the operation of the SSGA 1975 and make recommendations to improve both crowd safety and crowd control. The Final Report is often referred to as the Popplewell Report.

2.9 Drawing on recommendations in the Popplewell Report, the Green Guide 1986 included some significant changes, such as:

- a requirement for football clubs to have a designated safety officer "of sufficient status and authority effectively to take responsibility for safety at the ground"
- additional guidance on the use of turnstiles for spectators entering a ground, including an observation that the maximum number of supporters that could enter through a single turnstile each hour was unlikely to exceed 750
- a new chapter on crowd control, which had a specific reference to the need for clubs to work with the police to counter potential disorder

2.10 The Green Guide 1986 was the version in force at the time of the disaster.

2.11 The SSGA 1975 introduced a requirement for designated professional sports grounds to obtain a Safety Certificate. These were granted by local authorities, who were required to set terms and conditions to "secure reasonable safety" at the stadium. Local authorities were then responsible for checking whether the terms and conditions of the Safety Certificate were being met, and for deciding whether any condition of the Safety Certificate needed to be amended in response to changes at the ground.

2.12 Any stadium with capacity over 10,000 could be designated as needing a Safety Certificate, but in practice the requirement was initially just applied to the grounds used for Football League Division 1 (the equivalent of the modern-day Premier League) and those regarded as international football stadiums.

The Safety Certificate for Hillsborough Stadium

2.13 SWFC was not in Division 1 at the time. However, because Hillsborough Stadium was used regularly for matches like FA Cup semi-finals, which attracted crowds of over 30,000, the then Chief Constable of SYP believed the stadium should be required to have a Safety Certificate. He wrote to the Home Office to request that Hillsborough Stadium should be designated. In 1978, it was, so SWFC had to obtain a Safety Certificate.

2.14 The application form was submitted in September 1978; the capacity of the stadium was given as 54,950.

2.15 SWFC had by this time appointed local engineering firm Eastwood & Partners as structural advisers and to help the club meet its duties under the SSGA 1975.

2.16 The director of Eastwood & Partners, Dr Wilfred Eastwood, reviewed the layout of the stadium and assessed the capacity against the standards in the Green Guide 1976. In early 1979, he calculated, under a strict interpretation of the Green Guide, the capacity of 54,950 was too high. In a letter to SWFC, he explained that if the club made certain improvements, like upgrading some crush barriers, the capacity could stay above 50,000. He calculated maximum permitted capacities for each area of the stadium, based on his interpretation of the Green Guide; for the West Terrace, the maximum permitted was 7,200.

2.17 After work was done to upgrade the crush barriers as Dr Eastwood had recommended, Hillsborough Stadium was granted a Safety Certificate in December 1979. On the Certificate, the total stadium capacity was set at 50,174 and the maximum permitted capacity of the West Terrace at 7,200.

2.18 As part of his work for the Goldring Inquests, engineering expert Mr Cutlack made his own calculations of the maximum permitted capacities for each area of the stadium as it was in 1980, following the Green Guide 1976. He concluded that most of Dr Eastwood's figures were too high and that the maximum capacity of the West Terrace at that time should have been 4,518.

2.19 In this calculation, Mr Cutlack included the gates in the perimeter fence at the front of the terrace as part of the emergency exit provision. However, he also noted that it was not wholly clear whether those gates would be deemed suitable as emergency exits under the Green Guide 1976. They were narrow and had been designed primarily to allow police officers into the terrace rather than to allow supporters out. If these gates were not included, he calculated that the permitted capacity should have been 3,089.



Figure 2B: View of perimeter gate and perimeter fence from Pen 3 (Source: SYP)

2.20 In short, this meant that from 1979 onwards, there were many more supporters allowed on the West Terrace than should have been, according to the safety guidelines of the day.

Role of SYP in the issuing of the Safety Certificate

2.21 SYP had been instrumental in getting Hillsborough Stadium designated, so that it required a Safety Certificate. SYP was then part of the Officer Working Party (OWP), a multi-agency group responsible for advising the local authority on safety matters related to the stadium. SYCFS and later the Area Health Authority were also part of this group.

2.22 In this role, various SYP officers attended regular OWP meetings to discuss safety issues. At one of these meetings, on 15 August 1979, it was agreed that the Safety Certificate should be issued to SWFC, subject to identified ground alterations; SYP was involved in the decision-making process.

2.23 The OWP also conducted stadium inspections twice a year. SYP officers attended these too. In 1987, the OWP changed its name to become the Safety of Sports Grounds Advisory Group (SSGAG); SYP remained a member.

The 1981 FA Cup Semi-Final and its impact on stadium layout

2.24 On 11 April 1981, Hillsborough Stadium hosted the FA Cup Semi-Final between Tottenham Hotspur and Wolverhampton Wanderers. The game was attended by over 50,000 spectators.

2.25 Just after kick-off, a crushing incident took place on the West Terrace near the PCB. SWFC received reports that 38 people sustained injuries. SJA treated 30 supporters on site for minor injuries. Eight people were taken to hospital; three had broken limbs and two required stitches.

2.26 Following the match, SYP held an internal debrief, where senior SYP officers expressed concerns about the layout of the Leppings Lane terraces (the West Terrace and North West Terrace). Assistant Chief Constable Robert Goslin felt that, to assist with crowd control, the terraces required more divisions into separate pens, so that the supporters were not in such a solid mass. He also suggested that the permitted capacity of 10,100 for the two terraces was too high.

2.27 SYP followed this up with SWFC. Chief Superintendent Robin Herold (Ch Supt Herold), who had been the match commander for the 1981 FA Cup Semi-Final, had a meeting with Eric England, the Secretary of SWFC at the time. He explained SYP's concerns and the proposal that the terrace should be divided into pens. According to Ch Supt Herold's notes, Mr England disagreed with the view that the capacity was too high and suggested that, instead of fixed fences, portable barriers could be used to assist with crowd control.

2.28 SYP persisted, and the then Chief Constable wrote to the SWFC Chairman, reiterating SYP's concerns and recommending that the issues should be discussed with the local authority.

2.29 The OWP visited Hillsborough Stadium on 8 June 1981. Meeting minutes recorded that SWFC, together with SYP, were considering revising arrangements on the West Terrace. By early September, Dr Eastwood had been instructed by SWFC to arrange the installation of two fences on the West Terrace, to divide it into three approximately equal sections, each with its own entrance. This would allow parts of the terrace to be used by supporters of SWFC at home league games, with a smaller area allocated to away supporters, separated by the fences.

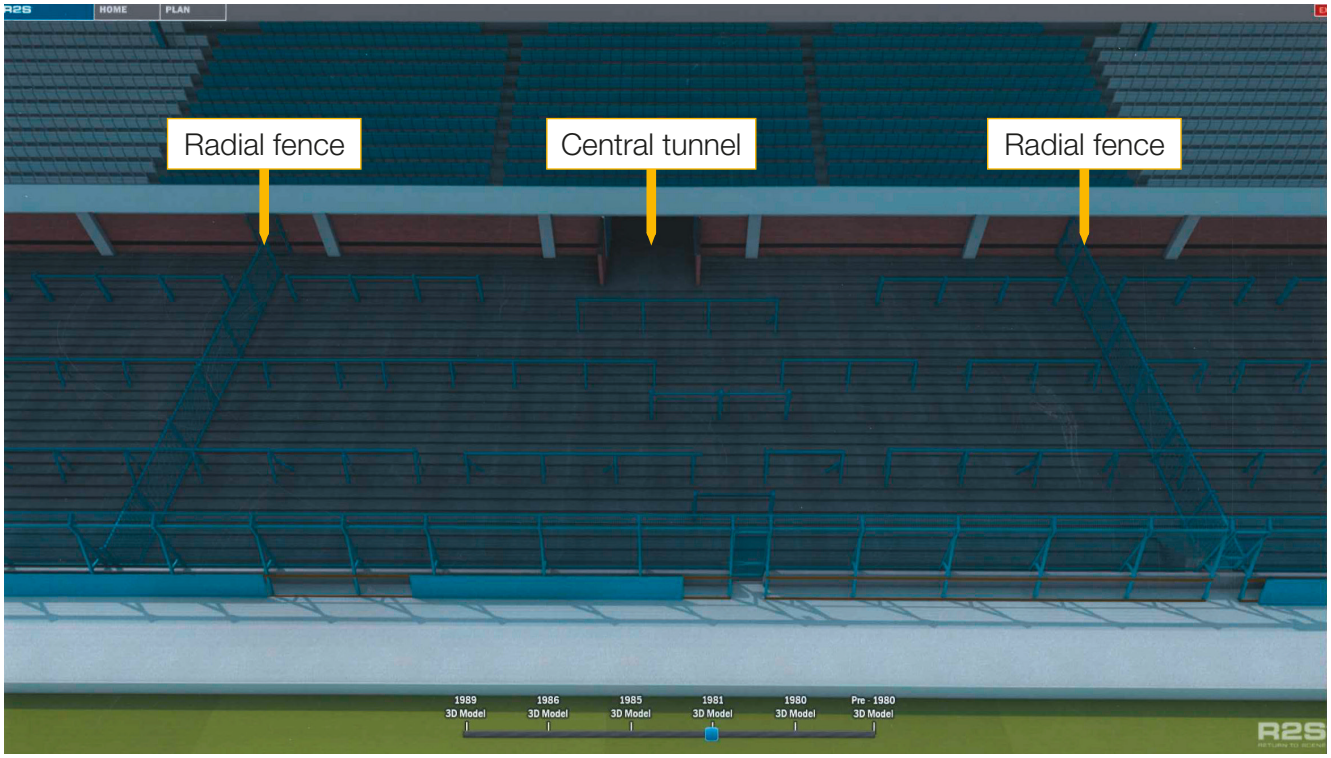


Figure 2C: 3D model of the West Terrace in 1981 following installation of the first two radial fences (Source: Return 2 Scene LTD (R2S))

2.30 There was to be a gate at the top of each fence, which could be either locked shut or secured against the back wall, allowing people to move between pens. The latter option would only be considered if the whole terrace was allocated to supporters of the same team.



Figure 2D: Example of gates in radial fence (Source: Dennis Bond, SYP)

2.31 According to Dr Eastwood and an SYCFS officer who regularly attended the OWP, if the gates were open, this would be under police control. SYP officers have disputed this and said they had no responsibility for managing the gates.

2.32 The plan was approved by the local authority on 14 September 1981, and the fences were installed in October and November that year. Subsequent documents indicate that SYP was largely happy with the new arrangements.

2.33 Following a change to the terrace such as this, the capacity should have been formally reassessed. There is no evidence that it was.

The installation of additional fences in 1985

2.34 In the summer of 1985, Eastwood & Partners installed two additional radial fences on the West Terrace. One radial fence extended from the mouth of the central tunnel to the perimeter fence, dividing the existing centre pen into what became Pen 3 and Pen 4. The second fence was installed parallel to an existing one, to create a 2m-wide corridor, referred to as Pen 5. This was for police use.



Figure 2E: Digital reconstruction of the West Terrace layout in 1985, following the installation of two further radial fences (Source: R2S)

2.35 The evidence tends to suggest that Eastwood & Partners installed these as part of a general review of the layout of the Leppings Lane end and arrangements for segregation of supporters, initiated at the request of SYP.

2.36 In his report, Mr Cutlack made clear that, following the installation of these additional fences, the capacity of the West Terrace should have been recalculated based on the revised capacity of the individual pens, rather than considered as a whole. He calculated that the changes that created Pen 5 reduced the combined capacity of Pen 3 and Pen 4 by approximately 26.5m^2, meaning that capacity should therefore have been reduced by a further 143.

2.37 He also highlighted that the installation of the radial fences should have resulted in a requirement for amendments to be made to the existing Safety Certificate.

2.38 Neither of these things happened.

Proposals for changes to the turnstile layout

2.39 Around this same period, there was also discussion between SYP and SWFC about changing the turnstile configuration at the Leppings Lane end. This occurred after SWFC returned to the top division and had larger numbers of away supporters at its games. SYP found it harder to keep these away supporters segregated from the home supporters accessing the Leppings Lane turnstiles. Figure 2F shows the layout at the time, which required temporary barriers to separate opposing supporters.

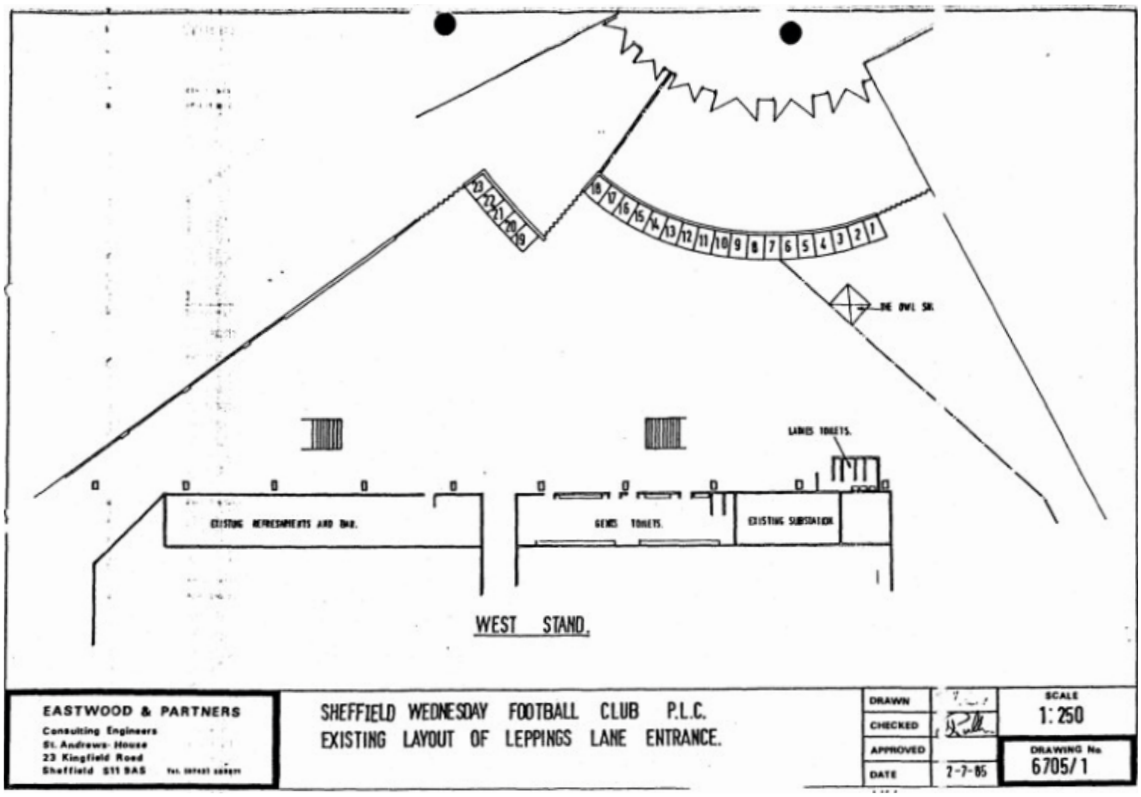


Figure 2F: Drawing of Leppings Lane entrance layout as it was in 1985 (Source: Eastwood & Partners)

2.40 Inspector Clive Calvert (Insp Calvert), who regularly policed the Leppings Lane end in this period, proposed that the whole of the Leppings Lane turnstiles, which were then in a crescent shape, should be demolished and replaced with new ones parallel to and near the rear of the stand. These new turnstiles would then offer direct access to individual pens and to the stands—meaning opposing supporters could be separated earlier. They would also have separate toilets and food and drink facilities, to avoid potential conflict. Senior officers agreed that this proposal should be discussed with SWFC, and the main match commander at the time wrote to the SWFC Secretary, Richard Chester, setting out SYP's suggestions.

2.41 Mr Chester discussed these with Dr Eastwood, and they agreed an alternative proposal, which would require less work but still offer complete segregation of opposing supporters. It involved adding six new turnstiles but not changing the entire layout.

2.42 This was discussed further at an OWP meeting, and SYP accepted the proposals, subject to a few additional recommendations. The design was revised and by the end of April a clear plan was in place, as shown in figure 2G. This would have resulted in 30

turnstiles rather than the 23 which existed at the time. Each block of turnstiles was also clearly aligned with a specific area of the stadium; for example, on the far left, turnstiles 28 to 30 would have offered access only to the south pen of the West Terrace.

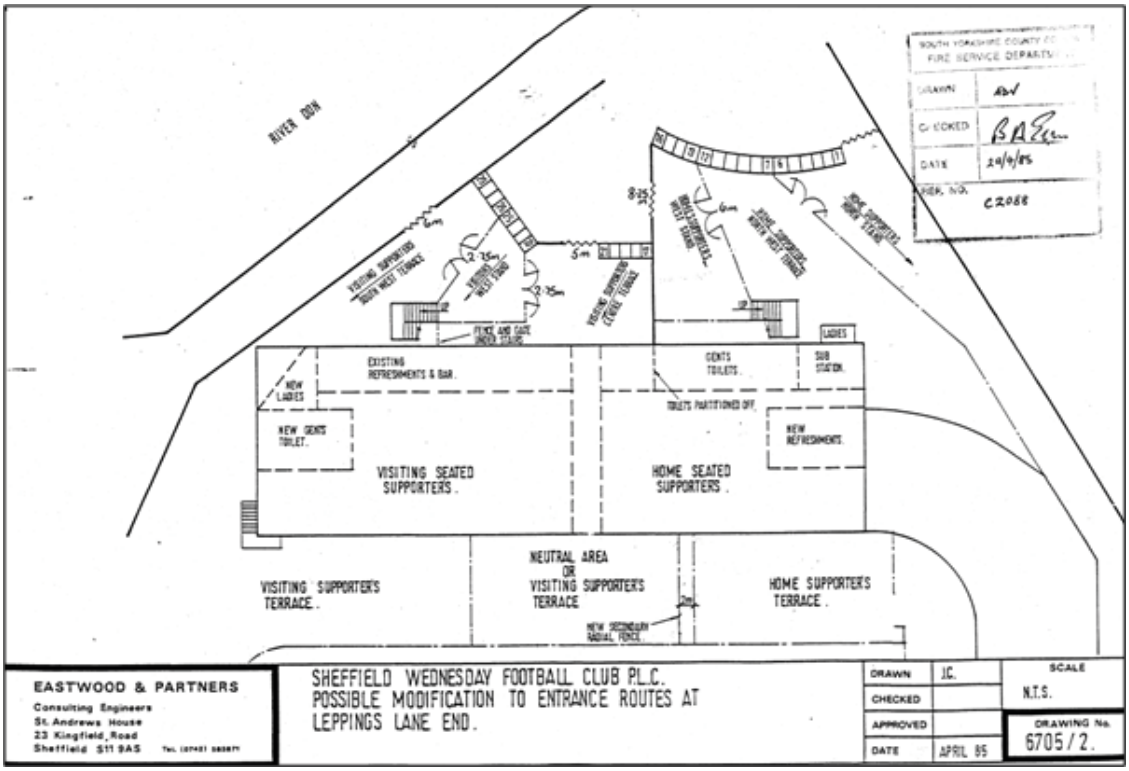


Figure 2G: Drawing of proposed modification to Leppings Lane entrance (Source: Eastwood & Partners)

2.43 In his first report, Mr Cutlack commented that if this plan had been implemented "it is quite possible that the events of 15th April 1989 would not have occurred with the same consequence." As well as having more turnstiles available, which would have made a crush outside less likely, he noted that the plan would have enabled better use to be made of turnstile count data. Because the banks of turnstiles would have been directly linked to specific areas, the data would have shown the numbers of spectators that had been admitted into each area. When an area reached capacity, the associated turnstiles would simply have been closed.

2.44 SWFC asked Dr Eastwood to provide an estimated cost for the work. At a board meeting on 2 May 1985, SWFC directors rejected the proposal as too expensive. A few days later, the Bradford fire occurred (see paragraph 2.8) in a wooden stand. Even before the investigation was complete, football clubs realised that they would need to fund fire safety improvements; SWFC was no exception.

2.45 There was further discussion between Eastwood & Partners and SWFC, and in August 1985, a revised plan was implemented. This involved no increase to the number of turnstiles but allocated each bank of turnstiles to a specific area of the stadium, to assist with segregation. Under this plan, there were seven turnstiles allocated to the terraces, eight to the North Stand and six to the West Stand.

2.46 Mr Cutlack commented that these alterations "resulted in it being more likely that over-crowding would occur outside the turnstiles because fewer turnstiles were allocated to the West Terrace." He added: "This was reasonably foreseeable by any competent party."

2.47 Once again, the changes to the turnstile layout should have resulted in a review of the Safety Certificate; they did not.

Changes to the barrier layout

2.48 In June 1986, Insp Calvert sent the newly appointed SYP match commander, Chief Superintendent Brian Mole (Ch Supt Mole) a summary of officers' suggestions for improving policing at Hillsborough Stadium. One issue he raised was that some of the crush barriers on the West Terrace caused congestion as supporters entered the centre pens from the central tunnel. He raised the concern that similar problems could occur with getting into the tunnel if an emergency evacuation was needed.

2.49 The primary cause of concern was barrier 144, a 7.625m-wide barrier consisting of three parts, located directly in front of the central tunnel. In evidence to the Taylor Inquiry in 1989, Insp Calvert explained that "the barrier was right across the entrance to the tunnel and the fans got to the barrier and stopped and we would have a build-up right back up the tunnel, fans would not move out and we could not control what was happening."

2.50 He and some colleagues felt that the West Terrace would be safer if the crush barrier was removed, or at least partially removed. After discussion with senior officers, it was agreed to propose this at the next OWP meeting, where after initial reservations by some members, it was agreed to remove parts of barrier 144.

2.51 In a statement from 1990, the surveyor from South Yorkshire County Council (SYCC), who was part of the OWP, recalled this and said he had agreed with the proposal. However, he noted two key points. Firstly, he understood that the police would be present near the tunnel entrance and would work to keep the area clear of supporters. Secondly, he suggested marking out a 'sterile area' in front of the central tunnel mouth that should be kept clear of spectators at all times.

2.52 Two parts of the barrier were removed as proposed and yellow markings painted on the floor to mark the sterile area. These markings are just visible either side of the radial fence in figure 2H, which was taken after the disaster. However, no evidence has been found that either SYP or SWFC managed the sterile area at the 1989 FA Cup Semi-Final or took steps to prevent supporters standing there.



Figure 2H: The location of barrier 144 and the central tunnel, April 1989 (Source: Philip Rich, SYP)

2.53 In his first report, Mr Cutlack commented: "Clearly, it was intended that the removal of part of barrier 144 was to have a beneficial effect on safety however in my opinion the reverse was true." He explained that "The removal of this barrier created an un-obstructed path for a crowd surge in the tunnel" and added: "In my opinion EP [Eastwood & Partners] should have resisted this alteration and advised the Club and the Police of the likely implications of removing Barrier 144."

2.54 On the day of the disaster, a crush barrier in Pen 3 collapsed. This has been identified as one of the key moments in the disaster. The evidence does not suggest that the removal of barrier 144 had any direct effect on the barrier that collapsed.

2.55 In his report, Mr Cutlack explained that during the crush, barrier 124A was subjected to a pressure greater than it had been designed to withstand, as a result of three factors:

- crowd density
- the depth of the crowd behind the barrier
- the fact that barrier 136 (higher up the terrace) was substantially lower than recommended, resulting in the crowd behind this barrier exerting a greater forward pressure

2.56 However, he did not believe that the removal of barrier 144 could have had any impact on barrier 124A, because the additional pressure on barrier 124A came from an area outside of where barrier 144 had been.

Review of the Safety Certificate

2.57 The various alterations to Hillsborough Stadium should have resulted in a review of the Safety Certificate and its terms and conditions, but did not. However, from 1986, work began to review the conditions of the Safety Certificate, both by SCC and, separately, Eastwood & Partners on behalf of SWFC.

2.58 However, by the time of the 1989 Semi-Final, this had only resulted in revised draft conditions being presented for consideration by the SSGAG. The revised version contained the same capacity figures as the original Safety Certificate, with the exception of the capacity for the Spion Kop, which had been revised upwards to 21,000 following work to extend it. SWFC and Eastwood & Partners had requested this upward revision, which increased the overall capacity of the stadium from 50,174 in the original Safety Certificate, to over 54,000.

2.59 In 1987, SWFC specifically asked Eastwood & Partners' advice as to the capacity of the West Terrace in light of all of the alterations that had taken place over the years. Eastwood & Partners advised that there was no need to change the capacity of 10,100.

Did Hillsborough Stadium meet the safety standards of the day?

2.60 Although Hillsborough Stadium possessed a Safety Certificate, it was identified as early as the Taylor Inquiry, and has since been confirmed in Mr Cutlack's reports, that there were various ways in which the ground in 1989 did not adhere to the recommended standards of the Green Guide 1986. For example:

- there were not enough turnstiles at the Leppings Lane end for the number of spectators

- the fact that Pens 3 and 4 had a shared entrance and exit
- there were some areas of Pens 3 and 4 where the distance to the nearest crush barrier was more than recommended
- some of the barriers were the wrong height—including one of the barriers higher up the terrace than the barrier that collapsed, which meant during the crush in the pens the collapsed barrier was subjected to a pressure greater than it had been designed to withstand
- the emergency exits from Pens 3 and 4 were not suitable—the central tunnel was too steep and the gates in the perimeter fence at the front were too narrow
- the permitted capacity for Pens 3 and 4 was far higher than it should have been

2.61 Despite these factors, and the fact that there had been previous crushes on the West Terrace, Operation Resolve has found no evidence that any party felt that Hillsborough Stadium was unsafe when it was considered as a venue for the 1989 FA Cup Semi-Final.

Choice of Hillsborough Stadium for the 1989 FA Cup Semi-Final

2.62 The evidence clearly indicates that the choice of the stadium to host the 1989 Semi-Final was made by the FA. The choice was based on geographical location and the perceived suitability of the stadium. Hillsborough Stadium had been used to host an FA Cup Semi-Final in both the previous two years, and these were viewed as having been successful by the FA, SWFC and SYP.

2.63 When the FA selected Hillsborough Stadium as the venue for the 1989 FA Cup Semi-Final, none of the authorities raised any objections or concerns.

2.64 SYP did have some input into the decision. When Hillsborough Stadium was proposed by the FA as a possible venue for a Semi-Final between Liverpool and Nottingham Forest, Mr Mackrell contacted Ch Supt Mole to ask if SYP would be willing to police the match. Ch Supt Mole made it clear that SYP would only agree if the same fundamental arrangements for the allocation of areas of the stadium were applied as had been used at the 1988 Semi-Final between the same teams. This was to facilitate the segregation of opposing supporters.

2.65 This meant that the Liverpool supporters would be allocated the West Terrace, North West Terrace, West Stand and North Stand, reflecting their likely routes to the ground. However, it also meant that Liverpool would receive fewer tickets overall than Nottingham Forest, despite having higher average crowds, and that all Liverpool supporters would be required to enter the ground through the turnstiles at the Leppings Lane end.

2.66 The then Secretary of Liverpool Football Club, Peter Robinson, asked the FA if it could change this allocation of ends so that more tickets would be available to Liverpool supporters. SYP refused and would not agree to policing the game if the arrangement was changed. This was accepted by the FA. Nottingham Forest supporters were allocated 27,754 tickets for the match, including 21,000 for the Spion Kop terrace. Liverpool supporters were allocated 23,542 tickets, including 10,100 for standing areas (7,200 on the West Terrace and 2,900 on the North West Terrace).

2.67 The number of standing tickets allocated to Liverpool supporters matched that on the Safety Certificate, but as has been made clear, the permitted capacity of the West Terrace was based on flawed calculations. It should have been reassessed and potentially reduced once the additional fences were installed.

Responsibilities for stadium safety

2.68 Questions about the safety of the stadium are crucial not only to understanding the causes of the disaster, but also to investigating the actions of the police and other organisations. In simple terms, if the stadium was not safe, this could indicate other parties—notably SWFC—were also at fault. Set against that, the police were responsible for managing the safety of spectators attending football matches at a stadium. This meant that if officers felt any aspect of the ground was unsafe, the police had a responsibility to raise concerns to the club and other partners, and to mitigate any perceived risks to supporters.

2.69 Evidence shows that the licensing authorities—first SYCC, then SCC—did not insist on a review of the Safety Certificate in response to changes to the stadium layout or incidents of crushing.

2.70 However, the core responsibility for ensuring the Safety Certificate was up to date rested with SWFC. Over the decade after the Certificate was issued, SWFC authorised a series of significant changes to the design and layout of the stadium and in July 1986, asked Eastwood & Partners to review the current Safety Certificate and advise the club of any alterations to the terms and conditions it considered appropriate. Despite this, the Safety Certificate was not updated, and the capacities of the different areas were not reviewed, except in the case of the Spion Kop, where capacity was increased after an application from Eastwood & Partners and SWFC.

2.71 Operation Resolve investigated both SWFC and Eastwood & Partners in relation to their responsibilities under the HSWA 1974 and the SSGA 1975. However, because neither organisation exists as the same legal entity it was at the time of the disaster, it was not possible to launch meaningful legal proceedings against either. In the case of SWFC, the company was still in existence but had no registered directors; Operation Resolve ensured it was kept active for sufficient time to explore these issues.

2.72 Although proceedings could not be considered in respect of any organisation, they could in respect of individuals. Over the course of its investigation, Operation Resolve identified a range of evidence that indicated Mr Mackrell may have failed to fulfil his duties as SWFC's 'responsible officer' under the SSGA 1975 and as safety officer as defined in the Green Guide.

2.73 Following the investigation by Operation Resolve, and consideration by the CPS, Mr Mackrell was charged with two offences under the SSGA 1975. These charges related to breaches of the Safety Certificate for Hillsborough Stadium alleged to have been committed by SWFC while he was the responsible officer. These charges were in addition to a separate charge against him under the HSWA 1974, which is examined in chapter 3.

2.74 During the trial of Ch Supt Duckenfield and Mr Mackrell, jurors were directed by the judge that it was not appropriate to proceed with the charges under the SSGA 1975 due to insufficient evidence.

The role of SYP in stadium safety

2.75 SYP was the primary driving force behind SWFC's initial application for a Safety Certificate under the SSGA 1975. It was then involved, as part of the OWP (and later the SSGAG), in discussions around the requirements of the Safety Certificate before it was issued.

2.76 The evidence shows that SYP officers continued to be involved in discussions around safety and stadium design. Following a crushing incident at the 1981 FA Cup Semi-Final, SYP expressed to SWFC the view that the capacity at the Leppings Lane end was too high. It also proposed the introduction of radial fences to divide the terrace into separate pens to assist with crowd control. The fences were introduced, but the capacity was not reviewed.

2.77 SYP was also instrumental in the installation of further fences in 1985 and the removal of parts of barrier 144, in 1986.

2.78 While these changes were proposed by SYP, they were then planned by SWFC and particularly Eastwood & Partners. The plans were considered by the OWP—of which SYP was a member—and agreed. The involvement of SYP within this process appears to have been appropriate and in keeping with expectations of the time.

2.79 Mr Cutlack observed that the removal of barrier 144 had a detrimental effect on safety. However, he commented that this should have been raised by the engineers and did not criticise SYP for suggesting it.

2.80 Both Eastwood & Partners and the SYCC principal surveyor have said that SYP offered to monitor the entrance to the pens from the central tunnel, as part of securing agreement for the changes to barrier 144. SYP officers have said they did not agree to any such duties, and police planning documents make no reference to any officers being allocated to this task.

2.81 SYP was also closely involved in a further proposal to redesign the Leppings Lane turnstile area. Mr Cutlack identified that the resulting plans, if implemented, could have averted the disaster or at least reduced its severity. However, the plans were deemed too expensive, and a less extensive change was made, which did not increase turnstile numbers and resulted in fewer turnstiles being available for entrance to the West Terrace.

2.82 Considered as a whole, the evidence gives the impression that SYP had an interest in the stadium layout, insofar as it affected the force's ability to police matches effectively.

2.83 This also appears to have been the primary factor in SYP's insistence that it would only agree to Hillsborough Stadium hosting the 1989 FA Cup Semi-Final if the same arrangements were used as in the previous year—despite the request from Liverpool Football Club to change the allocation of ends.

3. Police planning for the 1989 FA Cup Semi-Final

What was investigated?

Under the terms of reference for the managed investigation, Operation Resolve investigated:

Planning and preparation for the match by the police, including organisational and individual decision making in relation to:

a) the resourcing of the event

b) any role played by the police in allocation of areas within the ground to the visiting teams' supporters

c) the arrangements for the policing of the match, including arrangements for the arrival of supporters and their management outside the stadium

d) the arrangements (or lack of) for precise monitoring of the crowd numbers and their safety within the pens at the Leppings Lane end

What was found?

- **Though SYP officers have repeatedly insisted that their planning for the 1989 Semi-Final was broadly the same as for the 1988 Semi-Final involving the same teams, there were several important differences,** including changes in key personnel. **No allowances were made for these changes.**
- **For the 1989 Semi-Final, there was a 14% reduction in the number of officers on duty compared to the previous year.** In the area where Liverpool supporters would arrive, there were 21% fewer officers on duty. SYP had intended to reduce the number of officers on duty by just 10%.
- **A significant change made by SWFC to entrance arrangements for the terraces at the Leppings Lane end meant that all 10,100 Liverpool supporters who had standing tickets had to enter through just seven turnstiles.** For these spectators to get in on time, each of the turnstiles would have had to operate continuously at maximum speed for almost two hours. It is not clear whether any SYP senior officers understood the potential consequences of this change.
- **There were various gaps and inconsistencies in the key planning documents developed by SYP, known as Operational Orders.** A major gap was a total absence of contingency plans with clear tactics to address known risks that had occurred at previous matches, including crushing on the West Terrace. Another was around responsibility for monitoring capacity on the West Terrace to prevent such crushing occurring.

- **The three SYP divisions involved in the police operation all developed their own Operational Order without working together.** They were approved by senior officers in each division, without looking at the other Orders. This resulted in a lack of coordination. **Some accounts suggest that the Force Control Room was supposed to provide a coordinating role, but this was not documented anywhere.** Beyond that, SYP relied solely on briefing meetings led by the match commander to bring the different divisions' activities together.
- **The replacement of the highly experienced match commander Ch Supt Mole was poorly timed.** It was a direct result of the decision to move Ch Supt Mole from the role of divisional commander for F Division and to replace him with the newly promoted Ch Supt Duckenfield. There was an unwritten policy that the divisional commander would be match commander at Hillsborough Stadium.
- **There is no definitive explanation for the decision and no evidence that Ch Supt Duckenfield's appointment as divisional commander was inappropriate or conducted improperly.** However, it meant that someone who had never previously commanded a match at Hillsborough Stadium was given responsibility for a major game, with just a few weeks' notice.

Significant new evidence

The Operational Orders and police planning for the 1989 FA Cup Semi-Final have been examined by a range of previous investigations and inquiries. In this investigation, Operation Resolve was able to draw on the views of Douglas Hopkins, a former Metropolitan Police chief superintendent with a wealth of experience commanding football matches in the 1980s and 1990s. Mr Hopkins was appointed by the Goldring Inquests as an expert witness on the policing standards of the day. He also gave evidence at the criminal trials of Ch Supt Duckenfield and Mr Mackrell.

The planning process

3.1 On 20 March 1989, the FA announced that Hillsborough Stadium had been selected as the venue for the FA Cup Semi-Final between Liverpool and Nottingham Forest on 15 April. This was a repeat of the previous year's semi-final.

3.2 SYP officers have repeatedly stated that the planning of the police operation for the 1989 FA Cup Semi-Final was based on the plans for the 1988 FA Cup Semi-Final, which was viewed within SYP, SWFC and the FA as having been a success. The grounds for this are not wholly clear, but they appear to have been that there was no serious disorder and that the match had adhered to its intended schedule.

3.3 However, the HIP Report identified that at the 1988 match "at least 62 people experienced crushing in the central pens, some sustaining injuries such as bruised ribs." There had also been a small pitch invasion at the end of the game.

3.4 It is not clear whether the overcrowding at the 1988 Semi-Final or the resulting injuries were recognised by any authorities before Hillsborough Stadium was selected to host the 1989 Semi-Final. It appears that the fact that supporters had been injured was not covered during debriefs following the 1988 Semi-Final and the evidence indicates that the police planning team was unaware that there had been crush injuries. The pitch invasion, however, was known.

3.5 The planning process for the 1989 game largely followed the approach used in 1988. This consisted of some planning meetings involving representatives from most of the different organisations who would be part of the match day operation, and the development of Operational Orders.

3.6 There were three planning meetings in total, on 22 March, 29 March and 10 April. However, in a change from the process used in 1988, there was no meeting between SYP and SWFC in 1989. It is not clear why such a meeting was not arranged, when it would have provided an opportunity for all the relevant parties to discuss issues and review plans.

3.7 There were also three Operational Orders, each prepared by a different division of SYP.

- F Division was responsible for policing the area where Hillsborough Stadium was located. The F Division Operational Order was the main one for the match and involved the most officers.
- D Division was responsible for policing Sheffield city centre, including the main railway station. The D Division Operational Order covered operations beginning the night before the match.
- Road Traffic Division was responsible for road safety and traffic flow on roads in South Yorkshire. It had no responsibility for roads in other forces' jurisdictions, which covered the main part of the journey from either Liverpool or Nottingham to Sheffield.

3.8 For F Division, Ch Supt Mole appointed a planning team of three officers: Supt Murray, who was his regular deputy match commander at league matches, Chief Inspector David Beal (Ch Insp Beal) and Inspector Steven Sewell (Insp Sewell). The latter two both had considerable experience in planning police operations for matches at the stadium.

3.9 In his 1989 account, Supt Murray recalled meeting with Ch Supt Mole on 20 March to start the process. He said that "as this was a repeat of the same fixture the previous year, which had passed without serious incident we decided to base the order on the previous year's event."

3.10 However, Supt Murray also said he was "asked by Chief Superintendent Mole to aim for a manpower reduction on 1988 of 10% in the interest of most effective and efficient utilisation of resources as it was to my knowledge that the previous year, some officers had been under employed."

3.11 In the same account, Supt Murray said that following the 1988 game, he had identified a number of areas where he considered arrangements could be improved. None of these referred to overcrowding. Supt Murray did, however, refer to reinforcing security on the perimeter track at the end of the game to prevent a pitch invasion as occurred in 1988, and instructing officers in the West Stand to be particularly vigilant about preventing spectators from climbing into that stand from the terraces below.

3.12 A planning meeting was arranged for 22 March 1989 at Hammerton Road Police Station. The meeting was chaired by Ch Supt Mole and attended by the core planning team plus representatives of other organisations involved in the match, such as British

Rail, local public transport providers and the Highways Authority of the County Council. Representatives of SYP's D Division and Road Traffic Division also attended the meeting. No one from SWFC was present.

3.13 Supt Greenwood and Supt Marshall were both there; both had been sector commanders at the 1988 game and were selected by Ch Supt Mole to serve as sector commanders again for the 1989 Semi-Final. Ch Supt Duckenfield also attended, having been appointed as chief superintendent of F Division, taking effect from 27 March 1989. This meant he would be in post for the 1989 Semi-Final and would serve as match commander. According to his own accounts, and those of others present, he did not contribute to the meeting.

3.14 No minutes or other notes have been found for this meeting. Notes were first sought in 1989, shortly after the disaster, by SYP colleagues and then by WMP, but could not be located. Operation Resolve has also examined all available documentation but has not found anything relevant. The details of the planning meeting are therefore taken from the accounts of those present.

3.15 The overarching impression is that the meeting largely confirmed the intention to repeat arrangements from the previous year, with just a few changes, such as around traffic operations.

3.16 Police Sergeant Kenneth Jones (PS Jones) was one of the officers responsible for producing the D Division Operational Order. He commented that "The tone of the meeting from memory was that the F order and the D order would be based on the previous year." However, he said that he and his colleague wrote the D Division Operational Order from scratch.

3.17 PS Jones also said that at the meeting on 22 March 1989, he arranged for further meetings with South Yorkshire Transport (SYT), British Transport Police (BTP), British Rail and the SYP Road Traffic Division. These meetings did not include the F Division planning team, but he did liaise with Insp Sewell in respect of the unloading points for the SYT buses.

The second planning meeting

3.18 The next planning meeting took place on 29 March. By this time, Ch Supt Mole had moved to become divisional commander of B Division, based in Barnsley. He stated that, after the first planning meeting, he had no further involvement in the planning for the 1989 Semi-Final.

3.19 Instead, the meeting was chaired by Ch Supt Duckenfield and involved the three members of the F Division planning team. The purpose of the meeting was to review the F Division Operational Order. Ch Supt Duckenfield has repeatedly said they went through it page by page; he asked a few questions and suggested some minor amendments but was largely content to approve it.

3.20 At the Goldring Inquests, he was asked if he had raised any questions about any incidents in the stadium's history that he should have been made aware of. He replied that, as a new commander, he would have asked questions, but 26 years on he could no longer recall the specifics. He said he was not told anything about the history of the ground that caused him any concern.

3.21 He also stated that he was not alerted to any particular issues that had occurred at the 1988 Semi-Final.

Approval of the Operational Orders

3.22 On 6 April 1989, Ch Supt Duckenfield signed off the F Division Operational Order. It was very similar in its wording, structure and content to that for the 1988 FA Cup Semi-Final. It was circulated the same day to all officers of the rank of chief inspector and above involved in the operation.

3.23 In D Division, PS Jones drew up a draft Operational Order which he gave to Acting Superintendent Steven King. After some minor changes, it was approved and signed by Superintendent Leonard Bates on 10 April 1989, after which it was copied and circulated.

3.24 The Traffic Division Operational Order was written by Inspector George Scholey and reviewed by Ch Supt Nesbit, who was head of the Operations and Road Traffic Division, along with Superintendent John Brougham (Supt Brougham), who would be in charge on the day.

3.25 When interviewed under caution by WMP in 1990, ACC Jackson said that once the respective divisions had completed their planning for the match, he received copies of each Order for final approval. He said that he was satisfied with the arrangements made, and that if he had not been, he would have rejected them.

3.26 This meant each Order was approved without being assessed against the others for any potential contradictions or gaps.

3.27 Both Chief Constable Brian Johnson (CC Johnson) of Lancashire Police—the policing assessor for the Taylor Inquiry—and Mr Hopkins suggested that SYP would have been better served by producing a single forcewide Operational Order covering all three divisions. CC Johnson described the F Division Operational Order as “less than adequate and, in some cases, imprecise in much of the information it contained.” He reported that the complementary Orders produced for the day, dealing with traffic and the deployment of officers in other divisions, were “confusing and unco-ordinated.”

3.28 In his 1989 account, ACC Jackson explained that for the 1988 FA Cup Semi-Final, SYP had decided to have three separate Operational Orders, so that the divisional commander responsible for Hillsborough Stadium did not have to be responsible for the logistics of directing traffic and escorting supporters to the ground. He suggested that this approach offered flexibility, as police officers concerned in those duties remained available for redeployment in the gymnasium at the ground after they had completed their allocated tasks. It was therefore repeated for the 1989 Semi-Final.

3.29 When giving evidence at the Popper Inquests on 5 March 1991, ACC Jackson explained that the Operational Orders were developed following liaison between him, the relevant division and Ch Supt Nesbit. He said this meant it was “inevitable” that when the plan was complete, it would be right. He said that if someone identified a problem during the planning process, they would contact him and discuss the issues.

Gaps and flaws in the Operational Orders

3.30 Despite ACC Jackson's confidence, Operation Resolve found there were in fact numerous gaps between the three Operational Orders, as well as important details that were not covered in them.

3.31 For example, all three Operational Orders included some instructions for managing the arrival of supporters by car, coach/minibus and by train. Between them, the Orders identified the police resources that were to escort supporters from the train stations to the stadium. However, none of the Orders included instructions about who these officers should report to when they arrived at the stadium and how they were to communicate the numbers and locations of arriving spectators to the PCB at the ground. Effective communication would have allowed the PCB to know the numbers and at what time supporters would arrive at the ground, so that resources could be deployed to effectively manage their dispersal there.

3.32 Similarly, there was no clarity about how any issues that emerged away from the stadium—whether in Sheffield city centre or on the main routes to the city—would be communicated to the PCB. In theory, this could have happened through the Force Control Room, which could have then alerted the PCB, but the instructions around this were inconsistent.

3.33 Both CC Johnson and Mr Hopkins also noted that SYP did not seek or use relevant police intelligence about the opposing sets of supporters to guide the planning. SYP did request information from the respective police forces—Merseyside Police and Nottinghamshire Constabulary—that regularly managed home games for the two clubs. SYP's football intelligence team had an expectation, from previous experience, that Merseyside Police would provide little information. However, they did not make any additional or more specific requests to try to gain further insight.

3.34 Operation Resolve's analysis of the F Division Operational Order against SYP's Standing Instructions for the Policing of Football Matches identified some further gaps in its planning. These relate to issues that have been recognised in subsequent investigations as significant and that arguably should have been identified by the officer with overall responsibility for signing off the different Operational Orders (ACC Jackson).

3.35 For example, there were no instructions or contingency plans as to what action officers should take in relation to supporters who did not have a ticket for the match. After the disaster, many officers raised the presence of supporters without tickets as a factor in the crush outside the Leppings Lane entrance, but they were not given any direction to check supporters had tickets or instructed how to manage those without tickets. In his 1989 account, Supt Murray suggested that he did have contingency plans to deal with "large numbers of supporters without tickets", but this was not in the Order or any other written documentation, nor mentioned in any briefings.

3.36 Even though the Leppings Lane entrance was a known bottleneck and, as detailed in chapter 2, SYP had proposed changes to the entrance area to address this a few years previously, there was no clear instruction in the Order on how to manage the crowd outside the Leppings Lane turnstiles—such as using mounted officers to help create queues.

3.37 Despite previous crushing incidents on the West Terrace, there was no instruction anywhere about monitoring the capacity of the pens on the West Terrace and no officers were deployed there. Two units of officers (known as 'serials' and typically consisting of 10–12 PCs with a sergeant or inspector in charge) were assigned duties to "maintain order on the terraces" once the match had begun, but their deployment was to the tunnels rather than the terrace itself.

3.38 In fact, the arrangements for monitoring crowd numbers as a whole were poor, with no one being allocated responsibility for doing so. Even though the crushing in 1987 and 1988 did not result in as many injuries as had been the case at the 1981 FA Cup Semi-Final, there was a recurring issue at high-profile games that senior officers should have been aware of. It should also have been addressed in debriefs after the 1988 game, but Operation Resolve has not found evidence that it was.

3.39 ACC Jackson, Ch Supt Mole and Supt Greenwood have all stated that they were unaware of the crushing at the 1987 and 1988 FA Cup Semi-Finals because they had not been informed of it through the post-match debriefs. Supt Marshall has stated he was not aware of any crushing at the 1988 game but also commented that he did not attend any debrief following the 1988 Semi-Final. This raises questions about the rigour of the debriefs after these games and the information flow within the force.

3.40 Crucially, none of the debrief reports from 1988 referred to the closure of the central tunnel either. This was an action that SYP officers had taken at the 1988 Semi-Final to restrict access to Pens 3 and 4 once they were full. However, there were no instructions in either the 1988 or the 1989 Operational Order about closing the central tunnel, or when it might be necessary.

3.41 The SYP senior officers on duty at the 1989 Semi-Final have largely suggested in evidence that they had no knowledge of this as a police tactic and that any tunnel closure must have been instigated by officers on duty nearby. By contrast, several more junior officers who described closing the tunnel at previous matches have indicated it was a known contingency or operational tactic for league matches, where the West Terrace was not allocated wholly to supporters of the away team.

3.42 In his evidence to the Popper Inquests, Ch Supt Mole agreed that the tunnel could be closed at league games. He said the standard approach was for the crowd to be directed to the centre pens, Pen 3 and Pen 4, in the first instance, but if these were full the tunnel would be blocked, and supporters would be directed to the outer pens.

3.43 However, he said that at games where larger crowds were expected, such as semi-finals, the whole of the West Terrace was allocated to supporters from a visiting club. On such occasions, the gates between the pens were open and supporters were allowed to 'find their own level'. This theoretically meant that supporters were free to go wherever they wished on the terraces and to distribute themselves in the way in which they felt comfortable. In practice, moving between pens was difficult because there was just one narrow gate in each radial fence, at the top of the terrace.

3.44 In evidence to the Goldring Inquests, Ch Insp Beal commented that 'find their own level' was a flawed concept for big crowds.

The third planning meeting

3.45 The F Division Operational Order included an instruction to move any Liverpool supporters who had tickets for the Spion Kop to their own area of the ground. This was despite the fact that the match was sold out, so the West Terrace would already have been at maximum capacity.

3.46 Supt Greenwood has stated that he voiced concerns about this latter issue at the third SYP planning meeting on 10 April 1989. By this time, all the Operational Orders had been approved by ACC Jackson. The meeting was chaired by Ch Supt Duckenfield. Some of the officers in key roles on the day attended, along with representatives from D Division, Road Traffic Division and British Transport Police.

3.47 Supt Greenwood was one of the three SYP sector commanders for the match. He was in charge of sector 1, inside the stadium.

3.48 In a prepared statement given to WMP in June 1990, at the start of his interview under caution, Supt Greenwood explained that he raised the issue at the meeting "because I was concerned that the Leppings Lane end would become overcrowded if fans in such large numbers were transferred to that end." He further explained that at the 1981 FA Cup Semi-Final, some supporters who were in the wrong end were transferred to the West Terrace, which resulted in overcrowding and crushing. He said: "When it was suggested at the second meeting that a transfer would again be necessary I raised an objection on the grounds of the 1981 incident."

3.49 He also stated that he made Ch Supt Duckenfield, and everyone else at the meeting, aware of the importance of avoiding overcrowding and crushing on the West Terrace.

3.50 At the Goldring Inquests, Ch Supt Duckenfield said he had no recollection of a conversation with Supt Greenwood at the meeting on 10 April 1989 about the risk of overcrowding or crushing on the West Terrace. He was shown the instructions in the Operational Order and his attention was drawn to the fact that this would have resulted in the crowd on the West Terrace being over capacity. He responded that it was a defect in the Order that he had failed to see but reiterated that he had no recollection of the issue being raised at the meeting. Further, he said that at the time of the disaster he did not know about the incident of crushing at the 1981 match, or that SYP had raised concerns about the safety and capacity of the West Terrace following that incident. He said that had he been informed, he would have focused on that and taken the necessary action.

3.51 In a statement from 1990, Insp Sewell stated that he could not "…recall any comments being made regarding crushing at any previous Semi Finals or in fact at any match, or any of those present mentioning it." He added that at no time did Supt Greenwood speak to him regarding difficulties at previous semi-finals.

3.52 PS Jones also attended the meeting and said that he recalled Supt Greenwood making a point regarding the movement of supporters within the ground, but he could not be more specific.

3.53 Supt Greenwood subsequently instructed the inspectors under his command not to transfer Liverpool supporters from the Spion Kop to the Leppings Lane end, even though he knew this was against the Operational Order.

Changes in the Operational Orders

3.54 One of the significant changes in the SYP plans for the 1989 Semi-Final related to a change in personnel in key roles. At the 1988 game, Supt Greenwood had been the commander of sector 2, covering the arrival of Liverpool supporters and the Leppings Lane entrance. Supt Marshall had been the sector 1 commander.

3.55 For the 1989 Semi-Final, their roles were reversed. In evidence to the Popper Inquests, Supt Marshall said he had asked for the change in roles. Ch Supt Mole indicated it was his decision to switch them, to reflect the fact that Supt Marshall had regularly supervised the area outside the Leppings Lane end that season.

3.56 Ch Supt Duckenfield has confirmed he knew that Supt Marshall had not performed the role of sector 2 commander at previous semi-finals, but he said he was not aware, at the time, that the two had switched roles.

3.57 On the day of the disaster Supt Marshall assumed command of Serials 16 to 19 of sector 1, who were stationed on the outer concourse, in addition to his sector 2 responsibilities.

3.58 Both Supt Marshall and Supt Greenwood later acknowledged that this was in contravention of the F Division Operational Order. They separately explained that it was a result of their combined working experience at the 1987 and 1988 FA Cup Semi-Finals, through which both had recognised that the sector 2 commander (outside the stadium) was better placed to manage the police officers on the outer concourse prior to kick-off.

3.59 Operation Resolve has found no evidence that either Supt Marshall or Supt Greenwood reported any concern about the sector 1 commander's difficulty in being able to manage the outer concourse as part of the debrief process following the 1988 FA Cup Semi-Final or as part of the planning process for the 1989 fixture. Nor is there any evidence that they informed Ch Supt Duckenfield of the change to command arrangements for Serials 16–19 of sector 1.

3.60 Similarly, the head of the SYP Mounted Section, Inspector Paul Hand-Davis, stated that he amended the deployment of his officers from that set out in the Operational Order, based on his own experience and knowledge of trouble spots. There is no indication that these amendments were communicated to Ch Supt Duckenfield or the PCB.

3.61 These changes highlight a lack of precision and rigour in the process, as well as a lack of coordination between the different divisions and senior officers.

3.62 Operation Resolve identified that this lack of precision extended to other issues. For example, SYP aimed to encourage supporters to arrive at the stadium as early as possible. It made announcements on local radio stations in Sheffield, Liverpool and Nottingham and published articles in local newspapers and match programmes of the competing clubs. Letters were sent to coach companies encouraging them to arrive in Sheffield early, stating that the turnstiles would be open from 11am and that pre-match entertainment and refreshments would be available inside the ground.

3.63 Yet according to the Operational Order, the turnstiles were not due to open until 12 noon and no pre-match entertainment was provided. This inconsistency resulted in arrangements having to be made at the last minute to deal with the arrival of supporters before the turnstiles opened.

3.64 More significantly, there was also a substantial reduction in the number of officers on duty. In 1988, there had been 901 staff identified on the "schedule of manpower" (a single list of the officers on duty) in the F Division Operational Order, but in 1989 there were 729 on the equivalent list. This equated to a total reduction in staff of 19%.

3.65 This was therefore a substantially greater reduction than the 10% requested by Ch Supt Mole at the start of the planning process. There is nothing to suggest that SYP recognised this or revisited officer numbers as part of its planning.

3.66 Operation Resolve further analysed staffing levels in the schedule of manpower by operational sector. This showed that the reduction in sector 2, the area covering the arrival of Liverpool supporters, was 21.6% compared to 1988. By contrast, the reduction in sector 3, covering the arrival of Nottingham Forest supporters, was 14.5%.

3.67 Although these reductions appear significant, policing expert Mr Hopkins was of the view that SYP had allocated ample resources for policing a semi-final—as long as they were deployed and managed effectively.

3.68 Other changes in the F Division Operational Order for 1989 included the decision not to use a fixed-wing aircraft or 'spotter plane', even though some sources indicated it had been invaluable in 1988 in identifying potential traffic issues.

The replacement of Ch Supt Mole as match commander

3.69 In many eyes, the most significant change in the police operation for the 1989 game was that Ch Supt Mole was replaced as match commander by Ch Supt Duckenfield.

3.70 Ch Supt Mole had extensive experience overseeing police operations at Hillsborough Stadium, including being in charge of the 1987 and 1988 FA Cup Semi-Finals there. By contrast, Ch Supt Duckenfield had never commanded a match at Hillsborough Stadium or indeed commanded a match of this scale anywhere else. His experience policing football matches was limited; he had worked as an inspector at Hillsborough Stadium around a decade previously, including policing the 1980 FA Cup Semi-Final there.

3.71 He told the Taylor Inquiry that when he was a superintendent and deputy divisional commander of D Division, he had regularly policed matches at Bramall Lane, the stadium of Sheffield United Football Club (SUFC). However, at the Goldring Inquests he accepted that he only became involved in policing at Bramall Lane on the periphery, if a major match was played, and that he had never policed matches there on a regular basis.

3.72 The consequences of this change have been subject to considerable scrutiny, with numerous suggestions that if the vastly more experienced Ch Supt Mole had been in charge on the day, the disaster could have been avoided. This became more contentious when allegations emerged that Ch Supt Mole was moved from the role for disciplinary reasons.

3.73 Specifically, it has been suggested that Ch Supt Mole was moved following a 'prank' played on a probationary officer in the division. Though Ch Supt Mole was not in any way involved in the prank, he was the divisional commander, and this was seen as indicative of poor discipline in the division.

3.74 Operation Resolve investigated the circumstances leading up to Ch Supt Mole's transfer and found the evidence around it is inconclusive. Senior officers close to the decision had different recollections and opinions about why he was moved. Ch Supt Mole

himself told the Popper Inquests that the decision was made by CC Wright and that he had not applied for the move. However, he said that he had been divisional commander of F Division for several years and felt "the time was ripe for a move."

3.75 CC Wright died before the Operation Resolve investigation began and had never given a public explanation for the decision. However, DCC Hayes told the Goldring Inquests that Ch Supt Mole was moved for positive career development reasons—to offer him command experience in a different location which would improve his promotion prospects. He added that the prank "was of no consequence whatever" in the decision.

3.76 ACC Jackson on the other hand told the Goldring Inquests he felt sure the prank would have been a factor.

3.77 Assistant Chief Constable Stuart Anderson (ACC Anderson) was head of staff services for SYP, which covered human resources and related issues. In a prepared statement submitted to the Solicitors to the Goldring Inquests he provided a detailed explanation of the transfer of Ch Supt Mole and the promotion of Ch Supt Duckenfield. In this, he indicated it was beneficial to both officers in career development terms, and also beneficial to the force, in terms of filling a command vacancy in B Division. He did not mention the prank.

3.78 ACC Anderson stated that the proposed transfer of Ch Supt Mole was discussed at a meeting of senior officers, where those present at the meeting "were well aware of the impending FA Cup Semi-Final". He said that it was noted that the Operational Order had already been written, and all the same supervisory officers were in post—meaning that Ch Supt Duckenfield would not have to start the planning process. He also recalled that it was reiterated that the 1989 FA Cup Semi-Final involved the same teams that had been involved in the previous year's fixture, which was considered to have been a success in policing terms.

3.79 Operation Resolve has found no documentary evidence of a senior officers' meeting to support ACC Anderson's account. Further, it does not fit the known timeline. The appointments were announced on 6 March 1989, two weeks **before** Hillsborough Stadium was chosen as the venue, rather than after the Operational Order was written as ACC Anderson has suggested.

3.80 Operation Resolve has also examined the appointment of Ch Supt Duckenfield, including considering his career record to that point and the appointment process. The available evidence does not suggest that the decision to appoint Ch Supt Duckenfield as the head of F Division was inappropriate in the context of the established standards and approach at that time. He had been a superintendent for around four years and had recently attended a command course. Further, the decision appears to have been made before the match was allocated to Hillsborough Stadium.

3.81 It is nonetheless clear that he lacked experience of commanding football matches of the scale of an FA Cup semi-final. Yet, due to the expectation within SYP at the time, that the divisional commander of F Division would be the main match commander at Hillsborough Stadium, he felt obliged to do so, with just a couple of weeks to prepare. At the Goldring Inquests, he was asked what he thought CC Wright's reaction would have been if he had suggested that someone with more experience should manage the 1989 Semi-Final. He replied that he thought CC Wright would have then appointed a different officer to the role of divisional commander.

3.82 While this appears to have been the standard expectation, there was no documentary evidence that the divisional commander had to be the match commander. In fact, in an SYP document titled 'Duties and Responsibilities of the Chief Superintendent', there was no reference whatsoever to a chief superintendent having to take command of major events.

3.83 SYP senior officers have consistently stated they felt Ch Supt Duckenfield's experience was adequate for the role, particularly in response to suggestions that Ch Supt Mole could have remained as match commander for one more high-profile fixture. Expert witness Mr Hopkins disagreed and felt that Ch Supt Mole should have been asked to manage the 1989 Semi-Final.

3.84 Perhaps the biggest issue therefore is not the decision to promote Ch Supt Duckenfield, but rather the internal expectation that the divisional commander of F Division would be the match commander at Hillsborough Stadium, regardless of the officer's suitability for that role.

How Ch Supt Duckenfield prepared for the 1989 Semi-Final

3.85 As set out at the start of the chapter, Ch Supt Mole ensured that Ch Supt Duckenfield was invited to the planning meeting on 22 March. However, after that, there appears to have been minimal handover or knowledge transfer before the Semi-Final.

3.86 At the Popper Inquests, Ch Supt Duckenfield said that he did not recall having a detailed discussion with Ch Supt Mole about the match. However, he said he had been assured by Ch Supt Mole that the plan was well prepared, and he had an experienced team under him making the arrangements.

3.87 In evidence at the Goldring Inquests on 10 March 2015, Ch Supt Duckenfield recalled that he arranged to see Ch Supt Mole ahead of the FA Cup Semi-Final. However, he said: "I went to see Mr Mole, expecting to have a whole day with him, and he seemed, shall we say, in my view, disappointed to be moving, wanting to clear his desk, jealously guarding his relationship, I thought, with Sheffield Wednesday, and offered me little or no advice."

3.88 In preparation for the 1989 FA Cup Semi-Final, Ch Supt Duckenfield attended two league matches at Hillsborough Stadium.

- On Saturday 1 April, he attended the game between SWFC and Millwall (attendance 18,358).
- On Wednesday 5 April, he attended the evening game between SWFC and Wimbledon (attendance 15,777).

3.89 He said that he toured the stadium and spoke to some of those on duty. He could not remember exactly what he had seen or who he spoke to but said he did not see anything that concerned him.

3.90 However, he did not have any meetings with SWFC officials, who knew his predecessor in the role very well, in advance of the match. In previous years, including 1988, there had been a meeting between SWFC and SYP. It is not clear why this did not happen in 1989.

3.91 This meant that he did not have the opportunity to learn of any concerns that SWFC had, or of any changes to the SWFC planning. For example, this could have been an opportunity for SWFC to inform SYP in general, and Ch Supt Duckenfield in particular, of the change in turnstile arrangements for 1989.

The significance of a change in turnstile allocation

3.92 In total, there were 93 turnstiles at Hillsborough Stadium. Well over half of these were at the Spion Kop/Penistone Road end of the ground, which was where SWFC home fans would normally arrive for league games. The highest number of turnstiles provided access to the Spion Kop (the largest of the stands), but there were also turnstiles at this end that gave access to some areas of the South Stand and North Stand.

3.93 SYP had insisted that the segregation arrangements for the 1989 FA Cup Semi-Final had to replicate those used in 1988. To maintain the segregation between opposing supporters, 12 turnstiles, which would have allowed access to the North Stand from Penistone Road, were closed. Instead, all Liverpool supporters with tickets for the North Stand had to use the turnstiles at the Leppings Lane end, as did the Liverpool supporters with tickets for the West Terrace, North West Terrace and West Stand. This meant that in total, there were only 23 turnstiles available for almost 24,000 Liverpool supporters to enter the stadium. In both years, there were fewer turnstiles available at the Leppings Lane end than, according to Green Guide standards, there should have been for a crowd of that size.

3.94 However, for the 1989 game, there was a further change in the arrangements which meant that there was an additional change in the way the 23 turnstiles at the Leppings Lane end were allocated.

- In 1988, 13 of the 23 turnstiles had been used to grant access to the West Stand (permitted capacity 4,465), the West Terrace (permitted capacity 7,200) and the North West Terrace (permitted capacity 2,900). So 14,565 supporters had to enter through 13 turnstiles.
- For the 1989 game, 6 of these 13 turnstiles were used solely to grant access to the West Stand, with the remainder then dedicated to the West Terrace and North West Terrace. This change meant there were just seven turnstiles available to the 10,100 supporters with tickets for these areas. This equated to 1,443 supporters per turnstile. With a turnstile able to allow between 700 and 800 supporters in per hour, it would have required every turnstile to work continuously at full speed for almost two hours to let all the spectators in.

3.95 In contrast, at the Spion Kop, 21,000 supporters had 42 turnstiles through which to enter the ground, equating to 500 supporters per turnstile.

3.96 The decision to change the turnstile allocation was made by Mr Mackrell. It is not clear on what basis. Ch Supt Duckenfield did not know about the change. Supt Murray suggested he was aware of it, and understood its significance, but was uncertain when he had been told. At the Popper Inquests, he said that he had not questioned whether that was sufficient for the 10,100 supporters who needed to pass through them and that the turnstile arrangements were down to SWFC and nothing to do with him. Ch Supt Mole similarly told the Taylor Inquiry that “The arrangement for turnstiles is a matter of the Club’s responsibility”.

3.97 What is certain is that SYP did not adapt its plans in 1989 to reflect the change in allocation, for example, by considering whether to permit the use of some or all of the turnstiles at the Penistone Road end that would grant access to the North Stand.

3.98 In his 1989 account for the Taylor Inquiry, Ch Insp Beal confirmed that the possibility of Liverpool supporters accessing the North Stand via turnstiles 77 to 88 on Penistone Road was considered, but it was believed that this would have presented potential public order problems.

3.99 There was no mention of the change in turnstile allocation in the Operational Order. This also meant that the supervisory officers at the Leppings Lane end were not aware of the change in advance. Many of these officers had considerable experience policing matches there and may have been better placed to identify the risk of this change.

3.100 The change to the turnstile allocation was at the heart of the prosecution of Mr Mackrell under the HSWA 1974.

3.101 Sir Peter Openshaw, the judge in the case, explained the offence as follows: "… [Mr Mackrell] failed to take reasonable care, as the Safety Officer, in respect of the arrangements for admission to the Hillsborough Stadium and particularly in respect of turnstiles being of such numbers as to admit at a rate whereby no unduly large crowds would be waiting for admission."

3.102 Specifically, the judge stated that the charge against Mr Mackrell related to the changes he authorised between the 1988 and 1989 Semi-Finals to the allocation of the 23 turnstiles at the Leppings Lane end. The judge commented: "If the defendant had properly considered the consequences of this change of turnstile allocation which he made in 1989, he should have realised that there was an obvious risk that the so many spectators simply could not pass through just seven turnstiles in time before the kick-off; that being so, he should have realised that would cause a crowd to build up outside the turnstiles and he should have realised that that might present a risk of harm to those spectators waiting outside the grounds to pass through the turnstiles. ...that is exactly what happened."

3.103 On 3 April 2019, the jury found Mr Mackrell guilty of failing to discharge a duty under the HSWA 1974. He was sentenced to a fine of £6,500 and ordered to pay costs of £5,000.

Complaints and conduct matters relating to police planning

3.104 SYP asserted that its planning for the 1989 Semi-Final was largely the same as for the 1988 one. However, there were several differences that may have been significant, including the replacement of the match commander, and the lack of a joint planning meeting between SYP and SWFC meant that potentially significant information, such as the change in turnstile arrangements, may not have been communicated sufficiently to SYP. Taken as a whole, it suggests a laissez-faire and inadequate approach to planning, the disastrous consequences of which became apparent.

3.105 The crushing incidents at previous semi-finals amply demonstrated the dangers of overcrowding. The Operational Order should have not only described this risk but also set out clear responsibilities and guidance on contingencies to prevent overcrowding. This was not the case. This was one of several key issues that was not addressed within police planning, which was also poorly coordinated.

3.106 The failures of police planning were considered in complaint and conduct reports produced by Operation Resolve. The IOPC was of the view that both ACC Jackson and Supt Murray would have had a case to answer for gross misconduct, if they had still been serving, on the grounds that they failed to plan adequately for the match.

3.107 For ACC Jackson, the IOPC noted a series of failings, categorised as neglect of duty. These include that as the senior officer with overall responsibility for the planning process, he failed to ensure that learning from previous matches was properly gathered and used to inform future plans. He also failed to ensure that the Operational Order contained instructions about key issues, including how the queues to the turnstiles were to be properly supervised and how the capacity of the pens would be monitored—both of which were set out as key responsibilities in the Green Guide and other key guidance.

3.108 For Supt Murray, the IOPC identified that he would have had a case to answer for neglect of duty, for instructing officers that supporters should find their own level rather than giving explicit instructions that officers were responsible for ensuring that supporters were evenly and safely distributed across their allocated areas.

4. The events of 15 April 1989

This chapter includes witness accounts, images and descriptions of scenes that may be distressing.

What was investigated?

Under the terms of reference for the managed investigation, Operation Resolve investigated:

Actions of the police on 15 April 1989 prior to the disaster, including:

a) actions of police officers outside the football ground—including the alleged failure by the police to prevent supporters entering the Leppings Lane end, failure to prevent build-up of supporters outside the Leppings Lane turnstiles and filter supporters away from those turnstiles

b) the decision not to postpone the kick-off of the match

c) the monitoring of crowd numbers in the pens—both the alleged failure to prevent the pens from becoming overcrowded and the alleged failure to act once the pens became overcrowded

d) the opening of Gate C

e) the actions (or lack of) to direct supporters once Gate C was opened

What was found?

- **The briefings to officers on the day did not cover the gaps identified in the police planning for the match.** In sector and serial briefings, some officers then issued instructions that contradicted the F Division Operational Order.
- After addressing all officers on duty at the stadium in a 10am briefing, Ch Supt Duckenfield then toured the area around the stadium for over two hours before going to the PCB where he intended to base himself for the match. Though his activities in this period lacked focus and did not amount to adequate preparation for the match, **there is no evidence to support the allegation that Ch Supt Duckenfield drank alcohol in this time.**
- **From about 2.15pm, there were clear signs of crowd build-up outside the stadium.** Supporters arriving at the Leppings Lane entrance around this time have described their surprise at the size of the crowds they encountered, and some have described there already being a crush towards the turnstiles. Several have commented that there was a lack of control, especially compared to the previous year's Semi-Final.

- Officers inside the stadium—including some in the PCB—observed that the areas allocated to Nottingham Forest supporters were much fuller than those allocated to Liverpool supporters. However, **Operation Resolve did not find evidence that any concerns were communicated to the match commander, Ch Supt Duckenfield.** Further, no efforts were made to check this by reference to turnstile count data, which was readily available.
- From the PCB, it was possible to see the situation both on the West Terrace—directly in front of the PCB window—and outside the stadium, on the CCTV monitors. **At around 2.30pm, with the crowd increasingly built up outside, Ch Supt Duckenfield consulted Supt Murray on whether to delay the kick-off to ensure spectators could safely enter the stadium. Referring to a very limited set of pre-determined criteria to inform the decision, he chose to allow the game to kick off as planned.** He did not consult other officers or consider turnstile count data as part of his decision making.
- **Over the next short period, the situation at the Leppings Lane entrance deteriorated rapidly as supporters arrived more quickly than they could enter through the turnstiles.** Supporter accounts describe intense crushing; officers on duty outside feared for their wellbeing and police horses were lifted off their feet by the crowd. Many of the supporters who made it through the turnstiles appeared to be in discomfort.
- **By around 2.45pm, officers outside the Leppings Lane entrance had become increasingly concerned about the pressure of the crowd outside the stadium. At 2.47pm, radio requests were made to open the wide exit gates next to the turnstiles**, to allow supporters into the stadium at a greater rate and reduce the pressure outside.
- **Over the next ten minutes, all three exit gates (A, B and C) were opened. The most significant of these was a prolonged, uncontrolled opening of Gate C, which resulted in a large number of supporters entering the ground.** By contrast, the opening of Gate A was tightly controlled and caused no issues.
- It has previously been largely accepted that Gate C was opened at the instruction of Ch Supt Duckenfield. However, Operation Resolve's investigation casts doubt on this. **While Ch Supt Duckenfield did issue an instruction to open the gates, evidence indicates that no officers acted on this.**
- **One reason was that Gate C had already been opened, with a view to allowing small numbers of supporters into the stadium in a controlled way. However, the police lost control, and this became an uncontrolled flow.**
- **Those involved in this intentional opening of Gate C did not inform Ch Supt Duckenfield about what they were doing or why.**

- While opening Gate C did help to relieve the pressure outside, a lack of communication had catastrophic consequences. **No one inside the stadium was informed that officers were opening the gates and so they could not—and did not—prepare for supporters arriving at a far greater rate than through the turnstiles.** Officers near the gates had no awareness of the situation inside the stadium, where the centre pens of the West Terrace had become quite full while other areas were still comparatively empty. There was no attempt from the police to control or guide the supporters coming in, who headed in large numbers towards what appeared the most direct route to the terraces: the tunnel that led to the centre pens.
- **Though Ch Supt Duckenfield ordered the opening of the gates, he gave no instructions to anyone to manage the inflow of supporters.**

Significant new evidence

In examining the events of the day, Operation Resolve was able to draw on a substantial volume of existing evidence gathered by previous investigations. This included documents, photographs and video footage.

Using today's technology, investigators were able to synchronise the footage from different sources, including SYP and SWFC CCTV cameras and from broadcasters that had been filming the match. Many images shown in this chapter are presented with the synchronised time in the 24-hour clock format by hour, minute, second and video frame, for example, 14:55:29:13 (meaning 2.55pm and 29 seconds, frame 13).

Once the material was synchronised, specialist equipment and software enabled investigators to view moving footage at 25 frames per second, and to stop and start at any point and move the footage backwards and forwards frame by frame. This approach was used to follow the movements of those who died in the disaster, then combined with documentary evidence and photographs to provide individual timelines for the Goldring Inquests. It was also used to follow the movements of certain officers at key times, such as those involved in the opening of each of the exit gates.

Operation Resolve also examined in detail recordings and transcripts of police radio communications and telephone conversations, including those between the PCB and SYP's Force Control Room at Police HQ, some of which had not previously been open to scrutiny.

4.1 This strand of the Operation Resolve investigation examined the events of the day of the disaster, up to the critical point when the exit gates (Gates A, B and C) at the Leppings Lane end were opened. Using a broadly chronological approach, it brought together evidence from supporters, police officers, SWFC officials and other witnesses, as well as video material and photographs, covering the arrival of supporters at the stadium, the build-up of supporters outside the Leppings Lane entrance and how the police responded.

4.2 In particular, Operation Resolve undertook an extensive investigation into the sequence of events around the openings of Gate C. This involved frame-by-frame analysis of CCTV footage, radio transmissions, witness accounts and minutes of meetings after the disaster.

4.3 This chapter refers to numerous specific features of the Leppings Lane entrance area. These are shown in the diagram below.

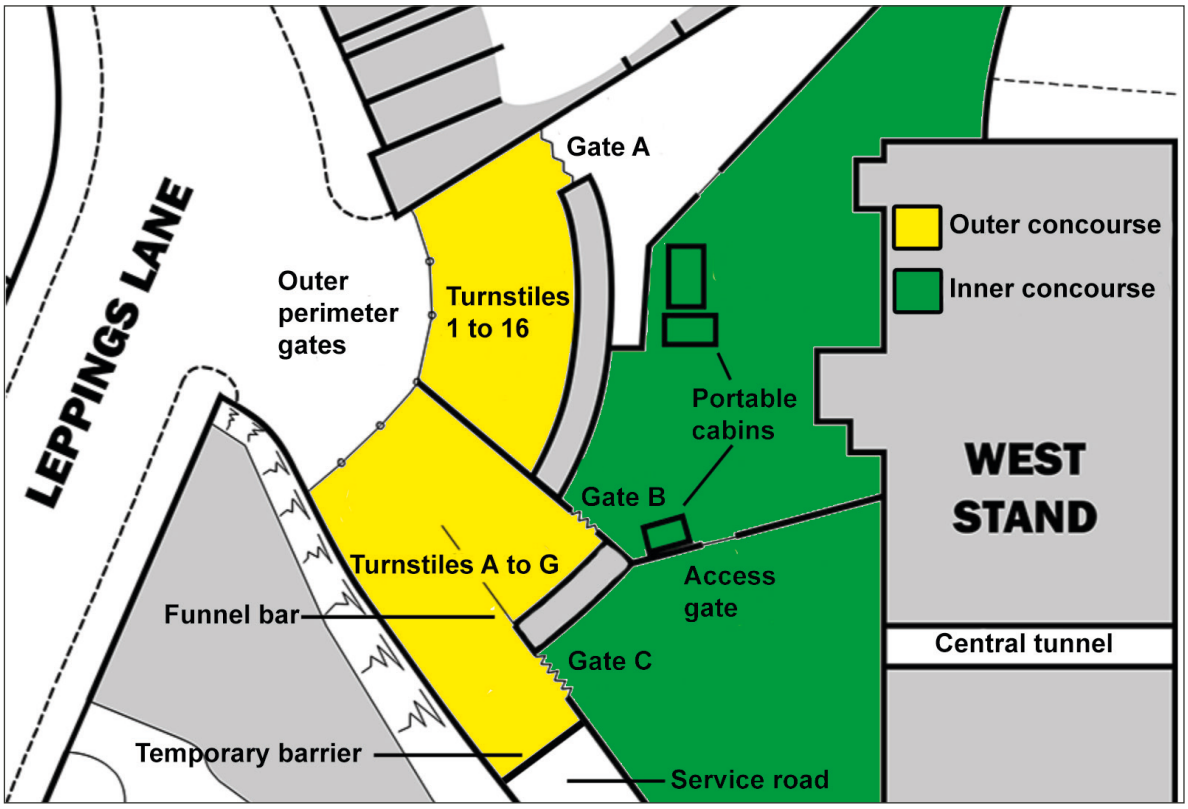


Figure 4A: Plan of Leppings Lane entrance area and turnstile locations (Source: Operation Resolve, based on Mr Cutlack's diagram)

Briefings for officers on duty

4.4 The turnstiles were scheduled to open at midday ahead of the 3pm kick-off. Officers on duty at or around the stadium attended a 10am briefing in the North Stand, led by Ch Supt Duckenfield. He used exactly the same briefing notes as he had for his briefing of senior officers the previous day.

4.5 The evidence of officers present suggests there was nothing particularly remarkable about Ch Supt Duckenfield's briefing. Following it, there was a series of sector and serial briefings, with more detailed instructions about the duties of individual officers. The majority of these were as officers expected, but a small number of discussions appear to have been significant.

4.6 Supt Greenwood, as ground commander inside the stadium, briefed officers on duty at the Spion Kop (the terrace allocated to Nottingham Forest supporters) about how they should deal with any Liverpool supporters that had bought tickets for that area. He instructed officers that any Liverpool supporters there should remain in a segregated area on the Spion Kop and not be transferred to the Leppings Lane end of the ground. This instruction was different from what was set out in the F Division Operational Order, in which officers were told to transfer Liverpool supporters found in the wrong area to

their own designated area. Supt Greenwood did not want to do this, because he was concerned that it could result in overcrowding on the West Terrace, as had occurred at the 1981 Semi-Final.

4.7 Despite this concern and other instances of overcrowding on the West Terrace, no officer appears to have given, or received, a direct instruction during a briefing to monitor capacity in the pens there. As no instructions to this effect were included in the F Division Operational Order either, no officers anywhere in the stadium were told that they had a responsibility for monitoring the pens. Ch Supt Duckenfield and other senior officers have all stated in evidence that they understood officers in certain areas of the ground had that responsibility.

4.8 There were separate briefings for D Division, who had commenced duty earlier in the city centre, and for the Dog and Mounted Sections, both of which were briefed at the Niagara Sports and Social Club, where they were based, a short distance from the stadium.

4.9 Ch Supt Duckenfield arrived at the Niagara Club before the Mounted Section had left, at around 11.30am. He spoke briefly to the mounted officers to wish them well.

4.10 This is one of few clear details about how Ch Supt Duckenfield spent the time between the end of the 10am briefing and his arrival in the PCB at around 1.50pm. Ch Supt Duckenfield's own accounts are vague on what he did in this period. Operation Resolve has used multiple sources of information to re-examine this issue, drawing together the accounts of different officers, witnesses at different venues and locations, and some AV material.

4.11 Some evidence indicates that Ch Supt Duckenfield toured the area in a police car with Insp Sewell and then went around the stadium—though there are few witnesses to this latter part. It appears they then went for lunch in the gymnasium at around 1.30pm.

4.12 Partly because his accounts are so vague, questions have been asked about what Ch Supt Duckenfield did during this period, and it has been alleged that he could have drunk alcohol during this time. Operation Resolve has found no evidence to indicate he (or any other officer on duty at the match) did so.

4.13 Nonetheless, the evidence gathered by Operation Resolve demonstrates that Ch Supt Duckenfield's activities and movements in this period lacked the focus and purpose that would be expected of a match commander. He did not use the time after the pre-match briefing to familiarise himself with the important areas of the stadium, to talk to officers on duty in different areas about their knowledge of previous issues and risks, or to gather their observations on the arrival of supporters.

4.14 Ch Supt Duckenfield subsequently acknowledged that he was not sufficiently aware of the structures of the stadium or the facilities available to him to be able to understand how to manage any foreseeable events.

Arrival of supporters

4.15 Up to at least 1pm, the number of supporters in the vicinity of the stadium was quite small, despite advance efforts by SYP to encourage people to enter the ground early. These included messages in match programmes at preceding home games of both teams and a promise of pre-match entertainment in the stadium (which did not take place).

4.16 The first cars and minibuses carrying Liverpool supporters began to arrive shortly after 11am, and the first coaches arrived in designated coach parks at around 11.45am.

4.17 After the disaster, a persistent theme in police officers' accounts was that supporters travelled to Sheffield early and then went to pubs or bought alcohol from shops. Evidence from a range of sources strongly indicates that there was nothing out of the ordinary about this. The licensee of a pub a short distance from the stadium—The Horse and Jockey—confirmed he was expecting to be busy with football supporters.

4.18 The likelihood of supporters drinking featured in numerous police briefings and instructions. For example, Serial 48 under Police Sergeant Derek Miller (PS Miller) had instructions to pay particular attention to licensed premises in the Wadsley and Middlewood areas. In a statement to Operation Resolve, PS Miller confirmed that they started patrol at 11.30am and visited several pubs which were busy with Liverpool supporters. He described them as being in "high spirits" but presenting no problems.

4.19 Though there were instructions to "pay attention", there was no direction within the Operational Order about how to deal with supporters drinking: a clear oversight given its likelihood.

4.20 Some 52 coaches of Liverpool supporters arrived between 12.30pm and 1.45pm. Some of those who travelled by coach went directly to the stadium; others felt it was too early, so chose to go for a drink. As the available pubs were mostly full, some bought drinks from shops instead.



Figure 4B: View of Leppings Lane and the entrance at 13:59:53 (Source: SYP CCTV)

4.21 From around 1pm, the numbers of supporters at the ground steadily increased. Figure 4B shows the scene at the Leppings Lane entrance at 13:59:53. It is taken from SYP CCTV footage, which would have been visible to those in the PCB.

4.22 While the situation at the entrance presented no issues, various witnesses have commented on how empty some of the areas of the stadium allocated to Liverpool supporters were at this time. Inspector Peter Darling (Insp Darling), on duty in the South Stand, visited the SWFC control room around this time. He told the Taylor Inquiry that someone in the control room had noted there were only 12,000 people inside the ground at that stage, compared to 20,000 at the same time at the previous year's Semi-Final. This information would have been based on turnstile count data, which was displayed on a screen in the control room. However, Insp Darling did not mention this to the PCB and there is no evidence to indicate that anyone in the PCB actively requested this potentially invaluable data.

4.23 Some officers have since acknowledged that, if they had known how few supporters were in the stadium at 2pm, they would have been concerned.

The build-up of the crowd

4.24 By about 2.15pm, officers in the PCB were discussing the disparity between how full the areas allocated to Nottingham Forest supporters were, and the comparative emptiness of the areas allocated to Liverpool supporters. This can be seen in figure 4C, which offered a similar view to that which would have been available through the PCB window.



Figure 4C: View of the West Stand, West Terrace and North West Terrace, 14:15:32 (Source: BBC)

4.25 While the centre pens of the West Terrace (shown in the foreground) appear quite full, the pen beyond the goal is comparatively empty, as is the West Stand above. A lot of space is also visible in the North West Terrace in the corner of the stadium.

4.26 By this time, the crowd outside was building, as can be clearly seen in the CCTV image at figure 4D, from 14:17:10.



Figure 4D: View of the area outside the outer perimeter gates, as seen from the West Stand, 14:17:10 (Source: SYP CCTV)

4.27 Various factors had contributed to this build-up, including the arrival of a special train at Wadsley Bridge station just after 2pm, from which mounted police escorted between 350 and 500 supporters to the stadium. Photographs of the supporters being escorted from the train show them walking calmly and there are no signs of supporters with alcohol.

4.28 In addition, at 2.10pm, PS Miller decided to close the Horse and Jockey pub and direct supporters towards the stadium. He suggested there were about 400 supporters there and alerted the PCB to his actions. As with the supporters on the special train, there were no reports of anyone causing problems.

4.29 Together with supporters arriving from other locations, this meant that up to 1,000 more people converged on the entrance area at around the same time.

4.30 Accounts vary as to what the situation was like at the turnstiles around this time. Some officers and spectators have said that up to 2.15pm, there were neat queues, with supporters laughing and joking. Others recall that from 2pm there was some pushing and shoving at the turnstiles; one supporter said that when he arrived at 2.10pm “There was just a sea of people at the turnstiles” and another commented that by 2.15pm there were no distinct queues and police officers could no longer organise the crowd.

4.31 In his 1989 account, Detective Superintendent Graham McKay (D Supt McKay), who was the senior detective on duty at the stadium at that stage, recalled that at about 2.15pm, he went to the service road to the side of the Leppings Lane turnstiles. He saw that officers were having great difficulty controlling the crowd and it was apparent that the turnstiles were not coping efficiently with the increasing number of supporters.

4.32 Supt Marshall was outside the stadium, on Leppings Lane. In an account from 1989, he said that by 2.15pm, Leppings Lane was full of supporters moving in both directions. He estimated there were between 6,000 and 8,000 supporters in the area. He said they were spilling off the footpaths onto the road and disrupting traffic flow. At 2.17pm, he radioed the PCB asking for Leppings Lane to be closed to traffic. A serial of officers was deployed to do this at one end, but the PCB was unable to contact the serial at the other end of the street. The road was not closed immediately and at about 2.22pm, Supt Marshall sent a further message reporting that there was still traffic coming along the road and asking again for it to be closed.

4.33 Both Ch Supt Duckenfield and Supt Murray commented in their 1989 accounts that, having seen the CCTV footage, they did not think closing the road looked necessary.

4.34 In describing the situation at around 2.20pm, the accounts of supporters are largely consistent. With just a few exceptions, they paint a picture of no discernible queues and a mass of people at the entrance. Those closer to the turnstiles referred to pressure building from behind and being unable to turn around or get out of the crowd. This pressure then increased further.

4.35 In their original statements, and again in statements to Operation Resolve, some supporters compared the situation at the 1989 Semi-Final with their experiences the previous year, where they recalled that the police operation seemed more organised, with officers checking whether supporters had tickets before they got close to the entrance area. There had been no such crowd pressure at that game.

2.30pm: Consideration of delaying the kick-off

4.36 By 2.30pm, the contrast in fullness between the Spion Kop and Leppings Lane ends was increasingly pronounced. The screens in the PCB showed a large crowd outside the Leppings Lane entrance, with supporters tightly packed in front of the turnstile block.

4.37 Police Constable Trevor Bichard (PC Bichard), the officer responsible for monitoring the CCTV cameras in the PCB, estimated that there were over 3,000 supporters waiting to get in. Police Sergeant Michael Goddard (PS Goddard), who operated the personal radio network in the PCB, recalled PC Bichard making a comment about the size of the crowd, and so he looked at the screens. He told Operation Resolve he estimated that there were about 3,000 to 4,000 supporters there and commented: “Only once before have I seen such numbers and that was when Sheffield Wednesday played Coventry City in an FA Cup 6th Round match in 1987 when the Coventry fans came to Sheffield in their thousands.”

4.38 Operation Resolve has established that some supporters at that game experienced severe crushing.



Figure 4E: View of the Leppings Lane entrance from the West Stand, 14:30:16 (Source: SYP CCTV)

4.39 At around 2.30pm, Ch Supt Duckenfield and Supt Murray discussed whether to delay the kick-off, so supporters could get in safely. In advance, they had agreed on a very small set of reasons which would necessitate delaying the kick-off. These essentially amounted to the late arrival of a large number of supporters due to circumstances beyond their control, such as poor weather or a major traffic problem en route.

4.40 They had received no information about any such delays, and Supt Murray assured Ch Supt Duckenfield that there should be sufficient time to get the waiting supporters into the ground by the scheduled kick-off time. They agreed that the kick-off should not be delayed.

4.41 In agreeing this, neither suggested consulting with other officers, such as Supt Greenwood inside the stadium or Supt Marshall outside, nor did they check the turnstile count data, which could have given them more information about how many supporters were still to arrive. Instead, they relied on their own visual assessment of how full the Leppings Lane end was.

4.42 Yet even this basic visual assessment should have been a cause for concern. Officers in the PCB have indicated that at 2.30pm they thought the North Stand was only about half full. Given its official safe capacity was 9,702, this would indicate that just under 5,000 supporters were still to enter. There were ten turnstiles available for the North Stand, so to fill it by 3pm, each of those turnstiles would have to admit more than 450 supporters over the next half hour. As detailed in chapter 2, the Green Guide advised that the maximum number of supporters that could enter through a single

turnstile each hour was unlikely to exceed 750—so 375 per half hour. Later analysis by the HSE concluded that, based on the number of people in the stadium at 2.30pm, it would have taken until around 3.40pm for all supporters to have entered safely through the turnstiles.

4.43 Subsequently, it was also established that there had been various traffic problems affecting several of the routes Liverpool supporters would have used if travelling from Merseyside. This information was not shared with officers in the PCB.

4.44 The D Division Operational Order contained an instruction that the Force Control Room at SYP HQ was to be informed of any traffic issues. However, Operation Resolve's review of the Operational Orders showed that there was no instruction in any of them for officers engaged on the road traffic operation or in the Force Control Room to inform the PCB of problems with the routes into Sheffield.

4.45 There were also no plans in place to liaise with neighbouring forces, to understand if there were issues in their areas that could affect the arrival of supporters into Sheffield. Major delays were reported in Greater Manchester and Derbyshire; it appears the SYP Force Control Room was not made aware of these, nor did it check. Certainly, no information about these was passed to the PCB, but neither did anyone in the PCB ask whether there were any problems on the roads.

2.30pm–2.48pm: the crush intensified

4.46 Having decided not to delay the kick-off, Ch Supt Duckenfield did not then consider whether there were other tactics that could be used to alleviate the situation at the turnstiles. Evidence from supporters and police officers suggests that in the period immediately after 2.30pm, the crowd outside the Leppings Lane entrance began to increase rapidly.

4.47 Supporters' accounts of this period describe being unable to move freely and being crushed against walls and turnstiles. Many have stated it was the worst crowd situation they had ever experienced, with some feeling faint or unable to breathe, and others recalling people screaming in pain. They also commented on police officers in the crowd, including mounted police officers, becoming overwhelmed.

4.48 Officers closed the outer perimeter gates, to reduce some of the pressure on the bottleneck at the turnstiles. However, the pressure outside was so intense that one of the gates sprung back open a couple of minutes later. It was later established that the bottom bolt holding it closed had buckled. Several mounted officers have described how their horses were being lifted off the ground by the sheer pressure of the crowd.

4.49 Chief Inspector Robert Creaser (Ch Insp Creaser) was one of the most experienced officers on duty outside the stadium at the Leppings Lane end. In his original account, he recalled that at about 2.30pm he could see that difficulties were being experienced at the turnstiles and commented that the build-up of supporters was later and larger than was usually the case.

4.50 Figure 4F, taken from CCTV footage at 14:33:35, demonstrates the density of the crowd outside the Leppings Lane turnstiles at this time.



Figure 4F: View of the crowd build-up outside the Leppings Lane entrance, 14:33:35 (Source: SYP CCTV)

4.51 With increased pressure on the turnstiles, some supporters climbed onto the walls and over the turnstiles to escape the crush. Turnstile operators recalled the state of supporters as they finally entered the ground, with many distressed, red-faced and out of breath. Another turnstile operator said that after 2.30pm, the crush was so intense that "some supporters were unable to take tickets from their pockets."

4.52 Figure 4G shows the situation at 14:37:03 from the opposite angle, looking towards the stadium from Leppings Lane. Supt Marshall has been identified between the turnstiles and the outer perimeter gates, surrounded by supporters. Police horses can be seen between the outer perimeter gates and the turnstiles, also surrounded by the crowd. Some supporters can be seen on the walls above the turnstiles.



Figure 4G: The crowd outside the Leppings Lane turnstiles at 14:37:03 (Source: BBC)

4.53 Inspector Robert Purdy (Insp Purdy) was part of sector 1, officially under Supt Greenwood. He was on duty on the outer concourse, by the turnstiles. In evidence to the Taylor Inquiry, he explained that around this time he felt the officers outside the turnstiles were no longer effective because they themselves were in danger, so he decided to redeploy them.

4.54 Other officers described their efforts to try to help particular individuals out of the crush, unable to control the crowd as a whole. Many mentioned supporters pleading with them to do something to relieve the crush.

4.55 Supt Marshall told the Taylor Inquiry that the situation was worsening by the minute with more supporters arriving. He had attempted to get a better vantage point away from the crush, by heading to a bridge outside the stadium, but from there he saw what he described as “A vast and progressively more unruly crowd” that officers were struggling to control.

4.56 Insp Purdy was also seeking a better vantage point by standing on the funnel bar, a railing that separated the turnstiles from the service road. He had initially attempted to direct supporters from there, but at 14:39:41 was handed an injured child from the crowd.

4.57 In a statement to Operation Resolve, he recalled: “I thought at first he was dead. He was limp in my hands.” However, the child was taken by another officer to a first aid point and recovered.

4.58 By the point at which the injured child had to be lifted out of the crowd, it should have been apparent to officers outside the ground that this was now a very serious crush, and that urgent action was required.

4.59 At around this time, Insp Purdy had a conversation with D Supt McKay, who was close by; D Supt McKay suggested that the gates would have to be opened.

4.60 Officers on the inner concourse were equally concerned. In a statement made in 2013, Inspector John Bennett (Insp Bennett) recalled sending a radio request for more officers to be deployed to the Leppings Lane end of the ground, based on both his own observations and the comments of supporters entering through turnstiles A–G that someone could be killed. He did not recall receiving an acknowledgement.

4.61 The PCB had received an earlier request for additional officers to be sent to the Leppings Lane end. In response, PS Goddard had radioed a Mounted Section sergeant to deploy all available mounted officers to the area, and Supt Murray also deployed reserve Serial 20 from the gymnasium. Insp Bennett said this serial arrived close to him at Gate A shortly after his request. Gate A was an exit gate closest to the North Stand. A few minutes later, another serial joined them there.

4.62 At about this time, Supt Marshall attempted to contact the PCB by radio to request that an announcement be made over the Tannoy system to urge supporters to queue in an orderly fashion. He also asked for Police Constable Michael Buxton (PC Buxton), who was driving a Land Rover equipped with a public address system, to make his way to Leppings Lane.

4.63 Though there was no reply from the PCB, PC Buxton himself confirmed by radio that he was on his way. He arrived a few minutes later. However, he could not be heard over the noise of the crowd. Believing that his messages were not getting through to the PCB, Supt Marshall radioed the Force Control Room at SYP HQ, to ask officers there to contact the PCB regarding a Tannoy announcement. This was one of several examples Operation Resolve has identified where problems with radio communications appear to have hampered the police response. More generally, officers have commented on the fact that radio communications were inaudible, or unclear; many simply did not have access to a radio.

4.64 By this stage, the crowds on Leppings Lane had extended beyond the funnel bar and were between the outer perimeter gates and Gate C. Figure 4H, taken from SYP CCTV footage, shows the situation at 14:44:51.



Figure 4H: The crowd outside the Leppings Lane entrance, 14:44:51 (Source: SYP CCTV)

4.65 At 2.47pm, Supt Marshall radioed the PCB again. This time, he requested that the exit gates at the Leppings Lane end should be opened, to allow supporters to escape the crush outside.

4.66 He did this after speaking to Insp Purdy near the outer perimeter gates. Insp Purdy commented that because he was unable to contact Supt Marshall, he had to force his way through the crowd to speak to him. Though this was a distance of only approximately 30 yards, Insp Purdy said it took minutes, rather than seconds to reach him.

4.67 In his 1989 account, Supt Marshall said that once he arrived at the outer perimeter gates, "Inspector Purdy told me that people at the front of the crowd by turnstiles A-G were being crushed and asked me to open gates." Supt Marshall further explained: "He was not specific as to which gates he thought should be opened but his anxiety was apparent."

4.68 Supt Marshall said he was reluctant to do so, as it would result in uncontrolled access to the stadium. However, because an officer with the experience of Insp Purdy seemed extremely concerned about the situation, he agreed to ask the PCB to authorise the opening of the gates.

4.69 Again, there was no acknowledgement, so he borrowed a radio of a different type from another officer and tried to send the message a second time. Still there was no acknowledgement. He made a third attempt, suggesting that if the gates weren't opened, people would be killed.

4.70 Supt Marshall has repeatedly stated that he requested the PCB's authority before opening the gates, and various officers have said that they heard his increasingly frantic radio requests.

4.71 However, Insp Purdy has consistently recalled that Supt Marshall gave him the authority to open the gates when they spoke. Specifically, he believed he had authority to open Gate C.

Re-examining the opening of the exit gates

4.72 Exit gates, as the name suggests, are primarily used as a means of exit from the stadium at the end of the game or in the event of an emergency. They are wide gates designed to allow people to go through unimpeded (in contrast to turnstiles at the entrance, which control access to the ground). They are not normally used to allow people into the ground.

4.73 As shown in figure 4A, there were three exit gates at the Leppings Lane end.

- Gate A was closest to the turnstiles allocated to supporters with tickets to the North Stand.
- Gate B was the middle gate of three exit gates at the Leppings Lane end of the ground. It was to the left of the area that gave access to turnstiles A to G. This exit gate was used to allow supporters from the West Terrace and the West Stand to exit the stadium.
- Gate C was at the far southern end, close to the river. It opened onto the service road at the side of the stadium and was slightly hidden from view behind the turnstiles allocated for supporters with standing tickets (see figure 4I).



Figure 4I: Photo of Gate C and surrounding area at the Leppings Lane end (Source: Provided by Yorkshire Ambulance Service, Sheffield Archives)

4.74 From the earliest stages after the disaster, the opening of Gate C was identified as a pivotal moment. When it was opened, large numbers of supporters came through it at the same time, in an uncontrolled flow. Evidence shows that the majority headed towards the central tunnel, which was the most obvious route to the terraces. The word above it reads “STANDING”. The only other sign to an alternative route to the terraces was not readily visible.



Figure 4J: Photo of the inner concourse of the Leppings Lane end, as viewed from Gate C, in 1989 (Source: WMP)

4.75 The central tunnel led directly into Pens 3 and 4 of the West Terrace, which is where the fatal crushing occurred, following the arrival of a large number of people into those pens at the same time. These pens were already full, or near full, but no action was taken to stop more supporters going into them. In the Taylor Interim Report, the fact that no action was taken to cut off access to the centre pens following the opening of Gate C was described as "a blunder of the first magnitude".

4.76 Since the disaster, it has been established that there were three different openings of Gate C which led to supporters coming into the ground. Gates A and B were also opened to allow supporters in. Each of these openings is considered in the following sections.

The situation in the pens

4.77 The difference in fullness between the areas allocated to Nottingham Forest supporters and Liverpool supporters had been noted early on. However, as kick-off approached, there was a further visible disparity in fullness at the Leppings Lane end, between the centre pens—Pen 3 and 4—of the West Terrace and the side pens.

4.78 On the day, supporters with tickets for the West Terrace could choose which pen they went to and—at least in theory—could move between pens as part of SYP's 'find your own level' approach to the distribution of spectators. The centre pens were accessed via the tunnel under the West Stand. The entrances to the side pens were at either end of the West Stand and not immediately visible or clearly signposted on entry.



Figure 4K: Aerial photo of Leppings Lane end, with arrows showing spectator entry routes to the West Terrace and North West Terrace on the day of the disaster (Source: Operation Resolve, based on photograph taken by Michael Warburton Lee, SYP)

4.79 There was an expectation that the centre pens would fill first, as normal, and on the day of the disaster, this proved to be the case. As shown in figure 4C, as early as 2.15pm there was a visible difference in fullness between the centre pens and the side pens.

4.80 Officers nearby recalled there being a good atmosphere in the centre pens, with a beach ball being thrown around. Though there were some instances of supporters climbing over the fences between pens, and in one case climbing to the West Stand above, these were not as a result of supporters seeking to escape a crush.

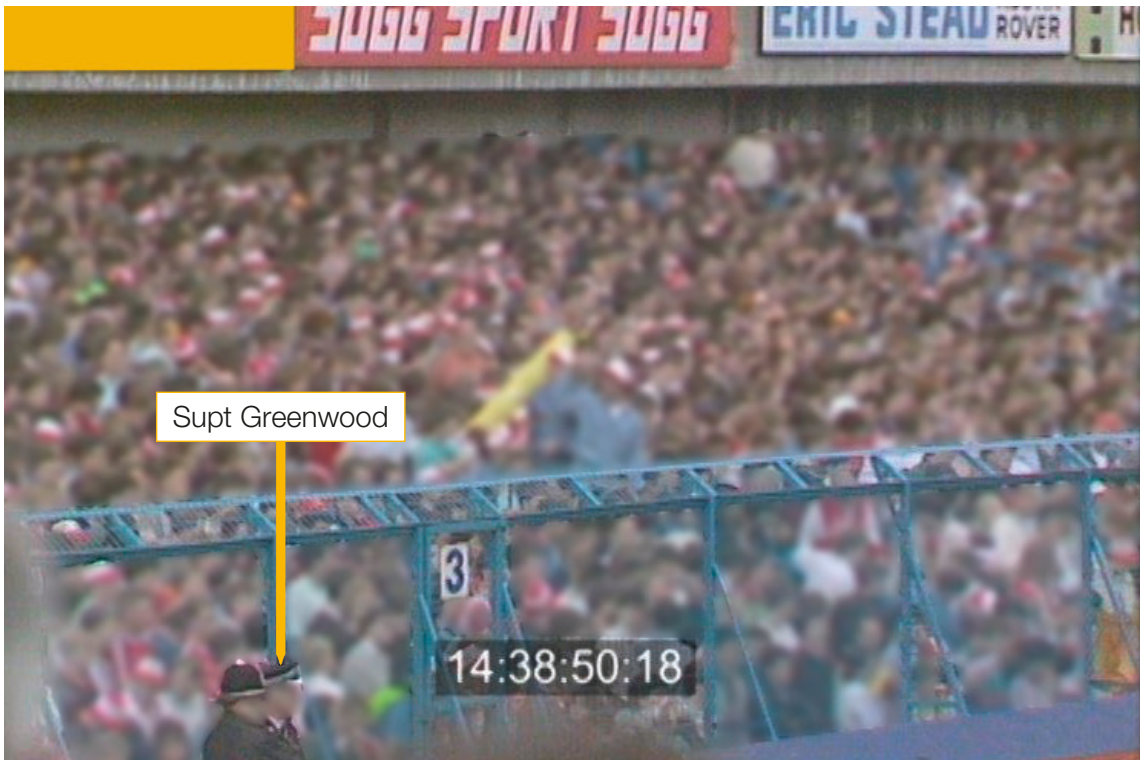


Figure 4L: View of Pen 3, 14:38:50 (Source: BBC)

4.81 At 14:38:50, Supt Greenwood was standing in front of the centre pens, talking to an officer on duty there. As figure 4L shows, there were no obvious signs of crushing or discomfort at this stage, but there was little room to move in the centre pens.

4.82 However, some supporters' accounts indicate that by about 2.40pm, the situation in Pens 3 and 4 was becoming uncomfortable. One sought to leave Pen 3 but was unable to; others described using crush barriers for protection against crowd surges from behind.

4.83 Officers stationed on the perimeter track in front of the West Terrace have broadly shared the view that up to at least 2.40pm–2.45pm, there were no discernible problems in any of the pens.

4.84 While the officers on the track were not concerned, BBC football commentator John Motson had a different opinion. In a statement dated 4 May 1989, he said that from his position on the camera gantry on the roof of the South Stand, he had an excellent view of the inside of the ground. He said that at 2.45pm, he was rehearsing the sequence of camera shots and commentary, and that during one of the rehearsals he stopped speaking. He explained: "The reason I stopped was that part of my script talked about 'an all ticket capacity crowd' but I suddenly spotted that two end sections of the Leppings Lane terrace were only just over half full. There was plenty of room in these two wing sections which I have since gathered are numbered 1, 2, 5, 6 and 7."

4.85 He said that, in contrast, the two centre sections were fully occupied and gave the usual impression of a solid, heaving mass of supporters who were chanting, singing and clapping. He recalled he was surprised that there was so much space in the wings of the terrace and thought that it looked as though two thousand ticket holders had not turned up.

4.86 Neither he, nor the officers on the track, were aware of what was happening outside the stadium at the same time. It is possible that, if those inside the stadium had known of the crush outside, they may have viewed the imbalance between the fullness of the pens differently.

4.87 As Operation Resolve's analysis of the Operational Orders has made clear, none of the officers on duty at the Leppings Lane end had a documented responsibility to monitor the capacity and safety of the pens. While they could have seen the situation in front of them, they were not asked to evaluate it or consider it in context.

4.88 Senior officers, including Supt Greenwood and Ch Insp Creaser, have indicated in their accounts to different investigations that this duty was not documented because it was effectively a commonsense expectation for experienced officers. They have argued that, if fellow officers saw that any of the pens were becoming full, they could take action.

4.89 Ch Supt Duckenfield told the Taylor Inquiry and the Goldring Inquests that he believed responsibility for monitoring the pens lay with SWFC stewards. He said, correctly, that this was in line with the Green Guide, which recommended that stewards were responsible for the safe dispersal of spectators on the terraces and for preventing overcrowding. However, SWFC's 'Instructions to match day staff' told stewards not to become involved in crowd control, as this was the responsibility of the police. At the Goldring Inquests, Ch Supt Duckenfield said he had never seen this document; Operation Resolve has, however, established that it was shared with the police planning team.

4.90 In his evidence to the Goldring Inquests, Ch Supt Duckenfield noted that officers from Serial 1, on the perimeter track, and Serial 13, in the West Stand above the West Terrace, had a role to play in monitoring capacity.

4.91 Inspector David Bullas (Insp Bullas) was in charge of Serial 13. He was asked at the Taylor Inquiry if his officers had been instructed to keep a particular eye on the size of the crowd in the terrace below. He replied: "There is no particular instruction, but it is common sense that one does look down, looking down at the crowd all the time if you are stood at the front, and obviously you will be monitoring the people in the stand with regard to exits and emergency exits, etc."

4.92 Police Sergeant Paul Burman was the Serial 13 sergeant. In a statement to Operation Resolve in 2013, he explained that he and members of his serial regularly worked in the West Stand and listed their duties. Monitoring the crowd was not included in the list he gave. However, at the Goldring Inquests, he said that he would expect the officers under his command to do that, and to bring any matters of concern to his attention.

4.93 Insp Darling was in charge of Serial 1. He told the Taylor Inquiry: "It is a general duty of ours to monitor the crowd and had anything happened or any sort of circumstances occurred within the crowd which needed our attention, then we would have taken the necessary action."

4.94 Police Constable Peter Smith (PC Smith) was regularly stationed in front of Pen 3. In his original account and evidence to the Taylor Inquiry, he said that monitoring the behaviour of supporters was part of his duties. He was asked by Counsel to the Inquiry if that extended to monitoring overcrowding. He replied: "That is something that is permanently monitored, sir. You would be looking for people in difficulty."

4.95 Inspector Harry White (Insp White) was in charge of Serials 14 and 15, whose duties included maintaining order on the West Terrace. He had considerable experience policing matches at Hillsborough Stadium. Following the disaster, he was asked to provide a report covering, among other things, "what instructions I have received in the past about, and what my understanding is as to whose responsibility it is to check and monitor the capacity each pen holds at any time before and during the match and their rate of fill."

4.96 He wrote that he had "never received any specific instructions as to monitoring content and rate of fill of the pens or stands". He commented that due to the location of the PCB he had "always exercised the common sense approach that the ground commander in the control box could assess best from this vantage point capacity and rate of fill." He added that if he thought the terraces were full, he would have alerted the PCB.

4.97 The consistent impression from their own accounts and other evidence is that officers on duty at the Leppings Lane end would keep an eye out for overcrowding, but had neither any specific instruction to do so, nor any clear understanding of what they might do if the pens became overcrowded.

4.98 At the Taylor Inquiry, Ch Supt Duckenfield stated that, at around 2.30pm, he had noticed the uneven distribution of supporters in the pens and asked for a public address message to be relayed for supporters to move forward and spread along the West Terrace. Counsel to the Inquiry asked him whether he had considered sending officers to encourage supporters to move. He said this did not cross his mind but indicated that officers could have taken this action of their own volition. Counsel pointed out the problem with this assumption: the officers with responsibility for maintaining order on

the West Terrace—Serials 14 and 15—were deployed on the inner concourse at this stage, so would not have been aware of the situation in the pens, unless they were specifically informed.

4.99 The evidence indicates that Ch Supt Duckenfield also did not consider the implications of the uneven distribution: that it meant there were many more Liverpool supporters still to arrive.

4.100 At this stage, officers inside the stadium had some knowledge of the situation in the pens—or at least, could see that the centre pens were approaching being full—but those outside had no idea that there were still gaps. By contrast, those outside were responding to an escalating crush that those inside the stadium had no knowledge of. The officers who could see both situations were those in the PCB, but they did not communicate this to either group of officers.

The first opening of Gate C

4.101 As detailed in paragraphs 4.62–4.71, at 2.47pm, Supt Marshall contacted the PCB to ask for the exit gates to be opened, in an attempt to relieve the crush outside. However, he received no response.

4.102 In the meantime, Insp Purdy returned to Gate C with the intention of opening it. In his original account, Insp Purdy described what he did next: "I returned to the barrier on the side of the turnstile. I organised the horses to block off the gates at the perimeter [outer perimeter gates]. It seemed that we could deal with the numbers in there if we contained the people outside. When that was secure by all the horses, now five perhaps, and uniform PC's, I caused the gate [Gate C] to be opened down the side."

4.103 He told the Taylor Inquiry that he had decided to open Gate C to create a space for people being brought under the funnel bar. He added that, because of its concealed location down the side, it seemed the best gate to open. In a 2015 statement to Operation Resolve, he also noted that there was no direct pressure on Gate C at the time.

4.104 Gate C, like the other exit gates, could only be opened from the inside. Operation Resolve established that stewards operating Gate C frequently opened it to let police officers and other authorised personnel in and out of the ground. Police officers also used the gate to eject supporters. Between 2.29pm and 2.48pm, Gate C opened 24 times for these purposes. No supporters entered the ground on these occasions.

4.105 SWFC CCTV footage shows that at 14:48:23, while Insp Purdy was heading towards Gate C with the intention of opening it, a police officer on the inside approached Gate C with a supporter who was being ejected. (Operation Resolve has been unable to identify the supporter ejected through Gate C, or the police officer with him.) PS Morgan was standing nearby among a group of officers.

4.106 This time, when the gate was opened by the steward, it remained open for over 30 seconds. There was a rapid influx of supporters; Insp Purdy was caught up in this and ended up on the inner concourse.

4.107 After the initial surprise, officers tried to close the gate. Figure 4M, taken from SYP CCTV footage timed at 14:48:55, shows a mounted officer positioning his horse across the open Gate C to stop the supporters from entering. A second mounted officer approached from the left.

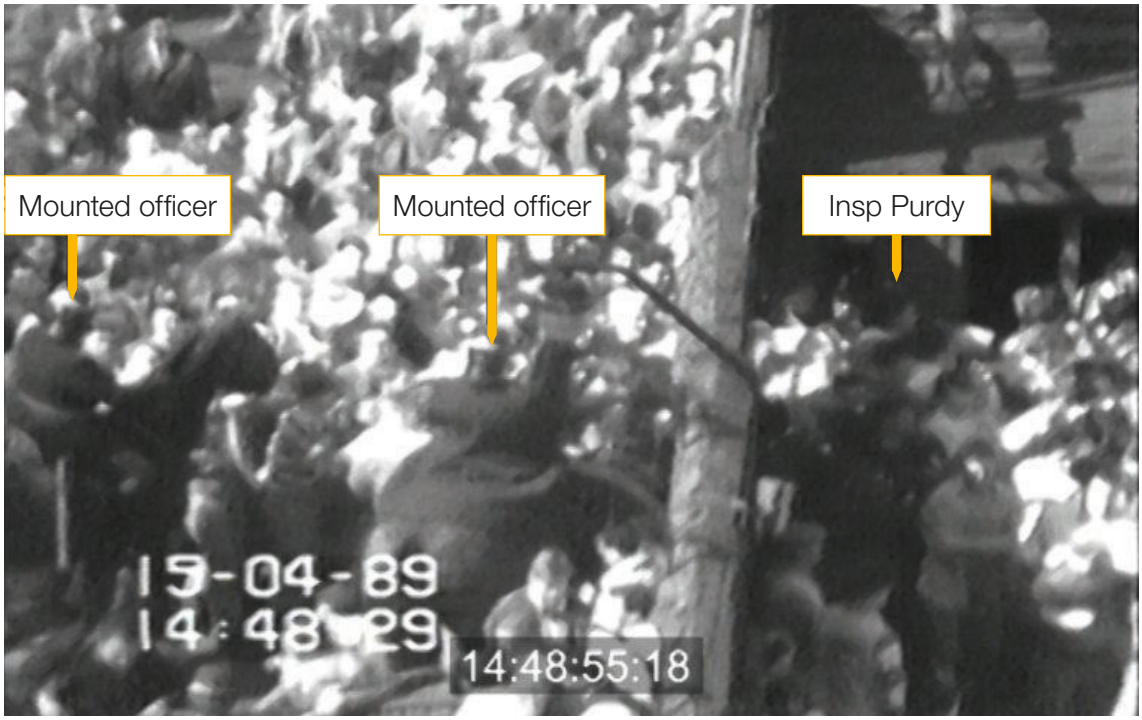


Figure 4M: Mounted officers positioning themselves in front of Gate C, 14:48:55 (Source: SYP CCTV)

4.108 Thirty seconds later, the picture looked very different (see figure 4N). Gate C was closed and mounted officers had cleared the area in front of the gate of supporters. Insp Purdy and PS Morgan have been identified inside Gate C.



Figure 4N: The situation at Gate C at 14:49:26 (Source: SYP CCTV)

4.109 Estimates suggest that between 130 and 180 supporters entered the ground through Gate C in this first opening. Once through the gate, they had free access to the stadium. Officers inside received no warning that spectators were entering in this way and had no influence over where these supporters went once inside.

4.110 As the evidence considered here shows, there remains a high degree of confusion and uncertainty about exactly who, if anyone, authorised the opening of Gate C at 2.48pm. Though it appears that officers outside—including Supt Marshall and Insp Purdy—wanted to open the gate to relieve the pressure on the turnstiles, there is no clear link between Supt Marshall's radio request and the actual opening of the gate.

4.111 Officers in the PCB have recalled that, though they had heard the request, the 2.48pm opening of Gate C took them by surprise and led them to the view that it had burst open. In his original account, Ch Supt Duckenfield said that while he was considering Supt Marshall's request, he saw on the CCTV monitor that the gate opened, supporters came in and then mounted officers managed to control the situation and shut the gate again.

The second opening of Gate C

4.112 However, after Gate C was closed, Supt Marshall made further radio requests—potentially without realising Gate C had even been opened. The evidence of the police officers in the PCB about this has been consistent. Having heard the increasingly desperate requests from Supt Marshall to open the gate, Ch Supt Duckenfield deliberated on what to do and then gave an instruction to open the gates. It is not clear exactly when this instruction was issued.

4.113 At 2.52pm, Gate C was opened again, possibly shortly before the instruction from Ch Supt Duckenfield, and remained open for several minutes. Estimates vary as to how many supporters entered the ground through Gate C at this point, but the commonly accepted figure is more than 2,000.

4.114 Despite comprehensive analysis, Operation Resolve has not been able to establish whether Gate C was opened at 2.52pm as a result of Ch Supt Duckenfield's instruction, as has largely been assumed, or whether it was opened for other reasons.

4.115 What is clear is that none of those directly involved in the opening of Gate C has at any point said they heard a radio message or received an instruction from the PCB to open it.

4.116 Further, Operation Resolve has found no evidence from the Racal recordings of communications from officers in the PCB, or from officers on duty elsewhere, that any further instruction was issued to officers inside the turnstiles, or inside the ground itself, that the gates were about to be opened, or even clarification of which gates were to be opened or by whom.

4.117 CCTV footage shows that Gate C was physically opened by steward Ian Marsh at 14:52:37. He was assisted by another steward. The recollections of both about exactly what happened have been inconsistent. Ian Marsh has accepted various possible explanations put to him, including that he opened the gate to allow a supporter out, and that he opened it in response to a request from a police officer outside.

4.118 Several supporters in the crush have described a police officer outside shouting to the stewards inside to open the gate. Others have described a police sergeant outside the ground directing them to Gate C, with the assurance that it would shortly be opened.

4.119 PS Morgan has confirmed that he did this, with the intention of allowing small groups of supporters in through Gate C in a controlled way to reduce the crush. However, he did not communicate this plan to other officers, with the possible exception of Insp Purdy.

4.120 Insp Purdy has also described an attempt to bring small numbers of supporters out of the crush and under the funnel bar, so that they could enter through Gate C in a controlled way when it was next opened. Mounted officers were being used to try to restrict the number of supporters waiting outside.

4.121 CCTV footage shows the situation outside Gate C twenty seconds before it opened.



Figure 4O: Mounted officers outside Gate C, 14:52:17 (Source: SYP CCTV)

4.122 In footage three seconds later, PS Morgan has been pinpointed close to the funnel bar, with Insp Purdy nearby. Figure 4P then shows PS Morgan and a group of supporters making their way along the service road towards Gate C at 14:52:26.



Figure 4P: PS Morgan leading supporters on the service road, 14:52:26 (Source: SYP CCTV)

4.123 Ten seconds later, Gate C was opened.

4.124 At the Goldring Inquests, PS Morgan was shown this footage. He accepted it was him but insisted he had not requested the gate to be opened at the point it was. Instead, even though he had intended the gate should be opened, his evidence was that it came as a surprise. He accepted the possibility that Gate C was opened by stewards for another reason at this time.

4.125 Though there was an immediate surge through Gate C—in which PS Morgan was swept into the crowd—CCTV evidence indicates that at first the opening showed an element of controlled access. At 14:53:20, mounted officers had formed a line of horses across the service road outside Gate C and were guiding supporters through the open gate. Four of the outer perimeter gates were closed and two partially open, being monitored by a line of mounted police officers, which helped control the rate at which supporters were approaching Gate C.



Figure 4Q: The area around Gate C at 14:53:20 (Source: SYP CCTV)

4.126 However, just after 2.54pm, one of the outer perimeter gates burst open, and supporters ran through the opening. Almost immediately, this was repeated at the other outer gates. A large number of supporters made their way onto the outer concourse, which had been cleared, and then through the open Gate C.

4.127 Crucially, there had been no plan in place for what should happen once supporters entered through Gate C. There were no officers in place to direct the incoming supporters, who made their way across the inner concourse to the most obvious route to the terraces: the central tunnel under the West Stand, leading to Pen 3 and Pen 4.

4.128 At 14:57:01, large numbers of supporters were still entering the stadium through Gate C, which had been open for more than four minutes. As figure 4R shows, there was still no sign of police control on the inner concourse. However, a line of mounted officers can be seen positioned at the end of the service road, close to the side of the funnel bar.

4.129 Not only had the officers at Gate C not communicated with those on the inner concourse, but there is also no evidence to suggest that the opening of the gate was communicated to the PCB. Ch Supt Duckenfield therefore did not know about the intention of officers near Gate C to allow supporters into the ground in a controlled way when he issued his instruction to open the gates. It is also not clear what those in the PCB knew once Gate C had been opened.

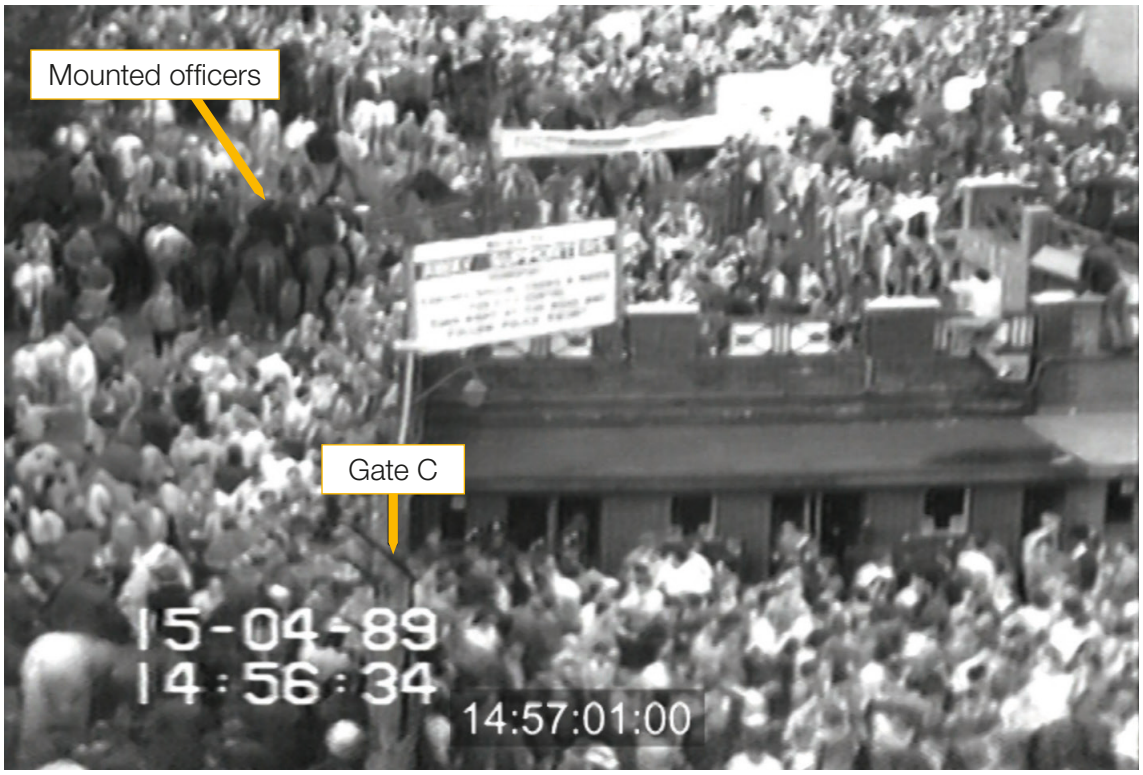


Figure 4R: The area around Gate C, 14:57:01 (Source: SYP CCTV)

4.130 At the Taylor Inquiry, Ch Supt Duckenfield confirmed that he had not given any specific instruction to police officers or stewards that the gate was going to be opened. He said that he had not thought to give instructions to the police officers on the inner concourse to try to direct the flow, because he had been busy watching what was happening.

4.131 He said that his instruction to open the gates was passed over the radio for all to hear at the ground; he hoped that the police officers on the inner concourse, who were trained to act on their initiative, would have done something around the central tunnel. He accepted that he had made a mistake by not giving an instruction for the central tunnel to be closed but said he hoped that others would have remedied that mistake.

4.132 At the Goldring Inquests, Ch Supt Duckenfield said he thought that the supporters would have gone onto the inner concourse and gathered themselves for a moment or two to recover. He said that he did not for a moment consider the possibility that they might go down the central tunnel.

4.133 Supt Murray and Supt Marshall have also both said, at separate times, that they did not think about where the incoming supporters would go. Crucially, Supt Greenwood was still not aware of the situation outside.

4.134 Strikingly, officers on duty on the inner concourse with experience of policing matches at Hillsborough Stadium immediately recognised the likely direction of supporters. Police Sergeant William Crawford told the Popper Inquests that if he had had prior knowledge that Gate C was going to be opened, he could have considered arranging for the central tunnel to be closed.

4.135 The cumulative result was a rapid influx of large numbers of supporters into the centre pens, which is examined further in the next chapter.

4.136 While it has not proven possible to establish on whose authority Gate C was opened, Operation Resolve's investigation has reaffirmed that it was opened in response to the fact that the police had lost control of the situation outside the ground. Further, the evidence is clear that the police did not take control of the situation, either inside or outside the ground, when the gate was opened at 2.52pm. The person with overall responsibility for this was the match commander, Ch Supt Duckenfield.

The opening of Gate A and Gate B

4.137 SWFC and SYP CCTV footage shows that Gate A opened between 14:58:26 and 15:00:01. The CCTV footage shows that police officers formed a cordon on the inside of the gate and managed the entry of supporters into the ground. No other gate was open at the time Gate A was opened.

4.138 Officers close to Gate A made the decision to open it in response to the severity of the crushing outside. They were concerned that it was going to burst open and had stewards attempting to hold the top bolts in place.

4.139 By 14:55:02, a group of officers had assembled by the inside of Gate A and formed a cordon. They then requested authorisation to open the gate, which they received, though it is not clear from whom: possibly from Supt Marshall, or PS Goddard in the PCB.

4.140 Despite the reluctance of the gate steward, the police insisted that Gate A should be opened. The officers channelled incoming supporters away from the gate to the North Stand. When the pressure outside had reduced, Gate A was safely closed. It is not certain who coordinated this opening, but it stands in stark contrast to the more chaotic situation that was witnessed at both Gate C and Gate B.

4.141 SYP CCTV footage shows that Gate B was opened at 14:58:58 and closed almost immediately. Estimates for the number of supporters who entered via Gate B range from 70 to 500, demonstrating the confusion about what happened and how long it was open for. It is not clear where incoming supporters went, but it seems likely some would have headed to the central tunnel. While the opening of Gate B may therefore have helped reduce the crush outside, it is also possible that it contributed to the subsequent crush in the centre pens.

The recurring issue: poor communication

4.142 Operation Resolve's investigation demonstrated that throughout the day of the disaster, there was a recurring issue in the way the police managed the situation: a marked lack of effective communication. This began early, when groups of officers chose to apply different tactics to those detailed in the Operational Order, without informing colleagues.

4.143 It continued as officers made their own decisions about managing supporters around the city. When PS Miller instructed that certain pubs should be closed, he didn't advise colleagues at the Leppings Lane end that he would be escorting a large group of supporters to the stadium. He did tell the PCB, but no one passed the message on.

4.144 The PCB was not alerted to potentially significant traffic delays further afield, which could have been important in the decision about whether to delay the kick-off. Nor did officers there seek to check the situation.

4.145 Most significantly, as the crush built outside the stadium, officers inside had no idea what was happening. They therefore had no reason to be concerned about the unequal distribution of supporters between pens on the West Terrace.

4.146 This communication failure culminated in the fact that before Gate C was opened neither the PCB nor the officers inside the gate were informed, so could not prepare. While some did have access to a radio, there were well-documented problems in terms of messages breaking up or simply being inaudible due to the crowd noise. Instructions were not precise and were uncoordinated. The result was the rapid influx of supporters, who took the most logical route to their target destination: the tunnel signposted "standing" which led to the full centre pens. The consequences of this are examined in the next chapter.

Complaints and conduct matters related to the events of the day

4.147 Operation Resolve investigated a number of complaints and conduct matters relating to the events of the day, up to the opening of the exit gates, and provided reports on each to the IOPC. Having reviewed the evidence detailed in these individual reports, the IOPC opinion was that four officers would have had a case to answer for gross misconduct, if they had still been serving. Some of the grounds for the IOPC's opinion are set out below.

4.148 Ch Supt Duckenfield would have had a case to answer for neglect of duty on several counts, beginning earlier in the day when he did not brief officers in sufficient detail about how they should police the arrival of supporters at the Leppings Lane end. This was then followed by a series of key failings of control as the crowd built.

4.149 He did not take reasonable steps to assess the number of spectators yet to enter the stadium, which was directly related to the subsequent decision not to delay the kick-off, also identified as a key failing.

4.150 Having failed to prevent a dangerous build-up of supporters outside the Leppings Lane turnstiles, he then authorised opening the exit gates without fully considering the likely impact of doing so. Nor did he give any warning to officers that the exit gates were about to be opened, or any instructions to officers about how to manage the influx of supporters.

4.151 Supt Murray would have also had a case to answer for neglect of duty in relation to his failings to prevent a dangerous build-up of supporters outside the gates and to control the movement of supporters following the opening of Gate C. He did not use his additional knowledge and experience to assist Ch Supt Duckenfield: he failed to anticipate that a dangerous build-up of the crowd could occur and advised Ch Supt Duckenfield incorrectly that all the supporters would be able to enter the ground in time for the scheduled kick-off. Neither of them checked turnstile count data.

4.152 He also specifically acknowledged that he knew supporters coming through Gate C would be most likely to head to the central tunnel, but he failed to consider the risks of this or give instructions to ensure the safe distribution of supporters.

4.153 Supt Marshall would have had a case to answer for neglect of duty because, among other factors, he failed to take steps to ensure that the supporters were able to queue safely for entry through the turnstiles. Once it became apparent that the police had lost control of the situation at the turnstiles, he failed to request that the kick-off should be delayed.

4.154 PS Morgan was subject to a conduct investigation, initiated by Operation Resolve rather than as a result of complaints. He would have also had a case to answer for gross misconduct, for the offence of neglect of duty in relation to two issues. The first of these was that he left his allocated area of responsibility on the inner concourse without good reason for over half an hour during the build-up to kick-off. It appears he did not return to this area as swiftly as he could have done, leaving his serial without supervision during the critical period when the crowd built up outside the turnstiles. The second allegation related to his role in the 2.52pm opening of Gate C. With evidence available to indicate that he asked for Gate C to be opened at this time, he failed to consider the impact of opening the gate—even though he had already witnessed the consequences of the 2.48pm opening—and also did not articulate any concerns to senior officers.

Timeline of 15 April 1989

1PM

1.45pm
Ch Supt Duckenfield went to the PCB at the ground.

2PM

2.15pm
A crowd started to build up outside the Leppings Lane entrance, where almost 24,000 Liverpool supporters had to enter through 23 turnstiles.

2.30pm
Ch Supt Duckenfield and Supt Murray discussed whether to delay the 3pm kick-off so the supporters could get in before the match started. They agreed it was not necessary.

2.45pm
Outside the Leppings Lane entrance, a crush had developed. Some supporters were in considerable distress and officers were becoming increasingly concerned.

2.47pm
Supt Marshall radioed the PCB to ask for the exit gates at the Leppings Lane end to be opened, to allow supporters into the ground. He received no response.

2.48pm
Gate C opened to allow a supporter out. It remained open for around 30 seconds, during which time between 130 and 180 supporters entered the ground.

2.52pm
Gate C opened again and remained open for several minutes, during which time an estimated 2,000+ supporters entered. The majority followed the most visible route to the terraces, a tunnel to the centre pens, Pen 3 and Pen 4.

2.52pm
At around the same time, Ch Supt Duckenfield gave an instruction to open the gates. It is not clear who heard the instruction, or whether Gate C was opened as a result of it.

2.57pm
The gate at the front of Pen 3 sprung open due to pressure from the crowd. Officers on the pitch side closed it, but it sprung open again.

2.59pm
The match kicked off.

3PM | 4PM | 5PM

3.02pm
Supt Greenwood arrived in front of Pen 3, to find out why supporters were on the pitch. He saw a crush in the pens and asked supporters to move back.

3.05pm
Supt Greenwood ran onto the pitch to ask the referee to stop the match.

3.05pm
Officers in the PCB instructed all officers at the stadium to go to the Leppings Lane end but did not explain why. They also asked for all available officers in the force area to be sent to the stadium.

3.07pm
The PCB issued a radio request for a "fleet of ambulances" to be sent to the stadium.

3.12pm
Ch Supt Nesbit arrived at the West Terrace and took control of the rescue effort.

3.14pm
The first SYMAS ambulance arrived outside Gate C. Police officers there could not give the crew any information about where they were needed.

3.15pm
A St John Ambulance arrived on the pitch and drove to the West Terrace.

3.15pm (approx.)
FA officials Graham Kelly and Glen Kirton came to the PCB to find out what was happening. Ch Supt Duckenfield led them to understand that a gate had been forced by Liverpool supporters. Mr Kelly subsequently repeated this to the BBC.

3.28pm
The first SYMAS ambulance took casualties to hospital.

3.35pm
In the SWFC boardroom, Ch Supt Duckenfield again gave officials the impression a gate had been forced by supporters.

3.51pm
The last casualties were taken out of the pens.

4.10pm
A message on the stadium PA system told supporters the match had been abandoned.

4.30pm
The last of the injured supporters were taken to hospital.

5. The emergency response

This chapter includes witness accounts, images and descriptions of scenes that may be distressing.

What was investigated?

Under the terms of reference for the managed investigation, Operation Resolve investigated:

Response of the police to the disaster, including:

a) the early police response to the crush at the Leppings Lane end, including allegations that the police were slow to respond/failed to act when it was obvious the people were in distress

b) alleged failures/refusals on the part of the police to open perimeter gates, and allegations that officers pushed supporters back when they were trying to climb to safety—this aspect of the investigation will specifically consider complaints made against PC Peter Smith and PC David Illingworth, as well as any other officers who may have been involved

c) subsequent police command and control of the disaster

d) the communication between the police and the other emergency services

e) the activation and implementation by the police of any pre-planned responses and emergency procedures for such disasters

What was found?

- **Accounts from supporters describe a sudden change in the situation in the pens at around 2.55pm**, when the pressure from the back suddenly intensified. This is consistent with the influx of supporters into the centre pens after the 2.52pm opening of Gate C. Officers and supporters in the West Stand recalled seeing a huge surge of people coming into the pens around this time.
- **Officers from Serial 1, stationed in their usual positions on the perimeter track, did not immediately realise the severity of the situation.** When Gate 3 in the perimeter fence burst open at 2.57pm, the officer there (PC Smith) immediately sought to close it again and prevent supporters coming through, assuming it was a pitch invasion. When Gate 3 burst open a second time, it was left open and officers allowed supporters through onto the perimeter track.

- **At around this time, a serial of officers from D Division, who were not normally involved in policing Hillsborough Stadium, arrived at the West Terrace. Some of them instantly saw there was something wrong and opened Gate 4, to try to free supporters from Pen 4 towards Pen 6.** The evidence indicates that Police Constable David Illingworth (PC Illingworth) from Serial 1 had not yet done so. Other members of the D Division serial have stated that they did not immediately think there was a problem inside the pens, but within a matter of seconds they realised there was. By 2.59pm, all the perimeter gates to the West Terrace were open.
- **When the officers in the PCB saw supporters on the perimeter track, they initially assumed it was a result of disorder,** and their first request was for dog handlers to be sent to the stadium. At 3.04pm, they saw Supt Greenwood signalling to them that the match should be stopped but still did not know why. Supt Murray was sent down to the pitch, but by the time he had got there, Supt Greenwood had reached the referee to stop the match. Supt Murray returned to the PCB but was sent back down to find out what was happening.
- **As soon as the match was stopped, Ch Supt Duckenfield called for Operation Support—**a request for all available officers to be immediately deployed from across SYP to assist. However, he did not have the authority to do this; it required ACC Jackson to confirm it, which he did a couple of minutes later.
- At almost the same time, **the PCB sent a radio message instructing all available officers at the ground to make their way to the perimeter track at the Leppings Lane end.** Neither request included any details as to what officers were responding to.
- **Most officers who did respond initially assumed that they were dealing with some kind of crowd trouble or pitch invasion.** However, as they got closer to the West Terrace, their views changed. Most SJA volunteers and the first SYMAS staff present indicated that their first thought had been the same.
- **SYP and SYMAS did not respond in line with their emergency procedures or incident plans.** Duties identified as pivotal to the correct allocation of resources and directing the response were not fulfilled. **No police officer declared a major incident, so the other emergency services were not correctly alerted to the severity of the situation.**
- At first, SYP's Force Control Room merely advised SYMAS that ambulances may be needed; the Force Control Room received a request from the PCB for a "fleet of ambulances" to be dispatched. This was in response to a message from Supt Murray on the pitch at 3.08pm. However, **the Force Control Room was only able to give SYMAS limited information about what had happened, so SYMAS rejected the request for multiple ambulances, instead authorising a limited initial response.**
- **When further ambulances did arrive, police officers outside the stadium did not know why they had been called or where they were needed.** The same issue recurred when teams from SYCFS arrived a few minutes later.

- **Rescue efforts were initially hampered by a combination of the narrowness of the perimeter gates, the pressure from the crowd and a lack of organisation.** Several officers have described getting in each other's way as they frantically tried to free trapped supporters. The situation changed after Ch Supt Nesbit arrived at around 3.11pm. He organised officers into chains at each gate, to enable supporters to be carried to safety. Around the same time, other officers, including PS Morgan, entered the pens through the central tunnel at the back, to encourage supporters to move away and help free those at the front.
- **There was no central organisation of the rescue effort and no instruction from the PCB.** Instead, it was left to those on the pitch to make decisions as best they could. This included SYMAS and SYCFS staff. The PCB did issue requests for help, such as a request for the local radio station to broadcast an appeal for doctors to attend. However, its communications remained poor: at one point, the PCB asked the Force Control Room to set up a "Major Incident Bureau", confusing two separate functions: a Major Incident Room and a Casualty Bureau. There was also a lack of clarity as to who was in charge.
- **Supporters, including some off-duty medical professionals sought to assist, but also received little or no instruction.** Numerous supporters helped carry the injured while medical professionals at first attempted resuscitation but were increasingly asked to certify death. There was no police coordination of this, as the SYP Major Incident Manual stipulated there should be. The sole focus appears to have been rescue, with no consideration of how the injured would be managed. The PCB did not offer any direction around this, which also meant that medical resources were not well deployed.
- **By 3.31pm, the front of Pen 3 was clear of casualties.** However, supporters were still being treated or taken to ambulances. A growing number were confirmed to have died.
- **Some of the actions of officers—such as forming cordons rather than assisting in the rescue effort—appeared inappropriate to supporters.**
- **Evidence has not been found of officers using their truncheons on supporters and there is insufficient evidence to substantiate allegations of officers physically preventing supporters from escaping the pens.**

Significant new evidence

There was already a wealth of existing evidence about the emergency response. Operation Resolve enhanced this by time-synchronising it, then using specialist technology to analyse it frame by frame. This provided further insight into the sequence of events and also assisted in the investigation of specific issues, such as the allegations that police officers had used truncheons on supporters.

Operation Resolve also examined in detail recordings and transcripts of police radio communications and telephone conversations, including those between the PCB and SYP's Force Control Room at Police HQ, and between the different emergency services—some of which had not previously been open to scrutiny.

5.1 This chapter focuses on Operation Resolve's investigation into the short period of time from around 2.45pm, shortly before the exit gates were opened, to 5.15pm when Ch Supt Duckenfield left the stadium. It examines the effectiveness of the SYP response to the situation, comparing what officers did with what—according to SYP's own Major Incident Manual and Major Incident Plan—they should have done.

5.2 It also includes evidence from supporters, police officers and other witnesses describing the situation in the pens, along with some images of the rescue effort. **Some may find these accounts and images distressing.**

5.3 There are, understandably, numerous inconsistencies in witness accounts about precise timings and the exact sequence of events. Where possible, Operation Resolve has used time-synchronised video footage and time-stamped photographs to provide accurate timings.

2.40pm–3.15pm: The experiences of those in the pens

5.4 Chapter 4 showed that by about 2.40pm, Pens 3 and 4 of the West Terrace were full, or very close to full, and according to some supporters, the situation there was becoming uncomfortable. By contrast, the side pens still had lots of space in them. Supporters have described in painful and traumatic detail what happened shortly after this point.

5.5 One supporter recalled that after getting through the turnstiles at about 2.45pm, he went with his father and sister through the central tunnel. He could see that Pen 3 and Pen 4 were packed, but in his opinion, they were not overly congested. The supporters did not appear to be being crushed and were able to stand still, rather than being moved around by the flow of the crowd. The supporter and his family took a couple of steps down to decide where to stand when there was a sudden surge from the central tunnel and the size of the crowd increased dramatically. He recalled that this surge carried him forward to the centre of Pen 3 with his feet not touching the ground.

5.6 A second surge shortly after took him forward further, until he was trapped against a metal crush barrier, which then collapsed. He was caught with his legs underneath the barrier and doubled up on the floor with the bar on top of his stomach. His head was face down on the corner of a step. He heard people screaming all around and could feel people falling on top of him. In his statement, he said that he could not breathe and thought he was going to die, so he just lay there until he lost consciousness. He awoke to feel someone pulling at his arms and managed to whisper to them that he was trapped under the barrier. Rescuers lifted the crush barrier slightly and were able to pull him out. An ambulance took him to hospital where, for several days, doctors treated him for severe injuries to his hips, stomach and back.

5.7 Several other supporters recounted similar experiences when the crush barrier collapsed. One supporter was desperately holding on to a man he didn't know, who was being crushed against the barrier in immense pain; the barrier then gave way. He recalled: "I lost my grip on this lad and fell forward onto the backs of the people in front of me, I totally lost my balance. I did not fall to the floor, but onto the backs of people who had fell over in front of me. I then felt people falling on top of me." He was unable to breathe or move but could see his brother on the pitch and screamed out to him. Eventually the pressure eased, and he was able to escape with the help of a police officer.



Figure 5A: Photograph of the broken crush barrier, taken in the aftermath of the disaster (Source: HSE)

5.8 Others were trapped elsewhere. A woman who had positioned herself behind the goal at about 1.40pm said that at about 2.55pm, there was a push from behind, which knocked her into the perimeter fence. She and others initially managed to push back, which relieved the pressure; she recalled that people were screaming at the police to open the gate at the front of Pen 3, but the police officers shook their heads and turned their backs. There was then a second surge which forced her into the fencing again. She said that this time "my arm was trapped across the fencing, and my legs were forced against the wall by the force of people from behind. I couldn't move my head at all." She estimated she was stuck in this position for almost half an hour before she was freed.

5.9 A supporter in Pen 4 described how they were squeezed down the tunnel into the pen, when almost immediately the person in front of him passed out. He tried to keep hold of the man but said: "My arms and shoulders were on fire with the pain and my legs were turning to jelly. The lad was a dead weight and by this time his head had slumped down to chest level. His legs were dragging on the floor and I felt myself going." He added: "I couldn't do anything and I was trying as best as I could to keep my feet on the ground to avoid being tripped. I felt my grip on the lad begin to go, his shirt rolled up around his chest and his trousers began to drop. The pain in my arms and shoulders became unbearable and I lost him in the crush."

5.10 While they were there, others were climbing or crawling over them towards the perimeter fence. He recalled officers on the other side of the fence telling them to push back, which they couldn't do. Eventually, he reached the fence, where a police officer guided his hand to the wire. He gripped on to this to get his breath back, before inching his way along the fence to the gate.

5.11 Many supporters witnessed horrific injuries or were acutely aware of others losing consciousness around them. Their fear grew, often worsened by being separated from friends or family.

5.12 A common theme is that the crush suddenly and dramatically intensified at around 2.55pm. The obvious conclusion is that this was a result of the rapid influx of supporters following the 2.52pm opening of Gate C. The evidence of Insp Bullas, who was in the West Stand above, supports this. He described how, at a point between the teams coming onto the pitch (which was at 2.54pm) and the kick-off, he saw what he described as a river of people suddenly enter the terracing from the central tunnel. He added: "This wedge of people seemed to go forward down the terracing but unlike the swaying motions that had taken place earlier on did not sway backwards but remained where it was." He said: "At this stage I could see the people towards the front of the terracing were being 'crushed forward'". He attempted to radio the PCB but could not get through.

5.13 It appears that shortly after this influx, the crush barrier in Pen 3 collapsed. Mr Cutlack believed that similar events were only narrowly avoided in Pen 4, where two barriers were severely damaged on the day of the disaster.

5.14 The accounts of supporters broadly indicate that police officers on the perimeter track in front of the pens did not initially recognise the severity of the situation, even when supporters were screaming for help. Many described officers simply telling or gesturing at them to move back, which they could not do.

5.15 PC Smith and PC Illingworth were two of the officers on duty on the perimeter track. This was a role they had performed frequently, and they were in their regular positions; PC Smith in front of Pen 3 and PC Illingworth in front of Pen 4. They had both returned there at around 2.50pm, following a meal break.

5.16 In his 1989 account, PC Smith wrote that as the teams came onto the pitch at 2.54pm, he made his way to stand in front of Gate 3 in the perimeter fence. He described some supporters jumping up and down and pushing, which caused the crowd to surge forward to the perimeter fence. He said the people at the front shouted and screamed, and the crowd then moved back. However, he didn't suggest this was anything out of the ordinary; he later told the Taylor Inquiry there were no signs of overcrowding.

5.17 Figure 5B was taken by a supporter in the North Stand at 2.54pm. The contrast between the density of the supporters in the centre pens and outer pens is evident.



Figure 5B: View of West Terrace, 2.54pm (Source: Maurice Price)

5.18 By 14:55:57, supporters could be seen climbing on the perimeter fence or the radial fences.



Figure 5C: View of the front of the West Terrace, 14:55:57 (Source: BBC)

5.19 At 2.57pm, Gate 3 burst open; PC Smith closed it immediately. This was in line with instructions to police officers not to allow anyone onto the pitch. In his 1989 account, he commented: "I assumed the pressure of a surge had opened the gate. There was no great pressure on fans at the front after the gate was re-secured."

5.20 PC Smith said that no one came out of the pen at this point. However, some supporters and at least two police officers have said that a small number of supporters did go through the gate but were immediately pushed back into the pen by the police.

5.21 One supporter's account described seeing the perimeter fence gate spring open and his son and two others being pushed through it by the pressure of the crowd. He said the police returned them to the pen. Other supporters indicate that those who went through the gate fell or stumbled out of the pen, rather than walking through it.

5.22 However, within under a minute the gate opened again. PC Smith stated he was not able to close it. He said that two other officers came to assist him, and that at this stage supporters were screaming and shouting that they were being squashed. PC Smith said he stepped back from the gate, leaving the other two officers there and saw "people were tight up to the fence, particularly two or three young women to my right of the gate." He tried to send a radio message to the PCB to ask if the gates could be opened: "I got no reply but think there was some message about a gate being opened elsewhere. The noise was terrible and people were screaming, a different type of scream and I opened the gate 3 fully." His account of attempting to contact the PCB is supported by Racal recordings, which included a message from an officer with his call sign at this time. The message itself was largely inaudible.

5.23 Other officers near the gate have said that when it opened a second time, their perception of the situation also changed.

5.24 The supporter whose son had gone through Gate 3 at its first opening said that when it opened again, he, his son and his son's friends were among the first to go through it. They walked along the track in the direction of the South Stand, where they sat down on a bench near the south-west corner of the pitch. This is confirmed by SYP CCTV footage timed at 15:00:17. He said that a police officer, later identified as Police Constable Fiona Richardson (PC Richardson), told them they could not stay there and took them to Pen 1 of the West Terrace.

5.25 Gate 3 remained open from this point and by 2.59pm, all the perimeter gates were open, as shown in figure 5D. A number of supporters can be seen on the perimeter track while others were climbing over the fence in front of Pen 4, or over the radial fence from Pen 4 into Pen 5.



Figure 5D: The West Terrace at 2.59pm (Source: Stephen Loftus)

5.26 The officers who assisted PC Smith at Gate 3 were from D Division. Their initial duty had been to escort Liverpool supporters on buses from Sheffield Midland Railway Station in the city centre to the ground. They got to the stadium following the last of these escort trips at about 2.50pm. Seeing the crowd at the Leppings Lane entrance, Police Sergeant Howard Swift (PS Swift) asked their driver to take them to the Penistone Road entrance, where they went to the gymnasium and reported to Insp Sewell as planned.

5.27 Almost immediately, a message came over the radio asking for assistance at the Leppings Lane end. PS Swift assumed it related to the situation outside the turnstiles. Insp Sewell sent PS Swift and his serial to the Leppings Lane end, and they walked around the perimeter track, which was the most direct route.

5.28 As they walked round, they noticed the difference in fullness between the centre pens and the outside pens. At about 2.58pm, they stopped in front of the centre pens and several members of the serial recognised that supporters were extremely distressed.

5.29 PS Swift decided to try to open the gate at the front of Pen 4 so that supporters could move into the emptier pens. He said that due to the noise of the crowd, it was not possible to use his radio to inform the PCB of his intentions, or to hear any radio transmissions. Instead, he waved to the PCB to indicate that he was going to open the perimeter gates. He said he knew that there were not enough police officers on the perimeter track to control the number of supporters he expected to come through the gates but recognised that those at the front of the pen were extremely distressed.

5.30 He was waiting for spectators to surge onto the track, but quickly realised the pressure was too great, so they had to pull each one out individually.

5.31 His recollections were supported by two other officers from his serial, Police Constable Philip Hooson (PC Hooson) and Police Constable Lillyan Akred (PC Akred). In his 1989 account, PC Hooson recalled: "As I neared Gate 4 I realised that the people in the West Stand were not shouting but were screaming. I realised then that something was seriously wrong and I heard people in the crowd screaming, 'let us out'." He said there were three police officers standing on the track, but they were not doing anything. In a 2013 statement, he said the situation was worsening by the second.

5.32 PC Akred said she didn't realise the gravity of the situation until she faced the crowd in front of Pen 4. In her 1989 account, she commented: "I then saw that people at the front of the crowd were going blue in the face and were apparently unconscious, only being kept up by the weight of people at each side. I shouted for people to try and ease back, but they were unable to do so."

5.33 She said that once they opened the gate, people were panicking: "Many were ignoring our instructions and just climbing over people who had already stumbled."

5.34 Several supporters who were in Pen 4 have referred to the efforts made by a bald-headed officer and female police officer to lead the rescue effort. These were PS Swift and PC Akred.

5.35 Operation Resolve investigated complaints about the initial response of both PC Smith and PC Illingworth; these complaints concerned whether they recognised the situation fast enough and the way they dealt with supporters. Having examined the evidence set out in individual complaint reports, the IOPC was of the view that neither officer would have had a case to answer, if they had still been serving. While they did not immediately recognise the severity of the situation, neither did others: it was not clear that any delay in their response was a result of neglect of duty.

5.36 Further, while the evidence—including his own later admission when interviewed under caution by WMP—does suggest that PC Smith did push a small number of supporters back into Pen 3, this was at the point when he and another officer assumed they were dealing with a pitch invasion. He has explained that once he realised the gravity of the situation, he did push some people out of the way as he attempted to rescue those who were trapped.

The view from the PCB

5.37 Several of the officers closest to the West Terrace described attempting to radio the PCB, to alert them to the situation, request assistance or ask for authorisation to open the gates. However, they said their messages didn't get through, or at least they didn't get a response.

5.38 The PCB was located on the corner of the West Terrace and South Stand, below the scoreboard. It had windows in line with the perimeter track and front of the West Terrace. Figure 5E shows the view from the PCB across the West Terrace.



Figure 5E: View of the West Terrace from the PCB, 1989 (Source: Richard Haylor, WMP)

5.39 This should have provided those in the PCB with a good view of the unfolding situation—both in terms of seeing the front of the pens and the perimeter gates and having a view from above the pens.

5.40 PC Bichard was the CCTV operator in the PCB. In his 1989 account, he said that at about 2.55pm, those in the PCB began to notice Liverpool supporters climbing up into the West Stand from the terracing below, with people in the West Stand helping them up. However, he said that the same thing had occurred at the 1988 FA Cup Semi-Final.

5.41 Shortly after this, they saw some supporters climbing the perimeter fence and others on the perimeter track. PC Bichard said that he and his colleagues in the PCB assumed it was some sort of crowd trouble.

5.42 In his original account, Supt Murray said that at about 2.58pm he became aware of something happening near the goal area. Though he could not see exactly what was going on, he realised that officers had opened either Gate 3 or Gate 4, or both gates. He said that a handful of supporters were on the perimeter track and were walking calmly and slowly towards Gate 1, while other supporters were standing aimlessly on the track. He recalled that the officer at Gate 1 appeared to be totally unaware of their

presence, so Chief Inspector Robert McRobbie (Ch Insp McRobbie), who was in the PCB to observe and not in any operational role, went down to the track to draw the officer's attention to what was happening.

5.43 In his 1989 account, Ch Supt Duckenfield described this scene in a very similar way. As the numbers of supporters making their way onto the track increased, he said he "considered there may have been a pitch invasion or that people were being taken out for re-location in the two wing pens."

5.44 At the Goldring Inquests, he was asked what he thought was happening and whether it occurred to him that it could have been a result of Gate C being opened. He replied that he thought there may have been crowd disorder and that he had made no connection with the opening of Gate C.

5.45 In his 1989 account, Ch Supt Duckenfield said that as the numbers on the pitch increased, he asked for Supt Greenwood to go and find out what was happening. Supt Murray similarly mentioned this in his 1989 account. However, Operation Resolve has found no evidence in Racal recordings or the accounts of officers outside the PCB of any communication with Supt Greenwood.

The decision to stop the match

5.46 At 3pm, Supt Greenwood was standing by the players' tunnel, in front of the South Stand by the halfway line. In an account dated 3 May 1989, he said he saw supporters climbing over the perimeter fence behind the goal at the Leppings Lane end of the ground. Because two or three police officers were with them, he immediately realised there must have been a crowd problem. However, he did not believe it was fighting or a pitch invasion, because he did not expect that to happen so early in a match. He immediately made his way to the West Terrace, along the perimeter track.

5.47 At this stage, he was still unaware that there had been any issues outside the stadium.

5.48 By 15:01:11, Supt Greenwood was close to Gate 1, which was open. CCTV footage shows that he walked past PC Richardson, who was ushering supporters into Pen 1, and past Ch Insp McRobbie, without apparently speaking to either. He arrived in front of Pen 3 by 15:02:01.

5.49 In his first written account of the disaster dated 3 May 1989, which was submitted to WMP and the Taylor Inquiry, Supt Greenwood recalled that he looked at the crowd in Pen 3 behind the goal and saw that people were being crushed against the perimeter fencing. He said the area behind the gate was heavily congested, preventing people from getting out, though police officers were trying to help them.

5.50 He climbed on an advertising hoarding to get a better view, and at first gestured to the crowd to move back, as he thought this could help. He said that when this proved ineffective, he decided to stop the match. In a prepared statement dated 27 June 1990, ahead of his interview under caution by WMP, Supt Greenwood said: "I broadcasted by personal radio to the Control Box that there were potential casualties and that the game had to be stopped. I also waived [sic] both my arms towards the Control Box in a signaling motion to the effect that the game must be stopped."

5.51 After doing so, he ran onto the pitch to attract the referee's attention to stop the match. Figure 5F, taken from BBC footage, shows Supt Greenwood on the pitch approaching the referee at 15:05:29. He then returned to the perimeter fence in front of Pen 3.

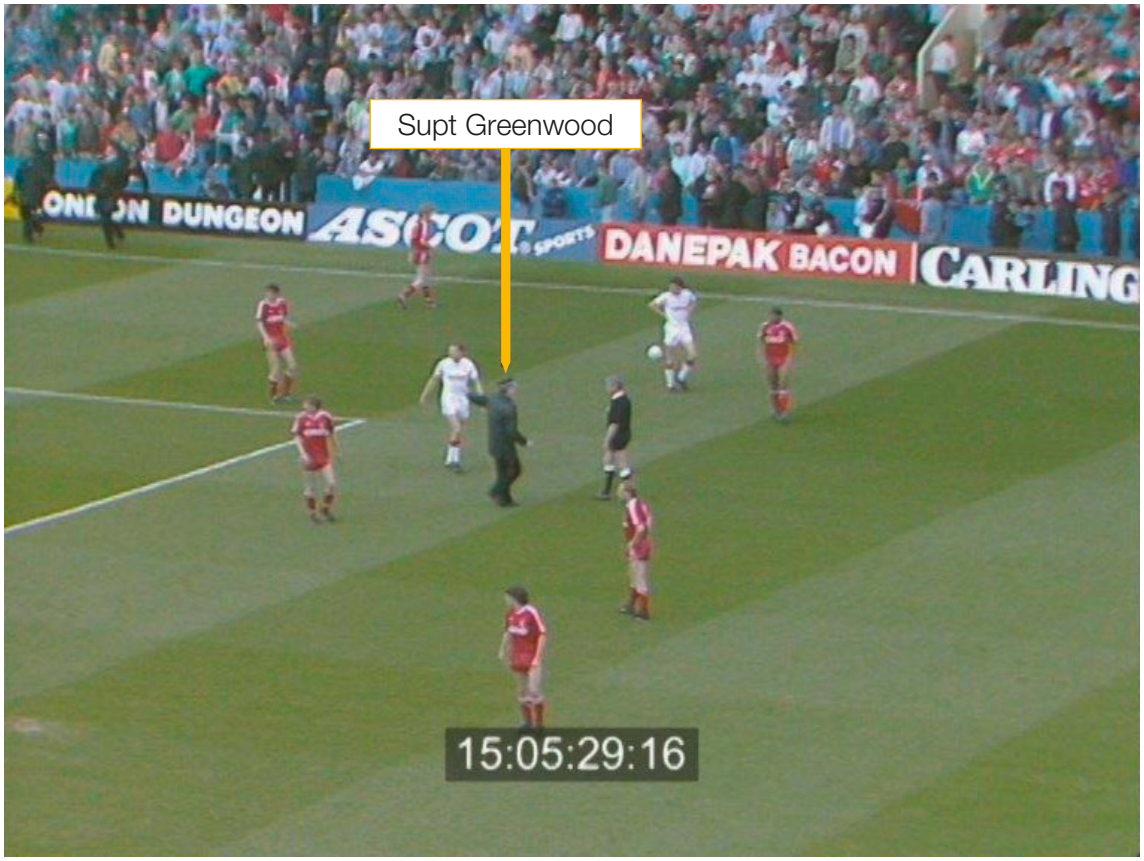


Figure 5F: Supt Greenwood approaching the referee, 15:05:29 (Source: BBC)

5.52 In their original accounts, both Supt Murray and Ch Supt Duckenfield referred to seeing Supt Greenwood signalling towards the PCB that the match should be stopped. Ch Supt Duckenfield said he sent Supt Murray to do this; Supt Murray said he was preparing to go, when Ch Supt Duckenfield confirmed he should.

5.53 Supt Murray suggested this was at 3.03pm. They both said that there were increasing numbers of supporters on the pitch by this stage. Racal recordings confirm that at 3.03pm, the PCB sent a radio message to the SYP Force Control Room at Snig Hill Police Station asking for dog handlers to be dispatched to the stadium, indicating they assumed they were dealing with some sort of crowd trouble.

5.54 When interviewed under caution by WMP on 25 June 1990, Supt Murray said that when he went onto the pitch, his intention was to stop the match. However, before he was able to attract the attention of match officials, he saw Supt Greenwood speaking to the referee, so returned to the PCB. He said he did not recognise that there was a serious problem on the West Terrace because he had not gone far enough across the terrace.

5.55 Figure 5G is taken from BBC footage timed at 15:05:43. It shows Supt Murray on the perimeter track facing the West Terrace, just after the game had been stopped. There were dozens of supporters on the perimeter track and officers at Gates 3 and 4 were engaged in an effort to help supporters out of the pens. Almost all of the D Division officers under PS Swift have given accounts in which they stated they were aware by this time of supporters being crushed. In the background of figure 5G, supporters can be seen on the pitch in front of the pens. It is therefore striking that even at this point Supt Murray and others in the PCB had not recognised the severity of the situation.



Figure 5G: Supt Murray on the perimeter track, 15:05:43 (Source: BBC)

5.56 During this same interview under caution, Supt Murray said that when he returned to the PCB, Ch Supt Duckenfield sent him straight out again to clear the supporters from the pitch. However, when he reached the pitch, he realised that the situation was different: he saw people crushed against the fence, so borrowed a radio to contact the PCB and asked for ambulances to be dispatched to the stadium. This call was made at about 3.07pm and is examined further from paragraph 5.79.

The first response from the PCB

5.57 At 15:05:37—within a few seconds of the referee stopping the match—the Racal system recorded a message from the PCB to the Force Control Room calling for Operation Support to be initiated. Operation Support was a documented contingency under which all available SYP officers would be immediately deployed to assist with an incident. It was generally understood to be used in response to incidents of large-scale disorder.

5.58 In his 1989 account, Ch Supt Duckenfield said that he called for Operation Support and evidence has not been found to suggest that anyone else was responsible for the initial request.

5.59 Because implementing Operation Support would have a significant impact on operations within the SYP area, the decision to do so required authorisation from the ACC (Operations) or the designated duty chief officer. As ACC Jackson was at Hillsborough Stadium on 15 April 1989, he was in a position to give such authorisation, but he was not in the PCB at the time it was first requested. He arrived a couple of minutes later, of his own volition rather than as a result of a request from the PCB, and authorised Operation Support at 15:09:07.

5.60 At about the same time that the request for Operation Support was made, the PCB sent a radio message instructing all available officers at the ground to make their way to the perimeter track at the Leppings Lane end. The message has not been recorded anywhere, but numerous officers have described hearing it. SWFC CCTV footage suggests that the radio message was broadcast at about 15:05:41, as it shows that a number of police officers were standing outside Gate C at that time; they promptly made their way through the gate into the stadium.

5.61 Though officers responded immediately, they did not know what they were responding to. Some indicated that the message referred to crowd trouble or disorder; others just assumed this was the explanation. When they saw supporters on the pitch, this appeared to confirm their views.

5.62 Inspector John Beresford (Insp Beresford) was dispatched from the gymnasium with Serial 21, to help deal with unspecified "trouble" at the Leppings Lane end. He saw spectators on the pitch and others climbing the fence, but when he arrived at the corner of the North Stand and West Terrace, he could not see the cause. In his 1989 account, he said: "The only police action which seemed obvious to me was to form an open cordon across the touch line from the northwest corner flag towards the goal mouth." Though Insp Beresford did not explicitly state the purpose of forming such a cordon, it is a relatively standard police tactic to manage the movement of a crowd. On this occasion, the logical reason for establishing one would have been to prevent a pitch invasion.

5.63 CCTV footage at 15:06:19 shows Insp Beresford appearing to organise officers into a cordon. However, in his 2013 statement, Insp Beresford recalled that as he neared the goalmouth, he realised that supporters were injured and that "this was no pitch invasion but a rescue operation." He said his officers quickly left the cordon to assist in different ways.

5.64 BBC footage shows the cordon being formed at around 3.06pm but becoming fragmented by about 3.13pm. By 3.16pm, it had fully dispersed.

5.65 The formation of this cordon, and others in different locations later, have been the subject of complaints from supporters, on the basis that officers should have been engaged in more practical assistance. The evidence suggests that officers in the cordons felt the same way; they had responded on limited information and followed instructions, but once they saw what has happening, many chose to leave the cordon to assist in the rescue effort.

5.66 However, there is also evidence of a further issue emerging: that officers, lacking instruction or coordination, were getting in each other's way in their frantic rescue efforts.

The initial rescue effort

5.67 Several of those who were closest to the perimeter gates have described how the combination of the crowd pressure, the narrow gates and the general level of panic slowed their ability to free supporters.

5.68 PS Swift recalled that Gate 4 only opened 90 degrees to form a right angle to the fence. He said that as a result "only two Officers of [sic] a time could efficiently work at pulling people free by approaching from the front and the left hand side. In our obvious frantic efforts to assist we were inevitably getting in each other's way."

5.69 Police Constable Adrian Taylor at Gate 3 had similar issues: "The gate was so narrow, with the gate opening outwards onto the field, it prevented assistance from the right and a lean to support on the left gate pillar prevented assistance from the left of the gate. Three officers or supporters could only enter the gateway at one time to pull because of the tight space."

5.70 He also highlighted further challenges: "The step up from the centre south enclosure caused people to trip over, falling to the ground, then on top of each other. The gate became eight deep in fallen people, so tightly packed that they could not be pulled free. As one supporter was pulled free your momentum followed the supporter back onto the field, other supporters and officers then took your place at the gate pulling."

5.71 Police Constable Martin Cooper was also at Gate 3, and he recalled that a further problem occurred if a supporter became stuck in the gateway for any reason. As some were unconscious, this happened on a few occasions.

5.72 At first, injured supporters were carried onto the pitch where officers, SJA volunteers and SYMAS staff—as well as fellow supporters—attempted to provide first aid or resuscitate them. This became a chaotic scene, with many people present and little organisation, as can be seen in figure 5H.



Figure 5H: The scene in front of the West Terrace, 15:07:04 (Source: SYP)

Initial response of SYMAS and SJA

5.73 The SJA and SYMAS staff present at this stage were those who had been at the stadium before kick-off. The accounts of several of the SJA volunteers stationed in corners of the ground indicate that they saw supporters coming out of the pens—either through gates or over the fence—but were initially unsure what was happening. As they got closer, they realised that supporters were being crushed; they began to treat casualties as best they could. They did so without any specific instruction from the police.

5.74 Two SYMAS officers were on their usual duty at the stadium: Station Officer Paul Eason (SO Eason) and Station Officer Patrick Higgins (SO Higgins). They were supported by Qualified Ambulance Officer Stephen Chippendale (QAO Chippendale) and Qualified Ambulance Officer Leslie Worrall. They were standing near their ambulance which was parked close to the gymnasium, the designated casualty treatment area at the stadium.

5.75 In a 1989 account, SO Eason said that at about 3.03pm, he saw what he believed to be a scuffle taking place in the middle of the West Terrace. He and QAO Chippendale walked along the perimeter track past the North Stand to investigate. As they got closer, they saw that several supporters were on the pitch and some seemed injured. SO Eason tried to radio SO Higgins to bring a stretcher and first aid equipment but couldn't get through.

5.76 At 15:05:48, when Supt Greenwood was on the pitch, SO Higgins contacted SYMAS Control. He advised them that there were some crowd problems and that one or two may be injured, but he thought the injuries could be slight.

5.77 In short, SYMAS officers did not recognise the severity of the situation at the West Terrace any sooner than the police. They were positioned further away from the pens than the police, but even on arrival in front of the West Terrace they did not immediately identify that there were large numbers of casualties.

5.78 Very soon after SO Higgins had contacted SYMAS Control, the SYP Force Control Room did too. This was after the PCB had requested Operation Support. Recordings show that Police Constable Kenneth Rook (PC Rook) in the Force Control Room at first told SYMAS: "There's been an incident at the Leppings Lane End at the Hillsborough Football ground, where we may—we may need a few ambulances. It's just an advisory at this stage. There's been pushing and shoving and there might have been quite a few injuries."

5.79 However, while PC Rook was speaking to SYMAS Superintendent Raymond Clarke (Supt Clarke), who was on duty in SYMAS Control, the SYP Force Control Room received an urgent radio request from the PCB for "a fleet of ambulances". This was timed at 15:07:15 and followed Supt Murray's message from the pitch.

5.80 The recording of the conversation between PC Rook and SYMAS Control shows that he passed this request on verbatim. Though PC Rook was not able to provide full details, he stated there were a lot of people injured. Supt Clarke replied that they would instigate an initial response and assess the situation.

Efforts to free the pens from the back

5.81 At around this time, PS Morgan arrived on the perimeter track having responded to the radio requests for assistance. In his 1989 account, he said that as he arrived, he saw Supt Murray, who seemed deeply shocked and told him simply to "do whatever you can". PS Morgan said that as he reached the pens, he immediately saw the horror of the situation but also noted a lack of organisation in the police response: "I quickly realised that I would be able to achieve very little if I remained on the track. A lot of officers were standing looking at the scene in stunned disbelief". He decided to enter the centre pens from the tunnel at the rear, so that he could get supporters to move back, or out, and reduce the crush. He ordered some officers to come with him.

5.82 He found no problems getting through the tunnel but when he reached the pens, spectators and police officers there appeared to have no idea what was happening. He went into the pens and tried to persuade supporters to leave. He said: "I was

obliged to grab each person and haul them backwards, just shouting, 'Get out' to each one as I progressed towards the front. Many were in deep shock and resisted me, pulling away and refusing to co-operate. The crowd was not densely packed and I was able to move quite freely."

5.83 While PS Morgan's actions may have had some positive impact, they were not coordinated with any other part of the rescue effort, and he did not communicate his intent to the PCB or any senior officer. Other officers also took action without seeking to coordinate them, adding to the sense of disorganisation at the heart of the police response.

The failure to declare a major incident

5.84 At around 3.08pm, ACC Jackson arrived at the PCB from his seat in the South Stand. In his 1989 account, ACC Jackson said that when he got to the PCB, he spoke to Ch Supt Duckenfield, who was unable to explain what had happened, so decided to go down to the pitch to see what the problem was.

5.85 In evidence to the Taylor Inquiry, ACC Jackson said that on the pitch he spoke to Supt Greenwood who told him there were injuries. He could also see that a rescue effort was underway. He said he went back to the PCB and was asked what he intended to do there. He replied: "The first thing in my mind was to ensure that sufficient ambulances had been called and also it was clearly a necessity to implement the major incident procedure."

5.86 In his 1989 account, ACC Jackson said that on his return to the PCB, he was made aware that a fleet of ambulances had been requested. He said: "Because of the seriousness of the situation and together with Chief Superintendent Duckenfield we gave instructions to the Control Room Staff for implementation of the major disaster plan."

5.87 While this may have been his intention, a range of evidence shows that SYP did not follow the correct procedure for implementing its Major Incident Plan (or major disaster plan).

5.88 In his 1989 account, Ch Supt Duckenfield said that as a result of the request for a fleet of ambulances, he had become aware of the gravity of the situation. He said: "I then began to give instructions to the Control Room staff in conjunction with Mr Jackson for the implementation of the Major Disaster Plan."

5.89 He further stated: "I asked for the Casualty Bureau to be set up, to warn hospitals of the large number of injuries, any doctors in the ground to Leppings Lane goal for deployment, off duty police officers to be called to duty and rendezvous at Hammerton Road Police Station. Mr Jackson supplemented my requests, asking Superintendent Torr to attend in respect of the Casualty Bureau; Detective Chief Superintendent Addis to attend to co-ordinate the investigation side of the enquiry. I asked for a Counselling Service and Victims Support Staff."

5.90 Ch Supt Duckenfield's 1989 account gave the impression that he remained in control and issued a series of orders, with ACC Jackson supporting the process. However, in 2015, Ch Supt Duckenfield gave evidence over seven days to the Goldring Inquests. During extensive questioning by barristers representing different groups and organisations, he conceded that, having given the order to open the gates, he froze.

The evidence of the other officers in the PCB tends to support this admission and indicates that they, and other officers at the ground, were increasingly acting on their own initiative.

5.91 The presence of ACC Jackson in the PCB meant the Force Control Room could ask for his authorisation for Operation Support, which was promptly given. The Force Control Room then issued the call for Operation Support at 3.10pm. At 15:17:01, the PCB asked SYP Force Control Room to contact the Northern General and Royal Hallamshire Hospitals.

5.92 However, despite the accounts of both ACC Jackson and Ch Supt Duckenfield that they intended to initiate the "major disaster plan", there is no evidence that at any point SYP declared a major incident.

5.93 This was a critical omission. The declaration of a major incident immediately informs all emergency services of the severity and scale of what has happened. It therefore demands a comprehensive response from the emergency services, who are obliged to take it on trust from those declaring the major incident that their services are required. Further, once declared, it requires a coordinated multi-agency response, which should be led by the police, as clearly stated in SYP's Major Incident Manual.

5.94 There were clear procedures in place in South Yorkshire for the declaration of a major incident, using an agreed code word, 'Catastrophe', to provide an unambiguous alert to all emergency services of the severity of the situation. Operation Resolve has found no evidence in Racal transcripts, or in the accounts of other emergency services or police officers who were on the pitch, to show that a major incident was declared, or that the code word was used.

5.95 The evidence shows that Ch Supt Duckenfield and ACC Jackson implemented certain aspects of the Major Incident Plan at the time the call for Operation Support was made. For example, instructions were issued for the Casualty Bureau to be set up, and for hospitals to be warned about the disaster. The instruction to set up a Casualty Bureau features as a consideration in both the Major Incident Plan and the actions to be taken after the call for Operation Support.

5.96 While some aspects of the SYP Major Incident Plan were initiated, they were not coordinated. Others within SYP were not informed that these actions were being implemented as part of a bigger response.

5.97 Ch Supt Duckenfield told the Taylor Inquiry that while in the PCB, he "gave the instructions to activate the Major Incident Plan." He was then asked what instructions he had given. He replied: "Only in general terms that we would require ambulances".

5.98 At the Goldring Inquests on 10 March 2015, Counsel to the Inquests asked Ch Supt Duckenfield about his knowledge of the SYP Major Incident Manual. Ch Supt Duckenfield confirmed that he was aware that it stated that the police were in control of the response to a major incident, and of the various roles and responsibilities described in the document. He said he understood how important it was to declare a major incident as soon as possible and to ensure that all of the emergency services worked in accordance with the major incident plans and procedures.

5.99 However, when asked specifically whether he knew the code word 'Catastrophe', he conceded that at the time of the disaster he did not.

5.100 In his original account from 1989, ACC Jackson wrote that, when he was in the PCB with Ch Supt Duckenfield, they instructed the PCB staff to implement the Major Incident Plan because of the seriousness of the situation. In a criminal and discipline interview under caution conducted by WMP on 28 June 1990, he was asked whether he was surprised that there was no record of the activation of the Major Incident Plan. He said he wasn't and suggested that when he confirmed that Operation Support should be called for and that a fleet of ambulances was required, officers would immediately implement the Major Incident Plan.

5.101 There was no guidance anywhere that suggested a major incident should or would be activated automatically if a request was made for both Operation Support and ambulances.

5.102 ACC Jackson told the Goldring Inquests that he believed either he or Ch Supt Duckenfield had declared a major incident. However, he accepted that communication records showed that no one actually used those words. He said he also regretted the fact that he never used the word 'Catastrophe', adding that he was aware that if he had, then everyone would have known the severity of the incident they were dealing with. He accepted the suggestion that he simply assumed that officers in the Force Control Room would implement the Major Incident Plan based on what the officers at the ground were saying. While Chief Inspector Malcolm Edmundson in the Force Control Room ultimately did inform the other emergency services there was a major incident, he was acting independently and had insufficient information to work from.

5.103 SYP's Major Incident Manual made it clear that the first essential action in the event of a major incident was to alert the other emergency services. In this instance, it did not take place. Further, the evidence not only indicates that neither ACC Jackson nor Ch Supt Duckenfield called a major incident, but that they did not instruct anyone else to do so either. This meant that even though Ch Supt Duckenfield and ACC Jackson had recognised there was a major incident, the other emergency services were still not aware.

5.104 Officers responding to the call for Operation Support had still not been given any clear indication of the situation they were attending, and those in areas such as the Casualty Bureau had not been given a clear picture either.

5.105 This persistent lack of effective communication was therefore a substantial failure of SYP's emergency response, and one of the reasons for the IOPC reaching the view that Ch Supt Duckenfield and ACC Jackson would have had a case to answer for neglect of duty.

5.106 During this period, FA officials Graham Kelly and Glen Kirton also visited the PCB to find out what was going on. Though there is no recording of what was said, Ch Supt Duckenfield led them to understand that a gate had been forced by Liverpool supporters. When speaking to the BBC shortly after, Mr Kelly repeated this explanation of what had happened. Ch Supt Duckenfield has since acknowledged it was a lie. The consequences of this lie in terms of public perceptions of the disaster are considered further in chapter 7.

Arrival of ambulances and the continued rescue effort

5.107 After alerting the other emergency services to a major incident, one of the next crucial steps is to coordinate the other services. SYP took no steps to do this or to achieve a common understanding of the situation. This was demonstrated when SYMAS did not immediately dispatch the requested "fleet of ambulances."

5.108 At 15:08:01, SO Higgins informed SYMAS Control that there were casualties and asked for the ambulance that was already on standby to be sent to the gymnasium entrance of the ground. In his 1989 account, SO Higgins said SYMAS Control asked him whether this was the same incident that the police had notified them of. He said that he simply confirmed the location and told them that they would need to access the pitch from the gymnasium end of the ground. He then began to treat other casualties at the ambulance.

5.109 At 3.09pm, the Racal system recorded a phone call from the SYP Force Control Room to SYMAS Control, reiterating that they wanted as many ambulances as possible on site immediately. SYMAS replied that one was on its way, and they would assess the situation. In his 1989 account, SYMAS Supt Clarke said that at this point, he assessed how many ambulances SYMAS would require to maintain normal duty cover and then arranged for the remaining eight vehicles to go to Hillsborough Stadium.

5.110 In a statement dated 8 May 1989, Deputy Chief Ambulance Officer Alan Hopkins (DCAO Hopkins) recalled that he was in the SYMAS Control Room on an unrelated matter when SYP telephoned and asked for a fleet of ambulances to attend the Leppings Lane end of Hillsborough Stadium. He said that he knew the liaison officers inside the ground would have difficulty getting out to Leppings Lane to report what was happening there, so he left the SYMAS Control Room to go to the ground. On his way out, he met Assistant Divisional Officer Rodger Morley (ADO Morley), and they set off for the stadium together. While they were on their way to the stadium, he could hear SYMAS Control sending multiple vehicles to the stadium. He said he told ADO Morley to radio SYMAS Control to instruct all ambulances to make themselves available for redeployment to Hillsborough Stadium as soon as possible, particularly those in the Sheffield area.

5.111 At 3.11pm, SYMAS Control radioed SO Higgins to ask for an update. He advised them that there were a number of people on the pitch, but that they were "probably just winded". Then at 15:12:08, SYMAS Control contacted him again to say they had received reports from the police that "There could be quite a number crushed." SYMAS Control asked SO Higgins to look into this. At 15:13:54, he advised them that there was a possibility that some people had died. He suggested that ambulances should not be directed to the Leppings Lane entrance but should come to the gymnasium, which was where he then headed.

5.112 At 15:14:19, the first SYMAS ambulance arrived at Hillsborough Stadium. It drove through the outer perimeter gates at Leppings Lane and stopped outside Gate C. The ambulance team recalled police officers giving them no direction; one said the officers seemed surprised at their presence "and were not aware that ambulances had been requested."

5.113 They were about to go into the ground when Gate C opened, and they met a group of supporters carrying a casualty with a chest injury. The casualty was taken to the ambulance for treatment. As they were dealing with the first casualty, more supporters

began to spill onto the inner concourse from the central tunnel. At the same time, police officers entered the stadium through Gate C, which was open. The scene became increasingly chaotic.

5.114 Supporters and officers began to carry casualties out of the tunnel and either laid them on the ground on the inner concourse or took them through Gate C to the ambulance that was parked there. Supt Marshall later recalled that police officers tried to take casualties out to the service road. He said the casualties "…were there separated into three groups – those apparently dead, those seriously injured, and those less seriously hurt."

5.115 While ambulances were arriving on the service road, with the number of casualties on the pitch increasing, police officers in front of the West Terrace became concerned about the lack of ambulances at their location.

5.116 Supt Greenwood dispatched a detective sergeant to ask the SJA ambulance to come to the West Terrace. The detective sergeant recalled that this took some persuasion, but at 15:15:29, the ambulance was driven onto the pitch from the vehicle access ramp at the north-east corner of the ground. It continued along the side of the pitch; BBC footage shows it coming to a stop near Gate 3 about two minutes later.



Figure 5I: The SJA ambulance arriving on the pitch (Source: BBC)

5.117 There were still no signs of SYMAS ambulances on the pitch. More had arrived close to the stadium, but due to limited access had parked a short distance away and gone to assess the scene. At 15:18:42, a qualified ambulance officer (QAO) from the crew that

had been dispatched at 3.05pm used the radio from the ambulance that was already at Gate C to inform SYMAS Control that this was a major incident. SYMAS Control did not pass the message on.

5.118 In his 1989 account, the same QAO then described the efforts being made by police officers, SYMAS staff and others to resuscitate supporters and help casualties into the ambulance. He observed: "During this time I did not see any sort of command and control structure anywhere around the ground. I saw a lot of police officers but no one seemed to be in control. All the officers I saw were busy treating casualties."

5.119 This was correct; the police had taken no steps to coordinate the medical response or triage the injured, focusing on rescue and in some cases resuscitation. While both tasks were vital, this meant that the available medical resources were not used as effectively as they could have been. The PCB for example could have identified an officer to oversee triage but did not.

5.120 Instead, its focus was on the lack of response from SYMAS. At 15:19:48, a message was sent to ask the Force Control Room to confirm the situation. The PCB operator said they needed at least 20 ambulances, but at present there were only three, all of which were near Gate C. At 15:20:47, the first SYMAS ambulance arrived on the pitch.

5.121 Though the number of casualties was still uncertain, at 15:21:26, SO Higgins advised SYMAS Control that was this a major incident. SYMAS Control assured SO Higgins that nine or ten vehicles were on their way to the stadium but still did not inform the other emergency services.

5.122 In his 1989 statement, SO Higgins recalled that at 3.23pm DCAO Hopkins and ADO Morley arrived and parked next to his ambulance. SYMAS Divisional Superintendent Trevor Dale arrived shortly after. This meant that several senior SYMAS staff were now on site. More ambulances followed shortly after.

5.123 SO Higgins said he told DCAO Hopkins that 30–40 supporters had died and many more were injured; DCAO Hopkins ran down to the pitch to see what was happening for himself.

5.124 In his own account, DCAO Hopkins said he returned almost immediately and told ADO Morley to contact SYMAS Control to get the major incident vehicle and ambulances to go to the Penistone Road end of the ground.

5.125 ADO Morley recalled that the matchday ambulance was parked on the vehicle access ramp with its rear doors wide open, but there were no wheeled stretchers inside and there were no SYMAS staff with it. He commented: "the whole area of the entrance off Penistone Road was bedlam at the time." He then began to organise the arriving ambulances to receive casualties.

5.126 SWFC CCTV footage timed at 15:28:00 captures the first SYMAS ambulance departing from Gate C taking casualties to hospital. Rather than reversing out, it went along the service road behind the South Stand towards Penistone Road.

5.127 By this stage, several of the tasks that formed SYP's Major Incident Plan had been undertaken but none of this was done in a controlled or systematic way. In his expert report for the Goldring Inquests dated 29 November 2013, paramedic David Whitmore observed that SYMAS staff had been left to act on their own initiative and without any formal command and control in place. He added that SJA staff had also been left "largely to their own devices."

5.128 Operation Resolve found no evidence to suggest that the police coordinated the activity of the other emergency services or SJA volunteers. Instead, the evidence highlights a lack of communication and coordination, particularly between SYP and SYMAS.

5.129 At 15:31:38, a radio message was sent from the PCB to the SYP Force Control Room, asking for SYMAS Control to be contacted so that the senior SYMAS officer could be sent to the PCB. While such coordination would have been desirable, this request from the PCB was almost 24 minutes after the initial request from the PCB for a fleet of ambulances, and almost ten minutes after DCAO Hopkins and ADO Morley had arrived at the ground. The ambulance operation was by this stage underway, taking casualties to hospitals. In short, the request was too late.

5.130 No evidence has been found to suggest that SYP took any action to locate the senior ambulance officer at the ground in an effort to coordinate the rescue activity.

Arrival of Ch Supt Nesbit

5.131 By 3.10pm, a huge number of police officers were involved in the rescue effort. Figure 5J shows the situation at 15:11:30. Numerous officers had climbed on the perimeter fence; some were in Pen 2, to the left of the photo. Many more were on the pitch. Some supporters were also on the fence; others were being helped into the West Stand above and still more were climbing the radial fences between pens.



Figure 5J: View of the West Terrace, 15:11:30 (Source: BBC)

5.132 Figure 5K, taken at 3.11pm, shows the chaotic nature of the response from a different angle. While some officers were predominantly engaged at the exit gates, others were standing further back from the fence, appearing unsure how to help. Some may have been part of a cordon. The photograph offers no sign of a coordinated rescue effort.



Figure 5K: The front of the West Terrace, 3.11pm (Source: SYP)

5.133 It was around this time that Ch Supt Nesbit arrived at the Leppings Lane end. Ch Supt Nesbit was the head of the SYP Traffic Division. In an account from 1989, he explained that he had been on patrol in Sheffield city centre and arrived at Hillsborough Stadium shortly after the referee had stopped the match. His arrival was not in response to the call for Operation Support. When he got to the gymnasium, Insp Sewell told him they were evacuating the West Terrace and that supporters had been injured.

5.134 Ch Supt Nesbit went onto the pitch at the Spion Kop end and saw what he first thought to be a pitch invasion. However, he then spotted that some of the supporters climbing over the perimeter fence were being assisted by police officers. In his 1989 account, he said that as he approached the goal area, he saw that the perimeter track was filled with police officers and supporters, and that a number of casualties were being attended to by SJA personnel and uniformed police officers.

5.135 He said that when he reached the front of Pen 3, "to my horror I could see bodies piled on top of each other with other spectators being pressed against the fencing." He said that Gate 3 was open but blocked by two supporters who were unable to move; he assumed they had died. He instructed officers to try to move them, to free the gateway.

5.136 He quickly realised that "Police Officers and spectators in their endeavours to help, were getting in each others way." He instructed officers to form a chain onto the pitch, so that casualties could be pulled out and carried away from the pens.

5.137 This approach began to create some order in the rescue effort. Figure 5L shows the scene at 15:20:24. By this time, Supt Greenwood was standing on what appears to be a stepladder with a loud hailer in his hand. Ch Supt Nesbit was in the open gateway, attempting to pull people out of Pen 3. There were fewer supporters at the gate, with the police taking control of the rescue operation.

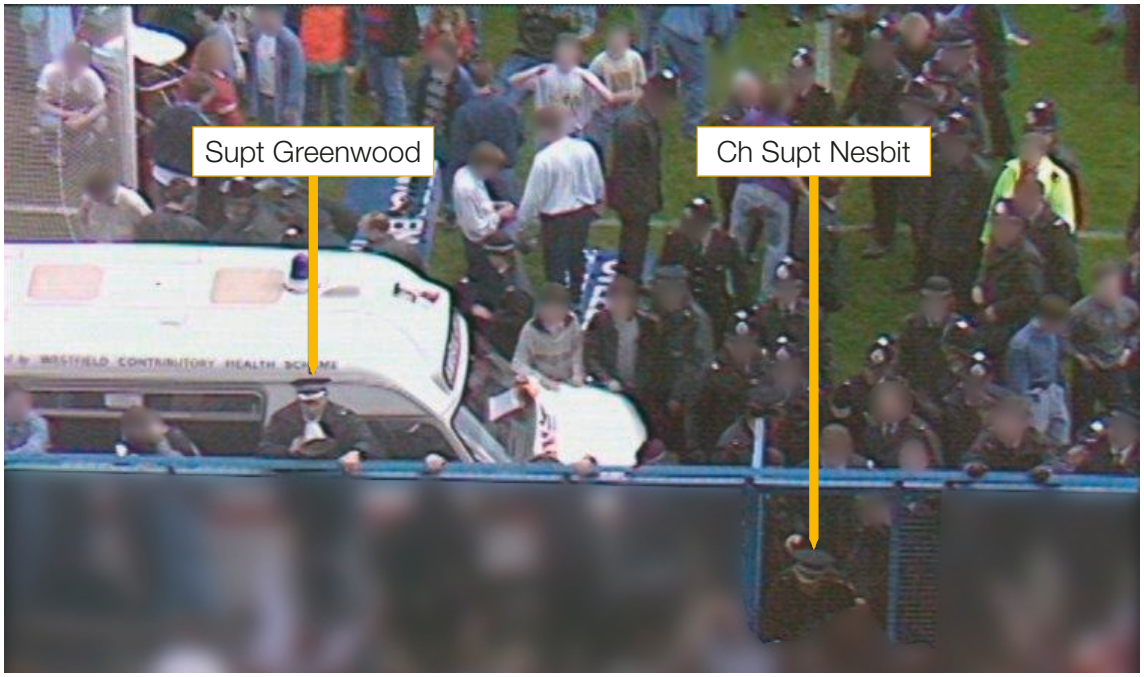


Figure 5L: The front of Pen 3, as viewed from the West Stand, 15:20:24 (Source: BBC)

5.138 The more organised response at the gates was assisted by having increased access to the pens. In a statement from 2014, Inspector Richard Dews recalled that shortly after Ch Supt Nesbit arrived at Gate 3, he saw police officers and supporters kicking and pulling the wire of the perimeter fence back to create another escape route. He said that he radioed the PCB and asked for bolt cutters to assist in cutting the mesh.

5.139 At 15:13:09, the Racal system recorded a radio transmission from the PCB to the Force Control Room, requesting that SYCFS be contacted to attend the stadium with cutting equipment. The Force Control Room promptly contacted their counterparts at SYCFS and requested this, but they were still unable to provide SYCFS with details of what had happened. However, the Force Control Room operator did refer to there having been a “major accident” and later in the conversation “a major incident inside the ground”, even though one had not been formally declared, and they did not have the knowledge or authority to do so. In accordance with the SYCFS Major Incident Contingency Procedures, SYCFS dispatched six standard fire engines, a control unit and an emergency tender (a vehicle designed to carry extra water supplies) to Hillsborough Stadium.

5.140 The first of these did not reach Hillsborough Stadium until 3.22pm. By this time, supporters and police officers had managed to bend back a small section of the perimeter fence at the front of Pen 3, adjacent to the radial fence with Pen 4. This created an additional escape route from the pens, through which officers and supporters worked to free more people. The impact of this is shown in figure 5M, taken from BBC footage a few minutes later at 15:26:28. By this time, large numbers of officers were inside Pen 3, both at Gate 3 to the right-hand side of the ambulance and at the newly created break in the perimeter fencing, at the bottom left of the image.



Figure 5M: The rescue effort aided by the hole in the perimeter fence, 15:26.28 (Source: BBC)

The arrival of SYCFS

5.141 With a hole already made in the fence, there was no longer a need for the cutting equipment brought by the fire service. Several SYCFS officers have said that when they arrived and asked where they were required, the initial response from the police was to suggest they weren't needed. Other police officers could offer no direction or information. The SYCFS officers decided to go into the stadium anyway; when they saw the situation, they recognised the most useful way they could assist was with resuscitation and first aid.

5.142 Station Officer Brian Fletcher (SO Fletcher) was the day shift station officer at Sheffield Central Fire Station, from where three SYCFS vehicles had been dispatched. In a statement made in 2013, he said that due to the large number of casualties, he decided to go to the PCB to find out who was in charge and to see if there was a designated area for casualties. When he got there, he was told that Ch Supt Duckenfield (who he knew) was in charge, but away at that time. They were unable to provide him with any information, so he "decided to return back to the pitch area to set up my own casualty handling area."

5.143 It appears this was at the time Ch Supt Duckenfield was visiting the SWFC boardroom, as discussed at paragraph 5.171.

5.144 In his 1989 account, SO Fletcher said that he instructed the SYCFS drivers to set up a casualty handling area behind the South Stand, as he knew there was access to that area, and to organise the ambulances when they arrived. He also arranged for his officers to provide first aid wherever necessary. He estimated that about 20–30 people were taken to the SYCFS casualty handling area on makeshift stretchers.

5.145 Station Officer Robert Horner, from a different fire station, described how he and his crew went straight onto the pitch when they arrived, bringing resuscitation equipment. He said that he and his crew spread out among the casualties to provide treatment and resuscitation where necessary. He recalled asking "two senior police officers if those spectators not injured in any way could be moved out of the congestion to enable those endeavouring to give assistance more room to work, the reply was 'we have already tried to do this'." He commented: "Police co-ordination and control seemed to be non-existent on the playing area."

5.146 The on-call SYCFS Divisional Officer David Lockwood arrived at the stadium at 3.24pm and assumed command of the fire service response. He too was unable to find a senior police officer, so went to the PCB and introduced himself. He said: "I didn't receive any direction from anyone in the police box as to what they wanted me to do."

5.147 The evidence of the SYCFS personnel who arrived at Hillsborough Stadium is highly consistent. All highlighted a lack of direction or instruction when they arrived, with police officers apparently surprised at the arrival of the fire service and having no idea why SYCFS had been called. This reinforces the lack of communication between the PCB—which had requested the fire service attend with cutting equipment—and the rest of the police officers on duty. When SYCFS officers sought to identify and speak to the SYP officers in command of the situation, they were unable to do so.

5.148 Some SYCFS officers have described similar difficulties in engaging with SYMAS teams on site.

5.149 In the absence of any direction from the other emergency services, the SYCFS officers sought to assist as best they could, predominantly by providing first aid, making use of their resuscitation equipment and organising aspects of the triage and casualty clearance response. They took numerous practical steps from clearing the pitch to aiding the movement of ambulances and providing advice to supporters. The one thing they had been specifically called to provide—cutting equipment—proved not to be needed.

Role of supporters

5.150 As well as the emergency services, supporters played a pivotal role in the rescue effort. Many tried to help those being crushed in the pens. Others, including some who had escaped from the pens themselves, sought to assist the injured. This included helping carry casualties to the gymnasium on advertising hoardings, which were used as makeshift stretchers.

5.151 Several off-duty medical professionals who were at the match as spectators also assisted, as did off-duty police officers. Like the other emergency services, they were hindered by a lack of information; there was no instruction for them to help, so they did whatever they could in response to the situation in front of them. When they tried to get information, police officers initially did not know where to send them and there was

no specific organisation. Several assisted with resuscitation efforts on the pitch; others helped in the gymnasium or at the back of the West Stand. They were also hampered by a lack of medical equipment, both on the pitch and elsewhere.

5.152 In addition to resuscitation efforts, some were involved in the triage of casualties, to prioritise who should be taken to hospital and to provide direction to SJA volunteers and police officers. The arrangements for assessment and triage of casualties on the pitch were largely driven by the individual response of the medical personnel. Operation Resolve has found no evidence that a systematic approach was put in place or facilitated by those in the PCB, or senior police officers on the scene.

5.153 The third primary role undertaken by off-duty doctors was to certify the deaths of supporters. Some were directed to the gymnasium to assist with this. The situation in the gymnasium is examined in chapter 6.

The end of the rescue effort

5.154 The efforts of those involved at the front of the pens and in taking casualties away had an impact. By 3.30pm, the front of Pen 3 had been cleared of casualties. This was 25 minutes after Supt Greenwood had caused the match to be stopped.

5.155 Tragically, this was already too late for many. At 3.29pm, an entry on the Force Control Room extended incident log recorded that the PCB requested that the Sheffield city mortuary, located at the Medico-Legal Centre (MLC), should be warned “to expect several bodies.”

5.156 There was still a major medical effort, including at the back of the West Stand, to try to resuscitate some and treat others.

5.157 There were also still large numbers of supporters on the pitch, and some police officers were concerned that there was a risk of confrontation between opposing supporters, with some Nottingham Forest supporters in the Spion Kop area chanting and whistling. This led to the police forming further cordons, to prevent Liverpool supporters on the pitch from reaching the areas allocated to Nottingham Forest. By 15:38:30, police officers had formed a cordon in front of the Spion Kop, near the edge of the penalty box.



Figure 5N: A police cordon in front of the Spion Kop, 15:38:30 (Source: SYP)

5.158 The cordon then moved up the pitch guiding supporters back towards the Leppings Lane end. There were no confrontations between rival supporters.

5.159 Shortly before the cordon was formed, at 3.37pm, two police officers on the pitch close to the Spion Kop had their truncheons drawn. This took place at a time when some Liverpool supporters were making their way towards the Nottingham Forest end of the ground. The footage shows that the truncheons were not used to strike anyone and were put away within moments of them being drawn.

5.160 Operation Resolve conducted a comprehensive review of all available video footage, in response to allegations that police officers used truncheons, sticks, canes or batons to prevent supporters seeking to escape from the West Terrace. This was the only instance found of police officers drawing their truncheons during the whole day. Operation Resolve did not identify any footage that supports the allegations. It should be noted that the footage, though extensive, is not continuous.

5.161 Further, Operation Resolve did not identify anyone who said they were struck by a police officer with a truncheon or something similar while climbing on or over the perimeter fence of the West Terrace.

5.162 SWFC CCTV footage shows that supporters and police officers continued to carry casualties through Gate C to ambulances that were still arriving. In total, SWFC CCTV filmed the arrival of 20 ambulances. The last casualty was carried out of the ground by supporters and police officers at 3.51pm.

5.163 At 3.56pm, Liverpool manager Kenny Dalglish gave a message over the stadium PA to ask supporters to remain calm and cooperate with the police. At 4.17pm, a further message was broadcast to inform supporters that the match had been abandoned. By around 4.40pm, Ch Supt Mole arrived at the stadium and went to the PCB, where he assumed command of the remaining operations, allowing Ch Supt Duckenfield and ACC Jackson to return to SYP HQ to brief the Chief Constable.

5.164 The focus shifted from the situation on the pitch to the gymnasium and the hospitals, which are examined in chapter 6.

Recurring issues: a lack of police control

5.165 Operation Resolve identified a series of recurring issues that restricted the effectiveness of the emergency response. The first of these was a lack of coordination, command and control. This was mentioned in many of the accounts of SYCFS officers who came to the stadium, but also by SYMAS and a significant number of SYP officers. The most visible police leadership came from Ch Supt Nesbit, in organising officers at the gates. Others—from each emergency service and some of the off-duty medical professionals—also took the initiative to provide some coordination, albeit of small groups, which made the response more effective.

5.166 Throughout, the processes that formed part of the Major Incident Plan and Manual were not followed. Key omissions included the failure to declare a major incident, and the failure to have a visible site commander in overall control of the emergency response.

5.167 Both Ch Supt Duckenfield as match commander and ACC Jackson as the on-call chief officer could have performed this role. Even after both have given evidence on multiple occasions, it is still not clear which of them was the site commander or who was in charge of the emergency response.

5.168 At the Taylor Inquiry, ACC Jackson told Counsel to the Inquiry that he did not at any point tell Ch Supt Duckenfield that he was no longer in charge. ACC Jackson said that as the senior officer there, he was at Ch Supt Duckenfield's side, assisting and making sure that everything was done that possibly could have been done. However, ACC Jackson agreed with Lord Justice Taylor that, by the time Ch Supt Mole arrived at the PCB, he had taken over control from Ch Supt Duckenfield.

5.169 At other times, ACC Jackson has insisted that Ch Supt Duckenfield had remained in control and assumed the role of site commander in the major incident response. Then at the Goldring Inquests, he said he couldn't remember whether Ch Supt Duckenfield had performed that role.

5.170 At the Goldring Inquests on 18 March 2015, Ch Supt Duckenfield told his own Counsel that ACC Jackson had not offered to take over command, had not overruled any of his decisions and had not given him advice. Two independent expert witnesses—both highly experienced match commanders—said they would have expected ACC Jackson, as the more senior officer, to have assumed command in this situation.

5.171 Aside from this lack of clarity about command, from 3.35pm to 3.48pm, both ACC Jackson and Ch Supt Duckenfield were away from the PCB in the boardroom, updating FA and SWFC officials about what had happened and their proposed approach. In the boardroom, Ch Supt Duckenfield repeated the lie that the disaster had been caused by supporters forcing their way into the stadium.

5.172 During this period, Supt Murray was left in charge, having recently returned to the PCB from the pitch. Operation Resolve found no evidence to suggest that Supt Murray was given any formal handover of control before ACC Jackson and Ch Supt Duckenfield left the PCB to go to the meeting in the boardroom. It was during this time that SO Fletcher visited the PCB to speak to the senior police officer but received no useful information.

5.173 Ch Supt Duckenfield told the Goldring Inquests that he was annoyed at being taken away from the PCB to brief the officials and suggested ACC Jackson should have done this alone.

Recurring issues: poor communications

5.174 Yet even while both were in the PCB, the police control of the incident remained poor. Though the PCB was in ongoing communication with the Force Control Room, at no point did it provide a clear explanation of what had happened. The Force Control Room operators therefore had to make assumptions in their communication with SYMAS and SYCFS counterparts.

5.175 Requests were made for Operation Support and for all officers at the stadium to head to the Leppings Lane end, but with no explanation given. Those responding did not know what they were responding to. As was the case earlier in the afternoon, those outside the stadium did not know what was happening inside and vice versa. When SYMAS and SYCFS teams turned up, the police officers at the entrances did not know why they were there and could provide no useful direction.

5.176 Throughout, radio communications were problematic, but there were other means of communication available. Despite the proximity of the PCB to the unfolding situation, Ch Supt Duckenfield did not at any point go on the pitch to make his own assessment. He has subsequently acknowledged that he froze. Supt Murray did go on the pitch but appears to have done little to assist; he did not provide any instructions beyond the reported words to PS Morgan to do whatever they could.

5.177 In short, though the senior officers in the PCB had the means to coordinate a response, and a view of the situation unfolding, they failed to manage the police resources and the other emergency services effectively.

5.178 Even by the time they left the PCB, they had still not provided the Force Control Room or other locations with clear information about what had actually happened. This inevitably hampered the efforts of those involved with attempting to assist traumatised supporters and the families and friends of those who were injured, missing or who had already died. This is the focus of chapter 6.

Complaints and conduct matters relating to the emergency response

5.179 Operation Resolve investigated a number of complaints and conduct matters relating to the emergency response and provided reports to the IOPC. Having reviewed the evidence detailed in these individual reports, the IOPC opinion was that ACC Jackson, Ch Supt Duckenfield and Supt Murray would have all had a case to answer for gross misconduct, if they had still been serving with the police. Supt Greenwood would also have had a case to answer for misconduct.

5.180 ACC Jackson would have had a case to answer for neglect of duty because he failed to take control of the situation. As the senior officer on call, he should have declared a major incident, rather than calling for Operation Support. Once he realised that Ch Supt Duckenfield was faltering, he should have assumed command of the rescue operation. While he did undertake some important actions, such as initiating the Casualty Bureau, he failed to provide overall coordination of the emergency services response, as according to the SYP Major Incident Manual the police should have done. Further,

by taking Ch Supt Duckenfield from the PCB to meet SWFC officials, he left a more junior officer (Supt Murray) in sole command for a 12-minute period without guidance or instructions.

5.181 Ch Supt Duckenfield would have had a case to answer for neglect of duty on a number of grounds. Despite having an excellent viewpoint from the PCB, he failed to act when it became obvious that Pen 3 and Pen 4 were overfull and that people were in distress. He then was slow to coordinate a rescue operation and did not organise and direct the officers under his command to help save lives. He too could have declared a major incident, but did not, and then failed to take control of the police response as set out in the SYP Major Incident Manual—for example, by failing to communicate effectively with the other emergency services and to coordinate their efforts.

5.182 Several of these same issues applied to Supt Murray, who would also have had a case to answer for neglect of duty for failing to respond to the situation, being slow to coordinate a rescue operation and not organising and directing the officers under his command to help save lives. Despite going onto the pitch at a key time, he failed to identify the seriousness of the situation in Pens 3 and 4 and failed to respond to it quickly enough. He did not effectively advise Ch Supt Duckenfield regarding the dangerousness of the situation. He also did not liaise effectively with others to coordinate a response to the disaster.

5.183 Supt Greenwood would have had a case to answer for misconduct for a range of allegations about his organisation of the rescue effort. While he did take a number of actions in response to the unfolding disaster, there were other steps he could have taken to better coordinate the police response. He focused his efforts on Pen 3 and was highly involved in the rescue effort: however, as the senior officer in that location, he could have directed others to do this and taken an overview of the situation, coordinated medical triaging and deployed police resources more effectively.

6. The treatment of families and friends of those who died

This chapter includes witness accounts, images and descriptions of scenes that may be distressing.

What was investigated?

Under the terms of reference for the managed investigation, Operation Resolve investigated:

f) the actions of police officers in the gymnasium, in particular whether the treatment and questioning of relatives was appropriate. The actions of police officers at the Hillsborough Boys' Club, and any other complaints about the treatment of friends or relatives on the day. The time parameters will be from 3.06pm on 15 April 1989 to the time when the last of the facilities shown below closed down—this will cover events between the match being stopped and the completion of arrangements to assist families at the following locations:

The gymnasium, Northern General Hospital, Royal Hallamshire Hospital, Ecclesfield Casualty Bureau, Merseyside Casualty Bureau, Hammerton Road Police Station, Hillsborough Boys' Club, Forbes Road Church Hall, Meade House, Kelvin Centre, Burngreave Vestry, and the Medico-Legal Centre

What was found?

- Despite the efforts of many volunteers, medical professionals and individual police officers, **the treatment of families and friends of those who died in the disaster lacked compassion. Procedure was adhered to in an unnecessarily rigid way, particularly in relation to the identification process, which added to the distress of families and friends.**
- **Families and friends repeatedly encountered a lack of information and coordination between sites.** This resulted in situations such as parents being taken to see their son who had died in hospital, only to discover that he had been transported back to the gymnasium for the identification process.
- **The identification process was largely determined by Dr Popper, the Coroner.** He decided that all of those who died must be formally identified at the gymnasium. He also decided that as a first stage in the identification process, those coming to identify a loved one would look at photographs of each of those who had died rather than having to view multiple bodies. This process was adhered to even when property found on someone who had died could potentially have spared friends and family that step of the process.

- **Police officers had the right to suggest alternative approaches to Dr Popper, but there is no evidence that they did.** Instead, they largely followed any directions from him to the letter, regardless of the impact this may have on families and friends.
- **Viewing the photographs was a harrowing experience and little consideration was given to the way the photographs were presented to families and friends.** For example, the photographs were not separated into age, gender or any other descriptive categories.
- Some families have said that officers they dealt with refused to allow them to touch their loved ones and on occasion told them they were the "property of the Coroner". While this was not the experience for all families, **there was no reason from a policing or coronial perspective why family members could not hold their loved ones.**
- **Many of those who gave an identification statement have said police officers asked them about their and their loved one's consumption of alcohol and possession of match tickets. Such information was not needed for any procedural purpose.** However, only a small number of the identification statements recorded included references to either issue. There is no record of any senior officer instructing colleagues to ask such questions.
- The Casualty Bureau set up by SYP should have been the single point of contact to help families and friends seeking their loved ones, and to help the police contact relatives, but it was overwhelmed by the volume of calls**. It was only the second time SYP had set a Casualty Bureau up and it had never been properly tested; numerous practical issues occurred, limiting its effectiveness.**
- One of these issues was that **the telephone numbers supposed to be used for contact between the Casualty Bureau and hospitals and police sites were given to the public—meaning there were no dedicated lines.** This disrupted information flow.
- The facilities made available for families and friends to wait in were chosen because they were convenient rather than because they were suited to the purpose. Though police officers were present, **support for families and friends was largely organised by social services and volunteers.**
- Throughout, **there was no overarching coordination of the different activities underway. No police officer was in overall control.** None of the SYP senior leadership team took any role or even showed any apparent interest in what was happening. This meant that support for families was disjointed, and the effectiveness of the efforts of the many volunteers, social care and medical professionals and individual police officers was limited.

Significant new evidence

The main sources of new evidence around the treatment of families and friends were additional statements, or testimony to the Goldring Inquests, from those involved. Some statements, such as those made as part of the investigation into a complaint about the way individuals were treated, specifically focused on the person's experiences in the hours after the disaster.

Operation Resolve made further use of the Racal recordings of conversations with the Force Control Room. It also examined two SYP books known as 'property other than found property registers' that were used at the gymnasium and MLC to record the personal possessions of a number of those who died.

6.1 In the years since the Hillsborough disaster, many family members and friends of those who died have provided harrowing accounts of their experiences in the hours that followed. Within these deeply personal stories, there have been common themes: the difficulty in getting information about their loved ones, the chaotic scenes at the various locations to which they were directed, the traumatising nature of the process used for identifying those who died and the repeated unfeeling bureaucracy of some officials. Many have also recounted how they were questioned by police officers either about their own alcohol consumption, or that of their loved one.

6.2 Together, these accounts have painted a striking picture of an ongoing response to the disaster that failed on both a procedural and personal level; that added to the anguish of those first hours and caused enduring distress and trauma.

6.3 This chapter examines the way that the families and friends of those who died were treated by the police in the immediate aftermath of the disaster. It covers the period from just after the match was stopped to the point when the last of the facilities made available to the families and friends was closed. It includes extracts from some of the accounts provided by family members and friends but does not seek to represent the experiences of the families or to speak for them. Instead, its focus, in line with the terms of reference for Operation Resolve's managed investigation, is on how SYP interacted with families and friends of those who died, and whether this followed the expected standards of the day.

6.4 Operation Resolve also investigated a number of complaints from families and friends about the way they were treated by the police. The complainants have been informed of the outcomes.

6.5 A further, more personal insight into the experiences of the families of those who died in the disaster can be found in Chapter 1 of the 2017 report by Bishop James Jones, the former Bishop of Liverpool and Chair of the HIP, 'The Patronising Disposition of Unaccountable Power: A Report to Ensure the Pain and Suffering of the Hillsborough Families is not Repeated'.

Overview of events and locations in the hours after the disaster

6.6 Once they were rescued from the crush on the West Terrace, injured supporters were taken to a range of locations including the gymnasium at the stadium, which was designated as both the place for medical treatment and the temporary mortuary on site, and to Sheffield's two major hospitals, the Northern General and the Royal Hallamshire.

6.7 Within minutes, it was apparent that some of those being carried to the gymnasium had died. From about 3.15pm, the gymnasium became both a casualty clearing point and the temporary mortuary, with the injured being treated in a separate area of the main hall. Those who were pronounced dead by medical professionals on the pitch were also taken to the gymnasium. They remained there until they were identified.

6.8 At about 6.45pm, Dr Popper attended the gymnasium and agreed a formal identification process with Detective Chief Superintendent Terence Addis (D Ch Supt Addis), the head of CID at SYP. As part of this process, Dr Popper instructed that all those who had died in hospital must be transferred back to the gymnasium for identification.

6.9 By about 9.15pm, 93 of those who had died were at the gymnasium ready for the formal identifications to begin. This commenced about 9.30pm. Just after 10pm, the 94th of those who died on the day was brought to the gymnasium from the Northern General.

6.10 Under the agreed process, a photograph was taken of the face of each of those who had died. These photographs were taken using Polaroid cameras so that they could be printed instantly. They were then displayed on boards. In small groups, the family members and friends completing the identification were brought into the gymnasium to look at the boards and asked if they could see their loved one. When they recognised them, the photograph was removed from the board, and the corresponding body was brought by police officers into a small, curtained area for viewing; the family members and friends had to then confirm the identity of their loved one.

6.11 The family members and friends were then taken to a different area of the gymnasium where they gave police officers a formal identification statement. It was during this point that some have said they were asked about their or their loved one's alcohol consumption.

6.12 Once a friend or family member had formally identified their loved one, the body was taken by ambulance to the MLC, which was the city mortuary in Sheffield, for a post-mortem examination. By early next morning, the majority of those who died had been identified and transferred to the MLC. A decision was made that anyone who had yet to be identified would also be taken to the MLC and identified there.

6.13 A police officer was assigned to stay with each of those who had died for the whole time, in line with a process known as 'body continuity'. The officer could then confirm that it was the same individual the family had identified, and that there had been no unauthorised contact with them. At the MLC, the officer formally handed responsibility for that individual to the officers on duty there.

6.14 By 6.30am on 16 April 1989 the operation inside the gymnasium was closed down. Later that day, post-mortem examinations began at the MLC in line with Dr Popper's instructions. They were concluded by 2pm on 17 April 1989.

6.15 Throughout this period, the situation was both distressing and extremely confusing for friends and family members. Some groups who had travelled to the match together did not have tickets for the same section of the ground, while many of those who did have tickets for the same area had become separated, whether during the crush at the turnstiles on entering the ground, during the crush on the West Terrace, or following their escape from the pens. While some were later reunited on the pitch or on their return to their pre-arranged meeting points, others were frantically searching for their companions and trying to obtain information. Mobile phones were not widely available at the time, so friends and family members had to rely on snippets of information they could get from others—including police officers on duty at the stadium—about where casualties may have been taken.

6.16 When this failed, the next course of action was to head to the nearest police station, Hammerton Road, to report their loved ones missing. Some then went to the hospitals, going from one to the other in the hope of finding information.

6.17 Many of those who had not been at the match attempted to contact SYP and Merseyside Police by phone, using dedicated Casualty Bureau numbers that were broadcast on TV and radio. However, the sheer number of calls meant that it was difficult to get through and speak to anyone; when calls were answered, the call handlers had little information to give. Many families then made the decision to travel to Sheffield, again trying hospitals but in many cases ending up anxiously waiting for information in various locations around the city that had been hurriedly transformed into reception centres. Those who had been at the game also gravitated to these same locations, typically deeply traumatised by their experiences that day. A large number of social workers, members of the church and other volunteers accompanied and supported the families and friends at those locations.

6.18 The main reception centre was at Hillsborough Boys' Club, a youth club close to Hammerton Road Police Station, which had limited facilities and offered little or no privacy. While there was some support available for the families and friends, the thing they wanted most—information on their loved ones—was in short supply. In some cases, when information did come through, it proved to be inaccurate.

6.19 Once the identification process had been determined, families were taken by bus to the gymnasium to identify their loved ones. For many, this involved a long wait outside the gymnasium before they were even allowed in, as the numbers of those inside were carefully controlled. Others simply had to wait in a state of increasing apprehension at the reception centres for the next bus.

Concerns raised by families and friends of those who died

6.20 Concerns about the way family members and friends of those who died were treated were first raised publicly within days of the disaster. They have been acknowledged in different arenas since, from media coverage to formal reports, and a range of issues related to the treatment of families and friends have been identified. These included:

- the suitability of the premises SYP used, from the gymnasium at Hillsborough Stadium which served as a temporary mortuary, to the locations used as reception centres
- the treatment of family members and friends in the temporary mortuary

- the fact that those who died at the hospitals were transferred back to the gymnasium for identification
- multiple aspects of the identification process, including the long delay before the process started and the fact that it then took a very long time and was poorly managed and insensitive, in particular through the use of distressing photographs as a first step
- the inconsistent and insensitive care and handling of those who died, including that in some cases, their faces were washed before they were photographed and the fact that police officers' collar numbers were written on some of the bodies
- the insistence on adhering to the formal identification process for all of those who died, even when some had already been identified by a friend or family member earlier on, and the fact that personal property and distinguishing features were not used to help in the identification process
- the fact that some of those involved in identifying a loved one were under the age of 18 and did not receive appropriate support
- the manner in which police officers questioned family members and friends after they had identified a loved one—in particular, that they asked about alcohol consumption and the possession of match tickets, neither of which was relevant to the identification
- the overall lack of information provided to families and friends both in Sheffield and remotely, and the quality, accuracy and timeliness of the information that was provided
- that family members were prevented from touching, holding or kissing a loved one
- several families specifically recalled being told that those who had died were "the property of the Coroner": this issue—which was brought to widespread public attention in the 1996 docudrama '*Hillsborough*' and covered further in the HIP Report—was the source of a number of complaints investigated by Operation Resolve

6.21 The concerns about the identification process applied to identifications made in the gymnasium and at the MLC. Other issues were broader and applied to the entire experience.

The initial situation in the gymnasium

6.22 The gymnasium at Hillsborough Stadium was a purpose-built sports hall, situated at the back of the North Stand, as shown in figure 6A.

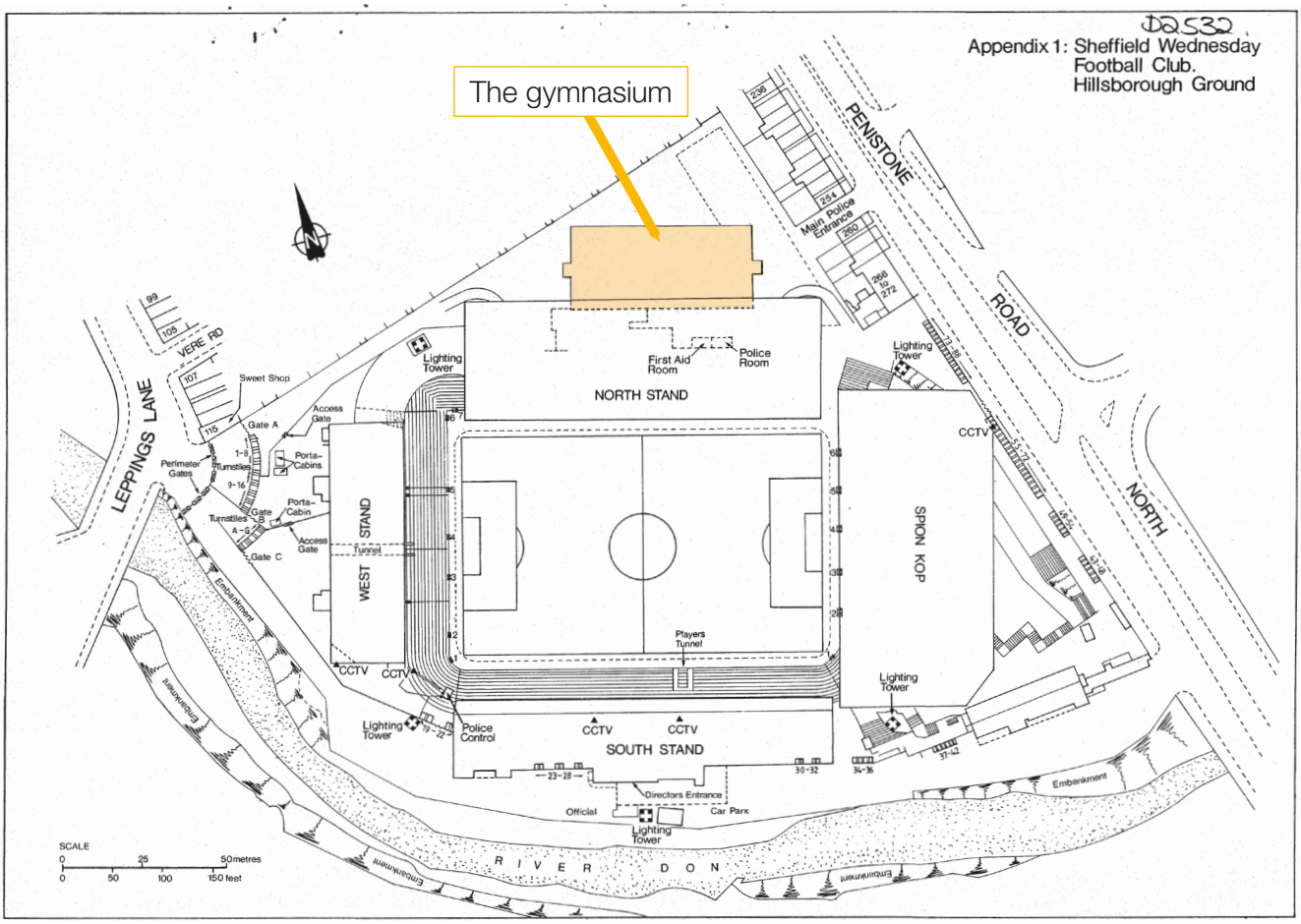


Figure 6A: Map of Hillsborough Stadium showing the location of the gymnasium (Source: SYP Archive)

6.23 After the disaster, the gymnasium almost immediately became a focus of activity. For several reasons, it had been pre-identified as a place to take casualties if needed: it was accessible from the pitch, via the path between the North Stand and the Spion Kop and had some (albeit rudimentary) facilities. It had also been pre-identified as a suitable location for a temporary mortuary if one was needed, and again it fulfilled relevant criteria for this purpose. It had good access from the road and was away from public view. There was also a telephone in the adjoining police room.

6.24 On the day of the disaster, many police officers were already in the gymnasium. Some were on standby, others were completing paperwork relating to arrests they had made, and some were having a scheduled refreshment break. Several have said that shortly after 3pm, Ch Insp Beal came in and shouted for the area to be cleared. Some recalled him explaining that it was to receive casualties, while others recalled him saying that it was to be used as a mortuary.

6.25 The situation there quickly became chaotic and its use as both a first aid centre and mortuary became untenable as the number of those who had died increased. There was a lack of preparedness and limited control and coordination across agencies. This reflected the fact that although the gymnasium had been selected as a suitable temporary mortuary location during a multi-agency meeting in 1986, no detailed consideration had been given to how this would work in practice. There was minimal medical equipment on site and there was no guidance in the Major Incident Manual, or anywhere else, about the possible layout of a temporary mortuary in the gymnasium. SYP had major incident boxes, which included essential documents setting out clear

processes for responding to such an incident and standard forms. These were located at key locations across the force area; however, they did not have one at the stadium, so one had to be brought from a police station.

6.26 Numerous practical issues emerged, most obviously the need to separate those who had died from those requiring and receiving treatment. There were also no protocols for attending to bereaved family members who had accompanied or followed loved ones into the gymnasium. Advertising hoardings that had been used as stretchers had been left in the gymnasium so that those who had carried them could quickly return to assist more casualties. However, as the number of hoardings left behind increased, they became obstacles.

6.27 There was also a procedural requirement to address body continuity: the process by which police officers and others ensure that, as a body is moved, identified and where necessary examined, all those involved are dealing with the same individual. Normally, the first police officer to attend would stay with the person who has died, but after carrying people to the gymnasium, officers returned to help with the rescue effort.

6.28 Once this was recognised, officers were instructed to write their collar number on the hand of the person who had died, before returning to the pitch.

6.29 Shortly after 4pm, D Ch Supt Addis arrived, having received instructions from ACC Jackson to ensure the temporary mortuary was functioning. He took charge of the situation there, putting in place processes for documenting details of each of those who had died. He also ensured that Dr Popper had been contacted and directed that officers be placed at the entrance to restrict access to the gymnasium. These actions brought some order to the situation.

6.30 D Ch Supt Addis has stated that his main priority was to maintain continuity of the identification and movements of those who had died. However, because identification was the responsibility of the Coroner, D Ch Supt Addis was unable to start a formal process. In the interim, he could have focused on other tasks to make the response more coordinated and effective and to consider the needs of families and friends.

6.31 Dr Popper was told about the disaster by 4.15pm; he was at home at the time. Having been given enough information to understand that a large number of people had died, he telephoned key colleagues, then went to the MLC, where he arrived at about 5.40pm. He met with a group of pathologists and coroner's officers to discuss options for the coronial response to an incident of this scale. With a smaller group of colleagues, he then went to the stadium to assess the situation. He had no direct contact with D Ch Supt Addis or anyone else in the gymnasium before he arrived at the ground.

Families' experiences in the gymnasium

6.32 A number of family members have raised concerns about how police officers treated them at the gymnasium, commenting that as they went there to look for their loved ones, some police officers prevented them from entering and did not provide them with any information.

6.33 Kevin Thompson went to the game with his brothers Patrick, who was killed in the crush, and Joseph. He said that after police officers had carried Patrick to the gymnasium, "They put him on the floor and left me with him. I was screaming and shouting." He added, "I just wanted to hold on to Pat because there was nothing I could do. The police made me leave and we were taken to the police station and then sent home."

6.34 Stephen Jones's wife Christine was also killed in the disaster. He had been separated from her in the crush and eventually made his way onto the pitch, where he found her lying on the touchline and instantly knew she had died. With assistance from Police Sergeant Julian Roper (PS Roper) and other officers, Mr Jones carried his wife to the gymnasium, where he sat with her and held her.

6.35 In a statement to the IOPC in 2015, he described a series of rude and inappropriate interruptions and interventions from police officers, after the third of which he became so frustrated at the way he was being treated, he kicked out at a chair. Two police officers took hold of him and told him to calm down. He commented that other than PS Roper, nobody had shown him any compassion, nor seemed to care or understand.

6.36 Barry Devonside's son Christopher was killed in the disaster. They had gone to the match together. Mr Devonside was seated in the North Stand, while Christopher went to the West Terrace.

6.37 In a statement to solicitors dated 1 August 2014, Mr Devonside said that he left the ground at 3.45pm following an announcement that the match had been cancelled and returned to the group's prearranged meeting place. When he got there, one of his son's friends told him that Christopher had died and was in the gymnasium. Mr Devonside said that he got directions to the gymnasium and arrived there between 4pm and 4.15pm.

6.38 He knocked on the gymnasium door and waited for a long time for it to be answered, only for a police officer to ask him without any empathy, "What do you want?" Mr Devonside explained what he had been told and the officer asked for his son's name. Mr Devonside recalled, to try and help identify Christopher, that he also told the officer that his son was wearing a Welsh international rugby shirt.

6.39 The officer told him to stay outside, then closed and locked the door, returning 10–12 minutes later with the news that his son was not there. Mr Devonside said that he told the officer his son had to be in the gymnasium, as his friend had carried him there and had given his full name and address to the police. However, the officer said, "I have just told you he's not here".

6.40 In 2014, he made a complaint about the manner of the police officer concerned. Operation Resolve investigated this complaint. Though it was not possible to confirm the identity of the officer involved, the IOPC upheld the complaint, on the basis that because the officer "spoke to Mr Devonside in an abrupt, unsympathetic and unprofessional manner", Mr Devonside did not receive the level of service a member of the public might reasonably expect.

The reporting of missing persons at Hammerton Road Police Station

6.41 Hammerton Road Police Station was the closest police station to Hillsborough Stadium, just over a mile away. SYP initially directed friends and relatives searching for their loved ones to wait there; from about 4pm, the station also became the designated point for reporting someone missing. This was in line with guidance in the Major Incident Manual to find a suitable location away from the incident.

6.42 On arrival, relatives and friends were taken into the CID office, where a team of officers filled out missing person forms. Standard SYP forms were used for this, rather than anything specific for the purpose. Once completed, the forms were intended to be

delivered to the Casualty Bureau, set up to coordinate information about all those injured or missing. This was a logical and reasonable process for SYP to adopt. However, communications were poor: forms could not be faxed over at first, and the telephone lines to the Casualty Bureau were constantly busy. Some forms were taken by a police motorcyclist.

6.43 More than 120 such forms were completed, but they appear to have had minimal impact on the identification of any of those who died, as completed forms did not reach the Casualty Bureau fast enough to help. There is evidence to suggest that, in some cases, officers sought to provide information immediately on completion of the form. However, in most cases they were unable to do so, because they had no information themselves.

6.44 As the number of people looking for loved ones increased, Hammerton Road Police Station became overwhelmed. Alongside acting as a centre for those reporting someone missing, it was also the meeting point for police officers responding to the disaster and a location for SYP's Major Incident Room (MIR). Once support workers and volunteers started turning up to assist families and friends, there was not enough room.

6.45 At about 4.15pm on 15 April 1989, the Hillsborough Boys' Club was opened to serve as a reception centre for people waiting for information. Once a missing persons' form had been completed, the friends or relatives were directed to the Boys' Club, reducing the pressure on Hammerton Road Police Station.

6.46 The Boys' Club was almost next door to the police station. It was also a large space and not in use for any other purpose. A member of the clergy who had arrived at Hammerton Road Police Station was able to open it so that it could be quickly put to use.

6.47 However, facilities there were limited. There were insufficient chairs for the number of people, poor toilet facilities and only one working telephone until more were installed later in the evening.

Organising support at the Hillsborough Boys' Club and other locations

6.48 Almost immediately, large numbers of people began to arrive at the Boys' Club. As well as families and friends trying to find information about loved ones, many social workers, faith workers and volunteers turned up, having responded to calls for assistance.

6.49 Accounts indicate that initially the scene was chaotic, but gradually the volunteers and care professionals created some order and provided a range of support services. Arrangements were made for a psychiatrist and psychologist to set up a bereavement counselling service in a quiet room upstairs, and the Women's Royal Voluntary Service (WRVS) arrived to provide refreshments. Each family group had one or two professionals or volunteers allocated to them.

6.50 The evidence strongly indicates that the police played little or no role in making these arrangements and had very little interaction with the families and friends waiting at the Boys' Club. Inspector Bernard Hogan-Howe (Insp Hogan-Howe) was the senior police officer there; in a statement to Operation Resolve, he confirmed he mostly spent his time upstairs in the office, attempting to get information from the hospitals and other locations.

6.51 There were well over 200 people there at some points, making the environment extremely noisy. As the Boys' Club became increasingly busy, a second reception centre was opened at around 5pm. This was at St John the Baptist Church Hall on Forbes Road, about 0.2 miles from the Boys' Club. The facilities there were more suitable. Again, the organisation of support was left to social services and volunteers, with little police involvement.

6.52 Later in the evening, steps were taken to differentiate the use of the Church Hall from the Boys' Club, with the Church Hall being used to provide additional support for family members and friends who had identified their loved ones at the gymnasium and were grieving. The Boys' Club was then used for those who were still waiting to go to the gymnasium or hear news about their loved ones.

6.53 Additional locations were also identified to offer further support to families, including facilities where people could sleep overnight. In the end, these were barely used.

6.54 From about 9.30pm, groups of those waiting at the Boys' Club were taken by bus to the gymnasium to begin the formal identification process. Many families and volunteers have said that they were not given any details of what they were about to experience at the gymnasium.

6.55 The operation at the Boys' Club closed down in the early hours of 16 April. The Church Hall stayed open for a few hours longer.

Families' experiences at the reception centres

6.56 For families and friends waiting at the Boys' Club and the Church Hall, the organisational issues came very much secondary to a bigger concern: the difficulty in getting accurate and timely information about their loved ones.

6.57 At both locations, information came through slowly and was often piecemeal. Various accounts have highlighted that for some, family members at home proved more valuable sources of information than the police or those who appeared to be in charge at the Boys' Club.

6.58 Francis Molloy attended the match with his nephew and two of his nephew's friends: Ian Glover who died in the disaster and Ian's brother Joseph. Mr Molloy was seated in the North Stand; his nephew was in the West Stand and Ian and Joseph Glover were on the West Terrace. Unable to find them, at around 5.45pm, he went to what he described as a temporary incident office at the far end of the North Stand, where he asked police officers for information.

6.59 He said that the officers told him to take a special bus, and he made his way to Hammerton Road Police Station, where he provided details of the three, and then went to the Boys' Club. He said that everybody there was helpful, but he had no information so didn't phone home. He recalled that at about 7.30pm, a number of people started arriving from Liverpool and he became aware of the full extent of what had happened.

6.60 A member of the clergy took him to an office and allowed him to use the phone. He spoke to his sister, who told him that his nephew and Joseph Glover were in hospital, but that Ian had died.

6.61 Alan Billings was an Anglican priest and SCC councillor. He initially attended Hammerton Road Police Station at about 5.20pm in response to a local TV news appeal for social workers to make their way there, and soon after went to the Boys' Club. On 17 April 1989, an article in his name was published in the *Sheffield Star*, a

local newspaper in the city. In it, he described accompanying the parents of a 21-year-old man while they waited for information at the Boys' Club. The parents had spoken to friends of their son and were aware that he had been hurt but did not know where he was.

6.62 After about three hours, their other son, who was at home in Liverpool, told them he had heard from a hospital in Sheffield that their missing son was there. Mr Billings accompanied the family to the Northern General. However, on their arrival, hospital staff were unable to locate their missing son. They telephoned home again and discovered that a friend of their son had driven him home.

6.63 Christine Milnes was a social worker based at Weston Park Hospital in Sheffield. In a statement made in 2016, she described how she made "several trips to the Northern General Hospital and the Royal Hallamshire hospital with people trying to locate their friends and relatives. After taking people to the hospitals, I returned to the boys club to try to help others looking for missing friends and relatives".

6.64 The very fact that families were having to travel to hospitals to look for loved ones demonstrates the lack of information that was available at the reception centres—something that frustrated police officers on duty too. Superintendent Derek Sleath (Supt Sleath), who had gone to Hammerton Road Police Station as soon as he heard of the disaster, commented that most of the communication between sites "was done by me walking or driving round."

6.65 Though the information flow overall was slow, some recalled one incident at the Boys' Club when a police officer read out a list of names of people who had been found safe and well. However, this list included the name Adam Spearritt, who it was later confirmed had died in the disaster.

6.66 Adam was 14. He and his father Edward had both been reported missing by friends who had gone to the match with them. When the friends were told Adam was safe and well, they telephoned his mother to let her know. The volunteer church worker who had been assigned to support them also recalled this happening. Further, the uncle of another young man who died in the disaster has also stated he heard a police officer announcing that Adam was alive and well.

6.67 Other witnesses also recalled a list of names being read out but did not remember any specific details; a further group said they had no recollection of a police officer reading out a list of names.

6.68 All of the police officers present have said they did not read out any lists of names. Supt Sleath specifically stated that they decided not to read out any lists of names of casualties but instead used the volunteers and support workers to inform families individually. Insp Hogan-Howe recalled that they did eventually obtain a list of people who had gone to hospital, but that he didn't remember him or anyone else reading it out.

6.69 Raymond Cooper was Chief Assistant in the SCC Family Services department. He took a lead role in organising the support at the Boys' Club, and lots of witnesses recall some interaction with him.

6.70 In a 1989 statement, he said that sometime during the evening, the police gave him a "list of fatalities" and a list of people who had been arrested in and around the ground. He agreed with the police that they would use these to approach families and friends individually and sensitively.

6.71 Conversely, in a 2014 statement to Operation Resolve, he said he only recalled the list of people arrested and had no memory of a list of those who died, adding that they couldn't have been identified at that stage. He was adamant there was no other list, such as of those who had been found safe and well.

6.72 The only individual who has said that they read out a list at the Boys' Club is social worker manager Kevin Ashby. In a statement to Operation Resolve in 2016, he said that "Within minutes of entering the Boys Club I was presented with a megaphone and a list of names with no clear instruction of what to do with them. I can't recall who presented me with the megaphone and the list of names. In relation to the list of names, I did not recognise the names and assumed it was a list of Liverpool fans names."

6.73 Someone then gave him a name; he saw it was on the list and called it out. He said he was subsequently informed that rather than doing this, he should have matched that name with a social worker.

6.74 Overall, the evidence about the reading of a list of names is inconsistent, in terms of what lists were circulating and how they would have been handled. Nonetheless, some of those who were at the Boys' Club have a vivid memory of a list being read out and in particular that Adam Spearritt was declared as being safe and well. Understandably, the later discovery that this information was incorrect was devastating.

The situation at the hospitals

6.75 The majority of those injured in the disaster, and a number of those who died, were taken by ambulance directly from Hillsborough Stadium to the nearest two hospitals: the Northern General (2.4 miles from the stadium) and the Royal Hallamshire (2.7 miles). A very small number of those injured in the disaster attended Barnsley District General Hospital. Each hospital implemented its own Major Disaster Plan before 3.45pm on 15 April.

6.76 Numerous family members and friends travelled to the hospitals, either to look for loved ones who were missing or to wait for news of those who were being treated. However, as in other locations, they encountered chaotic scenes and ongoing difficulties in getting accurate information about casualties.

6.77 This was exacerbated by the scale of the disaster. Within the first hour after it was notified of the disaster, the A&E department at the Northern General received 87 patients. A&E consultant James Wardrope confirmed this was more in an hour than it would normally receive in half a day. Of these, 17 were admitted to intensive care, again in the first hour. By comparison, in a routine 24-hour period, an average of 15 patients would be admitted to intensive care.

6.78 In some cases, mostly through the efforts of hospital staff and volunteers, families and friends did receive updates. This was largely in relation to those being treated for less serious injuries, who would have been able to provide staff with their names and details.

6.79 By contrast, some of the more severely injured were rushed into operating theatres for emergency surgery or placed in intensive care, without going through normal admission procedures. The need for an immediate medical response on unconscious patients meant that few if any details were documented. As a consequence, there was little information available about many of those who were critically ill.

6.80 The responsibility for providing information did not lie with the hospital staff: it was the role of the Casualty Bureau and the police more widely. The SYP Major Incident Manual reflected this, clearly instructing that when a Casualty Bureau needed to be set up in response to a major incident, police officers would be dispatched to hospitals. It stated: "The prime task of the hospital liaison officer at the hospital is to obtain and transmit information from the hospital to the Casualty Enquiry Bureau so that relatives and friends may be enabled to identify and trace injured persons as soon as possible. The second, but equally important task is to provide a line of communications between the hospital and Force Operations Room, and hence to the scene of the incident."

6.81 The evidence indicates that this guidance was followed on 15 April 1989. Around the same time that the Casualty Bureau was activated, teams of police officers were deployed to relevant hospitals to act as liaison officers.

6.82 However, the liaison officers' effectiveness was limited, in part due to communication problems with the Casualty Bureau, but also due to an apparent confusion as to their role.

6.83 One officer at the Northern General recalled that he was unable to assist much. He stated that he tried to call the gymnasium to help answer questions from families but struggled to get through. He did not mention contacting the Casualty Bureau.

6.84 The officer in charge of the police team at the Northern General, Insp Bennett, said that their role was to collate information about the injured and pass it to the Casualty Bureau. In a statement to Operation Resolve in 2013, he said that they "were not concerned about identification at that stage", and the only way they could have identified those who had died would have been from information passed by the hospital staff. He added: "It was not our role to search any personal property or remove clothing."

6.85 However, members of his team had a different view and described their involvement in exactly these tasks. They noted, however, that very few identifying documents were found.

6.86 Volunteers who went to assist at the hospitals, and some family members, have said they didn't see police officers at all. It appears officers sought to work behind the scenes, but this added to the confusion and volunteers decided to do what they could independently.

6.87 Vicar Roger Atkins was directed to the Royal Hallamshire by police so he could assist. Having arrived at the hospital, he went to the waiting area with other volunteers. In a statement made in 2015, he said: "I eventually got tired of waiting for further instruction on what was required from us. I decided to go to the wards where the casualties from Hillsborough were situated. I found out where they were located by asking hospital staff."

6.88 In a statement made in 2016, volunteer Amanda Mills explained that she went to the Royal Hallamshire from the Boys' Club with a list of names to look for. She said that when she arrived, the hospital reception was "…packed with people trying to find information about missing persons from Hillsborough. Members of staff in the hospital were dealing with requests from people shouting out names of those they were trying to locate."

6.89 With the help of a receptionist, she managed to locate the people she was looking for, then returned to the Boys' Club to pass on the positive news. She made three similar visits to the hospital and said that as far as she could recall, she found everyone she was looking for. She did not mention any police officers being present at the hospital.

6.90 Brian Ibell was Assistant General Manager at the Northern General. In a statement to Operation Resolve, he described how he gathered available information about those who had died and the injured and then went to the canteen area to speak to the families. He recalled that he introduced himself, explained what information he had and told the people there that he would return to the canteen every two hours or so to update them. He said that as the police passed him information, he stood on a table to address the relatives. He said that by the early hours of the morning, there were 200-300 people present. He recalled speaking to the friends and families about seven times in that way throughout the day and night.

6.91 At a certain point in the evening, Dr Popper issued an instruction that all those who had died be transferred from the hospitals to the gymnasium for the formal identification process. This transfer commenced without informing relatives who were waiting for news of their loved ones, causing considerable upset. While the decision was made by Dr Popper, there was scope for the police to challenge the decision or at least mitigate the worse effects through better communication and coordination. The fact that the police at the hospital were taken by surprise by the decision reflects the lack of communication and coordination that typified the wider operation after the disaster.

Families' experiences in the hospitals

6.92 Several family members have described how the situation in the hospitals compounded their distress. Mr Devonside went from one hospital to the other in search of his son Christopher, seeing devastating scenes but not finding him.

6.93 Trevor Hicks attended the match with his then wife, Jenni, and two daughters, Sarah and Victoria. Mrs Hicks had a ticket for the North Stand; Mr Hicks and their daughters had tickets for the West Terrace, but he went into Pen 1 while Sarah and Victoria went to Pen 3. Both Sarah and Victoria were killed in the disaster.

6.94 After the match, Mr Hicks travelled from Hillsborough Stadium to the Northern General in an ambulance with Victoria, who was pronounced dead shortly after arriving. He was accompanied by a police constable. There had not been room for Sarah in the ambulance, and Mr Hicks had been faced with the awful dilemma of having to leave her on the pitch, on the assurance that she would be placed in the next ambulance.

6.95 A short time after they arrived at the hospital, the PC informed him that Victoria had died. Mr Hicks then began to search the hospital for Sarah, who he assumed had arrived soon after. After an hour and a half of searching and waiting, he was taken to the section of the hospital where those who had died were being attended to and gave a description of Sarah to the police officers on duty there. He explained that the officers told him there was a young unidentified female and brought out a watch to show him. He thought it may have belonged to Sarah and said that after about 10 or 15 minutes he was taken to the hospital mortuary to identify the young woman. He expected this to be Sarah, but in fact, it turned out to be Victoria.

6.96 He said that he returned to the main hospital building for another half hour or so, during which time he was trying to find both Jenni and Sarah. He was told that some casualties had been taken to the Royal Hallamshire, but he could not get through by telephone. At about 6pm, he was taken to the Royal Hallamshire, where he gave Sarah's description to staff who checked to see if she had been admitted.

6.97 At about 8pm, he returned to the Northern General where he was reunited with his wife. He was appalled to learn that she had been told Victoria had died but had been refused permission to see her. He explained that his wife was distraught when he told her he had been unable to find Sarah. Mr and Mrs Hicks later identified both their daughters at the gymnasium.

6.98 Dolores Steele went to the Northern General with her husband Leslie in search of their son Philip, who died in the disaster. In a statement made in 2014, she recalled that on her arrival at the hospital, she gave her details to a member of staff and was told to sit down and wait. She said that a man in a white coat stood on a table and read out the descriptions of ten people who had died, and that the penultimate description referred to a person in possession of a signet ring engraved with initials. Philip wore such a ring, but the initials were given in the wrong order. She insisted that she was allowed to see the ring, and a police constable went to get it. Mrs Steele said: "I knew it was Philip's ring before they took it out of the bag".

6.99 She was told her son was in the hospital mortuary and the police constable took her there. They sat outside and waited for what she believed was over an hour, only to be informed that her son was no longer at the hospital, and that he had been taken back to Hillsborough Stadium. She commented: "It just all seemed to be hopeless".

6.100 The officer involved had no idea that this was happening and was hugely embarrassed and apologetic. Mr and Mrs Steele identified Philip at the gymnasium later that evening.

The failure of the Casualty Bureau

6.101 Throughout this period, SYP's Casualty Bureau was operating. It was opened to the public at 4.23pm. As set out in the SYP Major Incident Manual, it should have been the single point of contact to help families and friends seeking their loved ones, by gathering, processing and providing accurate information about those involved. However, almost from the moment the telephone lines opened, it was overwhelmed by the volume of calls.

6.102 With thousands of supporters at the match, thousands of families were anxiously seeking news. The only ways that those at home could gather information about the wellbeing of their loved ones were if someone in Sheffield telephoned them, or through the Casualty Bureau.

6.103 Given this, the Casualty Bureau—a room in the SYP training centre at Ecclesfield Police Station in Sheffield—was clearly too small. Figures 6B and 6C show the set-up at the time. There were eight telephones: four were dedicated for internal use and contact with the gymnasium, the hospitals and other sites. The other four were allocated to receiving calls from members of the public. It also had two direct links with Force HQ. The desks were close to each other, so there would have been limited space for privacy and conversations would have been overheard.



Figure 6B: View of SYP Casualty Bureau, 1989 (Source: SYP)

6.104 At the point it opened, the Casualty Bureau had no records of casualties and almost no information to give to callers. The call handlers had received minimal details from the ground, even though the setup of the Casualty Bureau had begun following an instruction from ACC Jackson at 3.17pm.

6.105 Staff took the personal details of the callers and the names and descriptions of the people they were enquiring about. Information was handwritten on casualty enquiry forms, with the intention that this could be matched with information received from the gymnasium or hospitals. Names and ages of those missing were then also written on whiteboards on the walls of the Casualty Bureau, so that they could easily be seen by fellow call handlers. However, the number of missing people was so high that the call handlers ran out of space and had to use the blinds in the room as additional whiteboards.

6.106 When additional staff were drafted in, they had to sit in a different room and could not see the whiteboards. In some cases, this led to the creation of duplicate records, which added to the overall confusion.



Figure 6C: View of SYP Casualty Bureau, 1989 (Source: SYP)

6.107 A further problem quickly occurred. The intention was that the Casualty Bureau should have separate telephone numbers for the public and internal use. However, when the telephone number for the public was released, the internal ones were too. This resulted in all lines being available to members of the public. With large numbers of incoming calls at all times, officers at the hospitals found it virtually impossible to contact the Casualty Bureau with details of casualties. Operation Resolve has not been able to establish who released the numbers, or how it happened.

6.108 Further, all of the telephones were on the same loop, which meant that when the Casualty Bureau number was called, all of the available phones rang simultaneously. This resulted in the phones ringing continually and there came a point when call takers left their phones off the hook to have time to complete their paperwork.

6.109 Some of these issues had been identified in an SYP Casualty Bureau working party meeting in December 1987. For example, it had been decided that four phone lines were insufficient, and the minimum requirement should be ten lines. However, no action was taken in response to this, until 7pm on the evening of the disaster, when BT installed four more lines.

6.110 A Casualty Bureau training exercise on 27 October 1988 had identified that installing a fax machine at a hospital provided better communication between the two sites. Yet fax machines were only installed several hours after the Casualty Bureau was opened.

6.111 The Casualty Bureau had only ever been used in response to one live incident, on a much smaller scale, so many processes had not been tested. For example, the forms in use for recording information about casualties were slightly different in each location, meaning there was some duplication of effort, but also some details missed.

6.112 Compared to some of the other issues identified in this chapter, the treatment of families and friends by the Casualty Bureau has been subject to few concerns or complaints. In the majority of cases, those who referred to attempting to contact the Casualty Bureau, or attempting to call the emergency numbers, have indicated that they either gave up trying to get through or that they received no useful information. As a result, they set out for Sheffield.

6.113 The SYP Casualty Bureau was also responsible for contacting other police forces, including Merseyside Police, which had activated its own Casualty Bureau, to ask them to visit family members of those individuals who had been identified, either formally or provisionally, as having died.

6.114 It sent out a series of messages, many of which were specific in their content and stipulated what response SYP required from the recipient police force. For example, there were requests to inform a named individual that a provisional identification had been made. In at least eight cases, the provisional identification had been made using details found on personal items such as rail passes, driving licences or other identification documents. A further six messages requested that a named individual should come to Sheffield "for the purpose of formal identification".

6.115 In some cases, SYP asked Merseyside Police to contact families even though other family members or friends had already identified their loved one. Operation Resolve has also established that on occasion the content of the message sent to another police force contained inaccuracies, which clearly had the potential to cause further distress and upset, beyond that already caused by the nature of the message. For example, one message sent to Merseyside asked for a woman to be visited to be notified of the death of her son; it was in fact her husband that had died. Further, a formal identification was still required.

The identification process

6.116 At around 6.45pm–7pm, Dr Popper arrived at the gymnasium with two Home Office pathologists. They met with D Ch Supt Addis, who advised Dr Popper that around 80 people had died. He also confirmed to Dr Popper that formal identification had not yet been started. This was despite the fact that some people had already identified friends or family members to police officers.

6.117 They agreed the process that would be followed in all cases, including the use of Polaroid photos, the requirement to give an identification statement and the fact that the identifications could not start until all of those who had died in hospital were returned to the gymnasium and photographed.

6.118 Both Dr Popper and D Ch Supt Addis have emphasised that Dr Popper made all the decisions around this process. Having agreed the process and authorised the transfer of all those who had died, Dr Popper returned to the MLC, while D Ch Supt Addis arranged to implement it.

6.119 In his statement to Operation Resolve in 2014, he explained that he instructed officers to separate the gymnasium into three sections by using the dividing nets that were in place. These were pulled across the room, and additional blankets were placed on them so that it was not possible to see through into the next area.

6.120 He said the first area was where those who had died were. A second area was used for police officers and the third area contained desks for interviewing and taking statements from the relatives and friends of those who had died. He added that there was an area set aside for identification purposes.

6.121 D Ch Supt Addis stated that he then "gave instructions to place the bodies in lines, having spaces between so that you could walk round." He instructed officers to search those who had died, removing personal property to be recorded and placed in bags. He commented: "This is normal procedure, it can help with identification."

6.122 Evidence suggests that many aspects of the process adopted were in line with standard practice at the time.

6.123 Dr Popper came back to the gymnasium at around 9.15pm, where he confirmed he was satisfied with the arrangements. The first identifications then began at about 9.30pm.

6.124 At the preliminary proceedings to the individual inquests on 18 April 1990, Dr Popper said that his "primary concern was to arrange for the post-mortems to be done as quickly as possible."

Families' experiences of the identification process

6.125 Family members and friends, and the volunteers and care professionals who accompanied them, have raised a range of concerns about both the agreed process and the way it was carried out. These began with the fact that many were transported to the gymnasium by bus, with no idea of what to expect. Once they arrived, they had to queue outside; with numbers inside strictly controlled, some had to wait for a long time on what was becoming an increasingly cold evening. Recognising this, a British Red Cross volunteer returned to his headquarters and collected about 30 blankets to hand out to people as they arrived.

6.126 A member of the clergy insisted to the police that families should not have to wait outside and instigated a different system, where families could wait indoors and be supported. Despite his efforts, Operation Resolve has confirmed that the gymnasium did not meet the standards set out in the SYP Major Incident Manual, as the waiting area did not have telephone and toilet facilities available for the families.

The decision to use photographs and its impact on families and friends

6.127 The decision to ask families and friends to identify their loved ones from a photograph in the first instance was designed to avoid them having the traumatic experience of looking at a large number of bodies. Dr Popper explained it in his opening remarks at the individual inquests in April 1990, saying he took responsibility and added: "Of course it wasn't nice, but it was the best I could think of, if you like, at the time and I still think it was the right decision." In a statement to Operation Resolve and the IOPC in 2014, Dr Popper described it as "one of the few good ideas I had."

6.128 Viewing the photographs was nonetheless harrowing. Some groups went in with no idea of what they were going to see. The photographs were ordered numerically, based on the identification numbers allocated by SYP; there was no separation or grouping of any sort, so families had to look at them all. To aid the process, police officers could have selected pictures of young males for certain groups, or selected only females, so that families and friends did not have to look at all of the photos. Operation Resolve found no evidence to suggest that officers considered this.

6.129 Some of those who had to look at the boards have also commented on the impact of seeing how many people had died. This was particularly true for those in the earliest stages of identification, when the boards were full; once an individual was identified, their photograph was removed.

6.130 The injuries some individuals had suffered meant that in some cases family members did not immediately recognise their loved ones in the photographs. On occasion this led to officers prompting them to look again, appearing to suggest that the officers already knew the identity of some of those who had died by the time family members or friends were asked to make the identification.

6.131 Francis Tyrell's son Kevin died in the disaster. When they arrived at the gymnasium, Mr Tyrell and his family were asked to look at the photographs. In a statement made to WMP, Mr Tyrell recalled the horror of this, commenting that in some cases, people's faces were so swollen and bruised that it was difficult to recognise any features.

6.132 He said that they looked at the photographs carefully but did not recognise Kevin. They thought one of the photographs might have been him; a police officer went away to check and returned after 10 minutes and told them that it was not. They were then asked to take a second look at the boards.

6.133 On their second viewing, there was a person they thought might have been Kevin, but they could not recall him wearing the clothing shown in the photograph. Mr Tyrell said that the police officer went away to check and when he returned this time, he told them that it was Kevin; there had been a coach ticket in his possession which bore his surname and address.

6.134 Mr Tyrrell said it immediately became clear that the police had known all along his son had been in the mortuary. He said that he could not understand why they had been put through so much suffering, when it was clear that the police already knew that Kevin had died.

6.135 In a 2015 account, he recalled that he twice went to a police officer with a number, thinking it might be his son, but it was not, so he told the police officer, "well he isn't there". He added: "I had not recognised him, partly because I was in desperate denial, partly because his face was unrecognisable and I was thrown by what looked like a black t-shirt under his outer shirt, when in fact it was his navy 'Nike' jumper. To this day I do not understand why we were forced to go through this horrendous and cruel process."

6.136 Mr Tyrell was one of several people who questioned why they had to go through the process of looking at the boards when the police already knew, or had a good idea, of the identity of some of those who died.

6.137 Joseph Hughes went to the gymnasium with a number of friends looking for their friend Alan Johnston. He couldn't see him on the boards, but an officer asked him to take another look, paying particular attention to one of the numbered photos. He realised it was Alan, and that the police would have known this because Alan had photographic ID in his pocket.

6.138 In a letter written in 1990, Margaret Aspinall asked why nobody in Sheffield had notified her family about the death of her son James sooner, as he had a bus pass bearing his photograph, name and address in his possession. She said that her husband had to go to Sheffield in the early hours of 16 April to identify their son and then phone the family, when using the bus pass could have spared them a night of anguish.

6.139 Evidence from police officers in the gymnasium indicates that they searched most of those who had died, and that several other individuals were provisionally identified using personal property. Property was also documented in ledgers used for this purpose. Operation Resolve has reviewed the lists of personal possessions for all those who died in the disaster and established that at least 25 individuals had items in their possession which may have helped identify them. These items ranged from papers or cards bearing a name, and in some cases an address, such as a driving licence, to photographic identification such as a bus pass or rail card.

6.140 Dr Popper and some of the senior detectives have emphasised that, even though the property may have helped identify individuals, they did not feel they could rely on it. D Supt McKay pointed out that it would be worse to misidentify someone as dead, based on property. D Ch Supt Addis said that while he had asked that officers search those who died to try to find identification, no officer came to him with a positive identification based on property.

6.141 The Interpol Manual on Disaster Victim Identification was the official guidance in use in England in 1989 relating to methods of identification in a disaster or major incident. It advised that property was "valuable circumstantial evidence of identity, but never proof." This therefore supports Dr Popper and SYP in saying they could not rely on it. Indeed, property would not necessarily be accepted as proof of identity of someone who had died today. Nonetheless, there was still the potential to have used the property more directly to assist with the identification process.

The requirement to re-identify those who died

6.142 There were a number of instances where family members and friends had already identified their loved one before the formal process began, and this was recorded in some way by SYP. Despite this, the families still had to go through the full process, including the requirement to view the boards of photographs.

6.143 For example, despite having identified his daughter Victoria twice at the hospital, Mr Hicks was required to identify her again at the gymnasium.

6.144 John McCarthy had been at the game with his brothers, Ian and Joseph (Joe) Glover, who were in the West Terrace. Mr McCarthy was in the North Stand. In a statement made in 2013, Mr McCarthy described how, after the match was stopped, one of his friends led him to Joe, who was kneeling by the wall outside the gymnasium in tears. Joe told him that Ian was inside. With the help of some of their friends, they persuaded the officers at the gymnasium door to let them in, and they found Ian. Mr McCarthy described how he was holding Ian, when a police officer came over to them and told them there was nothing they could do.

6.145 Mr McCarthy and Joe were then taken to Barnsley General Hospital where they were joined by their father. From there they went to the Boys' Club and were later taken by bus back to the gymnasium to make a formal identification. Mr McCarthy said:

"Outside the gym, there was a wall with photographs of the dead on it. We had identified Ian earlier and they had put a tag on him, however we were still made to look at all the photographs. At first I did not go over to the board. My Dad and Joe were looking for Ian on the photographs and they could not find him. I went over and picked out Ian's photograph straightaway number 37. I will never forget that my Dad said that that was not Ian. He either didn't recognise him or he didn't want to, I don't know which. We went inside the gym and Ian was wheeled out on a trolley. There was an old jumper covering his face. My Dad went mad. There was a priest in there and he gave Ian the last rites. I looked at Ian once and then had to turn away. I had already seen him."

6.146 Brian Anderson attended the match with his father, John Alfred Anderson (known to his family as Jack), who died in the disaster. The identification statement he gave on the evening of the disaster clearly described how he had to identify his father twice, to the same officer. The first time was behind the West Stand, where he saw some people lying on the floor with their faces covered. He stated: "I was looking at the bodies to see if I could find my father and saw that he was in fact one of them. I realised that he was dead and I identified him there and then to Police Constable 520 Hogg."

6.147 Later in the same statement, he said: "At 8.50 pm (2050) the same day I attended at the gymnasium at Sheffield Wednesday Football Ground. Police Constable 520 Hogg there showed to me, a photograph bearing the number 76. I identified that as being a photograph of my father. I was then shown the body of my father whom I identified to PC Hogg."

6.148 In a statement made in 2014, Dr Popper addressed the issue of why all of those who died on 15 April 1989 had to be identified following the same process, when a number had been provisionally identified already. He acknowledged that the identities of a few of those who had died were known at the time the formal identifications began. He explained that formal identifications were required for coronial purposes and said that at the time the process was agreed, he did not know if anyone had been formally identified.

6.149 Again, however, there was an opportunity for officers to show some flexibility around this, and progress straight to the identification statement.

Accounts that the bereaved were prevented from holding or touching those who died

6.150 The issue most frequently raised by family members about this next phase of the identification process was that they were prevented from touching or embracing their loved ones, or permitted to do so only briefly. Several families specifically recalled being told that those who had died were "the property of the Coroner".

6.151 Leslie and Doreen Jones are the parents of Richard, who died in the disaster. In an account dated 29 March 2015, Mr Jones said that his son was covered in a black plastic bag when he was brought out to them on a trolley. He said that they tried to bend down to touch their son, but the police officer told them not to. He said the police officer told them that their son was "the property of the coroner", which caused them extreme distress.

6.152 In a statement made to Operation Resolve in 2013, Mrs Hicks said that while at the Northern General, a police officer told her that she could not see her daughter Victoria because "she's the property of the coroner of South Yorkshire."

6.153 Stephen Kelly went to the MLC to identify his brother, Michael. In a statement made in 2014, he explained that he had to do this through a pane of glass, as is explained at paragraph 6.187. He said that when he saw Michael, it was a huge shock, and he wanted to go into the room with him. He said, "I explained to the police officers that Mike had been on his own all night and that I wanted to give him a kiss and let him know I was there. They told me I was not allowed to and that Mike was the property of the Coroner."

6.154 While these were not the only family members to raise this issue, the majority did not and some specifically stated that they were given time to hold a loved one. In short, the evidence indicates that the approach was highly inconsistent, across all locations.

6.155 Operation Resolve found no evidence that police officers dealing directly with the family and friends of those who died were given any instruction about what contact was permitted with their loved ones. In the absence of specific direction, the conduct of SYP officers in the gymnasium should be considered against the relevant Force Standing Order in place at the time, Standing Order 17A – Police Action in Respect of Sudden Deaths. This set out: "When a police officer receives information about a sudden unnatural death, he is in charge of the body and should take measures to ensure that the body and anything on it is not interfered with until it is decided whether it is to be removed to the mortuary…and the Coroners' staff take charge…".

6.156 Nonetheless, it is hard to see how a bereaved family member hugging their loved one in this situation would cause any practical issue for the coronial process. Further, there was nothing in the Coroners Rules 1984 or the Coroners Act 1988 that set out what contact could or could not be had with those who had died during the identification process. Therefore, there was no reason why families should have been prevented from physical contact with their loved ones. The IOPC therefore upheld all complaints about this matter.

6.157 It was notable that when interviewed by Operation Resolve in 2014, D Ch Supt Addis said: "as you know, when anybody dies, and the police are involved, the body becomes the property of the coroner." Though this was a misunderstanding or misinterpretation of the law, the fact that he used this specific phrase could suggest that he had used the same phrase at the gymnasium. However, Operation Resolve did not find any specific evidence to this effect.

Involvement of under 18s in the identification process

6.158 Almost a third of those who died in the disaster were aged 18 or under. A significant number of those involved in the identification process were also under 18. Some of those individuals, and members of their families, have since complained to the IOPC that it was not appropriate for them to have been asked to assist in identifying friends or family members and that they should have had better support.

6.159 Stuart Hamilton was 15 years old when he attended the match with a group of others, including his uncle and his father Roy. Roy died in the disaster. Stuart and his uncle were at the Boys' Club for several hours before being taken to the gymnasium just before midnight. They were not told where they were going and assumed they were

being taken to a hospital. He said that when they arrived at the gymnasium, they waited in a holding room for several hours, and during that time he told a social worker how old he was.

6.160 He said he was then taken to view photographs and saw between 30 and 50 before he identified his father, and the photograph was taken down from the board. He said that he was then taken to another room where he physically identified his father. He explained that his uncle was also there, but he had "broken down" by then and was "in no fit state by this point in time to act as a guardian for me or make an identification."

6.161 Stuart was then taken to a recovery room where he was reunited with other members of his family, who he said by that time had also been shown the photographs. However, because Roy's photograph had been removed, they mistakenly believed that he was still alive. Stuart had to explain that was not the case, that his father had died, and his photograph had already been taken down.

6.162 Reflecting on this in a 2016 statement to Operation Resolve, Stuart said that he believed there had been "a collective and fundamental supervisory failing in the entire identification process." He commented: "Throughout the process I was never treated as a child, as I should have been. Immediate consideration should have been given for me not to view the photos or be involved in the formal identification. Someone should have taken responsibility and stopped my involvement in the process; yet I feel no-one took my best interests into consideration".

6.163 Stuart made a complaint about the fact that as a minor, he was asked and allowed to view numerous photographs of those who died, to identify his father. His complaint was upheld by the IOPC as SYP and specifically D Ch Supt Addis should have provided guidance regarding the presence of juveniles, to ensure that their welfare and wellbeing was not negatively impacted by the process of identification.

6.164 Police Sergeant Stephen Royle supervised the viewings of the photographs. In a statement made in 2016, he said he didn't recall any children being involved and said that he would have advised that it was not appropriate for them to be there.

6.165 However, Detective Constable Michael Dynes told Operation Resolve in a 2018 statement that he recalled some children being present at identifications. However, he said that these children were accompanied by adult relatives and that it "was left to the relative to decide" whether the child should be involved. He added that "if totally inappropriate and the child appeared not fit to do so I personally would have challenged the decision."

6.166 While this appears a superficially considerate approach, Operation Resolve found no evidence of any specific instructions being given to this effect, nor of how officers would deal with a situation where the adult relatives were not fit to make decisions on behalf of the child.

6.167 There was no law or guidance in existence that prevented under 18s from being involved in the identification process. However, there was clear legal provision for recognising the vulnerability of those under the age of 18 and treating them differently. In line with this, it may have been expected that at least some additional support or consideration would have been given.

Taking identification statements

6.168 Once a family member or friend had identified their loved one, they were taken to a separate area where they gave an identification statement to a police officer. At that stage another police officer completed a standard SYP form, known as a GEN/18, which recorded information about the person who had died and the circumstances of their death. This same process was followed for identifications made at the gymnasium and later at the MLC.

6.169 Identification statements are a standard requirement when someone has died suddenly. Their primary purpose is to formally record the identity of the person who has died. Sometimes, those giving the statement are also asked to provide brief details of the person's movements on the day they died or, where relevant, other details about the person's health and background.

6.170 While the completion of these statements was a necessary step in the identification process, the manner in which this was done has since been subject to a number of complaints and criticisms. A significant number of those who gave identification statements, plus several of the volunteers who supported them, have consistently said that the officers taking the statements questioned them about both their and their loved one's alcohol consumption. Some also recalled being asked about whether they, and/or the person who had died, had a valid match ticket.

6.171 The immediate reaction of many of those giving the identification statements was that such questions were deeply insensitive and sometimes insulting; some also emphasised that they felt these matters were of no relevance to their loved one's death.

6.172 Paul Dunderdale, whose friend Graham Roberts died in the disaster, provided a statement to his solicitors in 2013 for use at the Goldring Inquests. He said that following the identification he was required to make a statement in the gymnasium. He recalled: "The first four questions were all about alcohol and how much Graham had drank…the police officer also asked about tickets and was pushy."

6.173 Andrew Brown identified his brother David Steven Brown (known to his family as Steven) who died in the disaster. In a statement made to his solicitors in 2014, Andrew said that following the identification, police officers took a statement from him in the gymnasium: "They both asked me questions mainly along the lines of how much we had to drink and what time we got there etc."

6.174 Methodist minister Ian Hamilton supported a number of families through the identification process. In a statement made in 2017, he said: "Questions were asked about the age of the deceased, who they went to the match with, and such like. One of the questions asked was whether the deceased had been drinking." He commented: "Whilst the questions may not have been scripted it did seem to me that the same questions were being asked of all the family members who had made identifications including the one about the consumption of alcohol which I thought was a little inappropriate."

6.175 Having since seen copies of the statements that were taken, some have commented that the questions they were asked were not recorded in their statements.

6.176 Operation Resolve has reviewed all of the identification statements made on 15 and 16 April 1989. Of, these, five contained references to alcohol or visiting pubs. All five were provided by people who had been at the match. In the identification statements

made by the families and friends who raised the issue to Operation Resolve, there was no mention of the alcohol consumption of either the person who died or the person giving the statement.

6.177 Operation Resolve interviewed several officers who had been involved in taking identification statements. Only one thought that he asked about alcohol consumption. In a statement made to Operation Resolve in 2017, Detective Sergeant Russell Hallows said that he believed this to be standard procedure for all deaths he dealt with and said there was no instruction to do so after the disaster.

6.178 The consistent response from officers involved in taking identification statements has been that they received no instructions to ask about alcohol consumption and did not do so. Similarly, the senior officers involved in the gymnasium have stated they did not instruct anyone to ask families and friends about alcohol consumption and that doing so would have been inappropriate.

6.179 With the evidence indicating there was no instruction to officers about alcohol, the question remains why so many of the families and friends who gave identification statements recalled being asked about it.

6.180 In addition to the criticisms family members and friends have made of police officers asking them questions about alcohol consumption and match tickets, a number were also critical about the insensitive way police officers treated them at the gymnasium.

6.181 In a statement made to his solicitors in 2015, Leslie Jones described his upset at having to provide three statements to police officers at the gymnasium after he had identified his son Richard and Richard's partner Tracey Cox. Mr Jones recalled that a senior police officer remained by his side throughout that time and interrupted him as he made the identification statements, questioning anything he said, when all he wanted was to get his family out of the place they were in. In 1989, he asked WMP to identify the senior officer, so he could complain; WMP was not able to do so.

6.182 Mr Jones added that by the time they finished making statements, it was 3.30am, some 10 hours after he and his wife had arrived in Sheffield, and when they left the police station no police officer asked about their welfare.

6.183 Social worker Howard Waddicor assisted the Jones family during the identification process. In a statement made to Operation Resolve in 2015, he said the most difficult part of the process was the interview the family had with CID officers. He described the questioning as "brutal", with no effort to comfort them. He said he did not get a sense of there being a conspiracy by the police to treat the family badly, just that there was no feeling or understanding and that it was "really tough" for the family.

6.184 It should be acknowledged that other family members and volunteers have said that the police officers they dealt with were sympathetic and handled the situation and overall identification process with sensitivity.

6.185 This suggests that families had very different experiences, depending on the officers they engaged with.

The transfer to the MLC

6.186 By around 5am on 16 April, the majority of those who died had been identified and transferred to the MLC. A decision was made that the remaining individuals, who had yet to be identified, would also be taken to the MLC and identified there. Operation Resolve has established that 17 of those who died were yet to be identified at that stage.

6.187 The same process was followed for identifications made at the MLC, but the layout of the building meant that the physical identification had to be done by looking through a window into a viewing area. Because the viewing area was only accessible through the mortuary and examination room, families were not permitted to go through it.

6.188 However, some families were not told this before the physical identification, so they were not expecting to be looking through a window and unable to touch or hold their loved one. Others did receive an explanation of the arrangements.

6.189 There were family members who went to the MLC simply to see their loved one, who had already been identified by a friend or another member of the family. Many of them were also not informed about what to expect and remembered it as extremely upsetting.

6.190 Other issues also recurred at the MLC, including families being questioned about alcohol consumption and officers treating them in an offhand or insensitive manner.

6.191 After the conclusion of the original Inquests, Dr Popper sent a letter dated 27 September 1991 to the Secretary of the Coroners' Society. In this, he summarised some of the issues that had been raised by relatives of those who died in relation to their experiences. While many of these related to the wider identification process, Dr Popper did highlight that the viewing arrangements at the MLC, which required families to stay behind the glass partition, had been unsuitable.

Recurring issues: a lack of communication, coordination and compassion

6.192 A recurring theme across all the locations used in the aftermath of the disaster was an adherence to process rather than a focus on compassion and care. With a lack of overall command and coordination by police, individuals defaulted to procedure and were often overwhelmed by what they were dealing with. While the evidence shows officers taking control of specific aspects of the process—for example, D Ch Supt Addis taking control in the gymnasium and, later in the night, Supt Sleath seeking to coordinate reception facilities for the families—Operation Resolve has found no evidence of any senior leader within SYP officer taking strategic command of the response.

6.193 This was the same overarching issue that affected the emergency response at the ground.

6.194 Many individuals at each site tried hard to perform essential tasks such as recording missing persons, providing family reception and ensuring accurate identification. There were large numbers of volunteers from local authorities, support groups and churches of different denominations, who offered practical and emotional support, as did some local residents. Many police officers involved in the disaster response did

their best to establish information, organise processes and conduct essential tasks with compassion and sensitivity. However, they were hampered in these efforts by the lack of overall coordination.

6.195 It would have been challenging for any organisation to respond to a disaster of this scale, and the initial response to any substantial disaster is always chaotic. Nonetheless, as the evening and night progressed, the lack of leadership and poor coordination became increasingly apparent and had several consequences.

- The demands and perceived requirements of the Coroner became the key element in the disaster response. The impact on families and people affected by the disaster often took second place to following procedures. Dr Popper's instructions were not questioned or challenged, even where a more flexible approach around issues such as viewing the photographs or using earlier identification statements could have reduced distress for the families.
- Different functions and sites operated in silos. There was no effective coordination of the different agencies, especially social services and support agencies. These services provided invaluable practical, emotional and spiritual support, but the lack of wider police coordination meant they were not used as effectively as they might have been.
- The lack of clear guidance meant individual officers used their own discretion, sometimes appropriately, sometimes not.

6.196 The evidence examined by Operation Resolve clearly shows that the lack of control and coordination contributed to and exacerbated a chaotic response that on too many occasions made an already devastating experience worse for families, friends and those affected by the Hillsborough disaster.

The IOPC investigation

7. SYP's interaction with the media after the disaster

What was investigated?

Under a term of reference covering SYP's engagement with the media and MPs in the aftermath of the disaster, the IOPC investigated:

The interactions of police officers with the press and politicians, in particular:

a) whether any police officer was involved in the passing of inappropriate or inaccurate information to a journalist, including whether any police officer was involved in passing written accounts to the press

b) whether any police officers passed inappropriate or inaccurate information to any Member of Parliament—whether individually or at meetings. This will include investigation of the actions of Chief Inspector Norman Bettison in visiting Parliament and the evidence he presented, its content and subsequent use by others

c) whether the briefing which was given to the Home Secretary and Prime Minister on the day after the disaster contained any inaccurate or inappropriate information

d) whether the evidence demonstrates that such interactions were directed or encouraged by SYP

This chapter focuses on part a and some interactions with MPs, in relation to what they then said to the media (part b). Chapter 8 covers parts b and c.

What was found?

- **The IOPC has not found any evidence to suggest that the behaviour of supporters caused or in any way contributed to the disaster.** There was little or no evidence to support the main allegations reported in the media about the behaviour of supporters on the day of the disaster.
- **In relation to supporters' alcohol consumption**, there was a clear divide between the evidence of many police officers, who broadly suggested that there was an unprecedented level of alcohol consumption, and the evidence of most supporters, who indicated that there was nothing out of the ordinary. **The majority of third-party accounts, images and video do not support the suggestion that drinking was at unprecedented levels.**
- **The allegation that supporters burned a police horse with cigarettes is not supported by evidence.** In fact, the evidence gathered by the IOPC shows that this claim was not only improbable, but implausible.
- Though it has long been assumed that *The Sun* was the first newspaper to print stories which painted the supporters in a negative light, the IOPC confirmed that similar **allegations had been reported by local news outlets the *Sheffield Star* and White's News Agency the day before they were published in *The Sun*.**

- **The available evidence suggested that a key source of information for the White's news feed—and possibly the *Sheffield Star* article—was Irvine Patnick, the then Conservative MP for Sheffield Hallam.** Mr Patnick's own notes from the time show that he spoke to several police officers on the evening after the disaster; they told him various stories about supporters, which he then repeated to the media.
- **No officer admitted being the source of the anonymous comments published in *The Sun* or any of the other media coverage.** With just one exception—the probable identification of a chief inspector quoted in one article—the IOPC was not able to identify the officers who spoke to journalists.

Significant new evidence

To investigate police interactions with the media, the IOPC contacted almost 200 journalists who had been at the ground on the day, or whose name appeared on any of the articles published in the days that followed the disaster, asking them about the sources of their stories and whether they had spoken to any police officers.

7.1 Media coverage of the Hillsborough disaster has been a source of enduring controversy, primarily due to the way that Liverpool supporters were portrayed.

7.2 From the earliest reports, there were suggestions in the media that the disaster had been caused by the actions of supporters. A central allegation was that large numbers of supporters had been drunk. Further coverage then insinuated that supporters had hindered rescue efforts and, in the most notorious article published by *The Sun*, even claimed that some supporters had acted disrespectfully towards those who had died.

7.3 This led to a lasting public perception that the behaviour of supporters was, at best, uncaring and unsavoury; at worst, that it directly contributed to the disaster.

7.4 This coverage has been repeatedly discredited, not least following the conclusion of the Goldring Inquests, where the jury found the behaviour of the supporters did not cause or contribute to the dangerous situation at the Leppings Lane turnstiles.

7.5 The tone and content of the media coverage has caused enormous distress to many Liverpool supporters and residents, to those who were at the game and to those who lost family members or friends. The IOPC investigation focused on the role of the police in the coverage, looking at what officers may have said to journalists and whether there was any evidence of a coordinated effort to influence media coverage.

Initial media coverage

7.6 From the afternoon of the disaster onwards, media outlets turned to police forces and individual officers for information about what had happened. The first TV and radio reports from the BBC (which was broadcasting at the game) included suggestions that the disaster had occurred after supporters forced open a gate to gain entry to the stadium. This same explanation had been given by Ch Supt Duckenfield, in his first conversations with senior officials from the FA and SWFC who were at the game.

7.7 These suggestions were corrected by CC Wright on the evening of the disaster. In a press conference, he confirmed that the gate had been opened by the police. Nonetheless, the next day some newspapers included the suggestion that supporters had forced a gate.

7.8 During the Goldring Inquests, Ch Supt Duckenfield admitted that his account to FA and SWFC officials had been a lie and apologised for it.

7.9 In the days that followed the disaster, reports in the national and regional media described Liverpool supporters at the game as drunk, and repeated allegations that supporters had forced entry into the stadium. While this was by no means the tone of all the media coverage, the focus on the behaviour of Liverpool supporters intensified. On Tuesday 18 and Wednesday 19 April, numerous newspapers published articles which alleged that some supporters had attacked police officers and stolen from those who had died. One of these reports was an article in *The Sun*, headlined 'The Truth'.

7.10 Many of these reports quoted unnamed police sources, making comments that were highly critical of the behaviour of Liverpool supporters. Some of these police sources were described as "senior officers"; *The Sun* attributed comments to "a high-ranking officer at the ground".

7.11 The HIP Report cited a range of documents and other material that raised questions about the accuracy of the information given to the media by police sources in the immediate aftermath of the disaster. It found no documentary evidence to support many of the stories that had been repeated in media coverage over the years.

7.12 It also raised a more serious allegation: that SYP, in an organised and deliberate way, may have sought to use the media as a means of deflecting the blame for the disaster away from the police, on to Liverpool supporters.

The focus of the IOPC investigation

7.13 The focus of the IOPC investigation was not on the accuracy or appropriateness of the coverage itself—the IOPC has no authority to investigate the media—but on the roles played by police officers in the media reporting. The IOPC also looked into the interactions of SYP officers with journalists.

7.14 Following the publication of the HIP Report, SYP referred a range of allegations to the IOPC for investigation. This referral identified various potential criminal offences, including attempting to pervert the course of justice by misleading the press, and perverting the course of justice by providing copies of officers' accounts to White's News Agency.

7.15 WMP also referred some matters to the IOPC, including the leaking of SYP accounts to the media, because evidence suggested that this happened after WMP had collected officer accounts from SYP.

7.16 The IOPC also received a number of complaints relating to police interaction with the media.

- Some related to Ch Supt Duckenfield's comments to officials from SWFC and the FA that the disaster had been caused by supporters forcing a gate, which the officials then passed on to the media.
- Others referred to an interview with CC Wright, which was published in the *Sheffield Star* on 5 February 1990. In it, he was quoted as making critical comments about the Taylor Inquiry and suggesting "a different picture" would emerge at the forthcoming inquests. The complainants alleged he deliberately misled the journalist and could potentially have prejudiced jurors at the forthcoming inquests.

7.17 To investigate these allegations, IOPC investigators reviewed hundreds of newspaper articles related to the disaster, from national and local publications. This was supported by a review of existing statements and documents held in the archived material, including the SYP press log, which was intended to provide a record of all contact between the SYP press office and the media. Through this approach, the IOPC was able to build a detailed timeline of the evolving media coverage.

7.18 When taking statements from (former) SYP officers, investigators routinely asked them if they had any contact with the media in the aftermath of the disaster. The majority said they did not; some recalled being contacted by journalists but said they had not provided them with any information. The IOPC also took statements from SYP officers or civilian staff who were known to have interacted with journalists, including those who worked in the SYP press office at the time.

7.19 IOPC investigators traced and, where appropriate, took witness statements from newspaper journalists whose names appeared on the articles, as well as others who were known to have been in the press box at the stadium on the day of the Semi-Final. Almost 200 journalists were contacted and asked about their recollections of the disaster and its aftermath; based on their responses to investigators' preliminary questions, 44 were asked to provide statements to the IOPC. Of these, 24 worked on local or regional newspapers, six were national media journalists who were in the press box on the day of the disaster, and 14 were national journalists who appeared to have used material from the White's news feed.

7.20 Journalists were also asked about any interactions they had with police officers. Many said they did not speak directly to police officers; a small number recalled they had done but could not remember the officers' names or any identifying details. Some specifically told the IOPC that if they could remember the officers' names, they would have willingly disclosed them, as they felt any right the sources may have had to anonymity had been lost by the fact that the stories had been false.

Media coverage on the day of the disaster

7.21 The first reports of an incident came shortly after the match had been stopped. Gerald Sinstadt, working at the ground for the BBC, told viewers of the TV show *'Grandstand'* that some Liverpool supporters were on the pitch because there had been "too many spectators" at the Leppings Lane end. He noted that some supporters were receiving treatment from SJA.

7.22 At 3.25pm, also on *'Grandstand'*, commentator John Motson said: "I have to say that this what [was] not caused by as far as we know by misbehaviour, except the reason it happened was because one of the outside gates here was broken and non ticket holders forced their way in and overcrowded the section at the Leppings Lane end occupied by the genuine authentic ticket holders."

7.23 In a later statement, he said that this was based on information he had been given by the BBC producer, who he believed had been told this by the police. The producer had no recollection of this.

7.24 At 3.40pm, in a live broadcast, BBC radio commentator Alan Green stated that there were unconfirmed reports that a door had been broken down at the Liverpool end of the stadium.

7.25 This was followed at 4.15pm by an initial media statement from SYP: "About five minutes after game started there was a serge [sic] of fans at the Leppings Lane end of the ground which was occupied by the Liverpool supporters. There was a spillage onto the ground and a number of people were injured."

7.26 At 4.30pm, Mr Green reported on BBC radio that there had been a surge at the Leppings Lane end, "composed of about 500 Liverpool fans and the police say that a gate was forced and that led to a crush in the terracing area."

7.27 At 4.49pm, FA Chief Executive Graham Kelly gave an interview to the BBC and stated that there were "two versions of what went wrong. The first is that a door or doors were forced down the second is that a door or doors was or were opened by someone in authority."

7.28 Cumulatively, this amounted to a series of reports via a national broadcaster that indicated the disaster had been a result of supporters forcing their way into the stadium.

7.29 At 7.15pm, CC Wright addressed a press conference at SYP HQ. He informed journalists that 93 people had been confirmed dead (which was correct at the time he gave the information) and at least 200 had been injured. He also stated that a gate had been opened at the request of the police to relieve the crush outside the stadium, but said he was "not aware of any connection between the opening of the gate and the surge on the terrace." As he left the press conference, he shouted words to the effect that his officers would be vindicated.

7.30 Though CC Wright was quite clear that a gate had not been forced, the damage had been done. The next day, some newspapers reported that the gate had been forced by supporters. This, and the initial broadcast media reports, were hugely influential in the growth of an enduring and widespread public perception that the supporters' actions had caused the disaster.

7.31 A range of evidence supports that the most likely source of this story was Ch Supt Duckenfield—albeit indirectly. At 3.15pm, he spoke to Mr Kelly and the FA's Head of External Affairs Glen Kirton and led them to understand that a gate had been forced by Liverpool supporters. Then at 3.35pm, he gave a similar impression to SWFC directors and others in the boardroom at the stadium.

7.32 The IOPC has not found any evidence to indicate that Ch Supt Duckenfield spoke directly to TV or radio broadcasters on the day of the disaster, or to any media in the days that followed. Despite this, the comments he made were widely reported in the media. Lord Justice Taylor confirmed this in his Interim Report, writing that Ch Supt Duckenfield "gave Mr Kelly and others to think that there had been an inrush due to Liverpool fans forcing open a gate. This was not only untruthful. It set off a widely reported allegation against the supporters which caused grave offence and distress."

7.33 A transcript has been found of an interview Mr Green conducted with Mr Kelly, but the exact time is not confirmed on it. In this, Mr Kelly stated that he had "been in the Police Control Box and they tell me that a gate or gates was opened or broken and fans came in." When Mr Green responded that they had heard reports that a gate was opened under police orders, Mr Kelly replied: "I've only spoken very briefly to the Police commander and that wasn't the impression that I got."

7.34 In his evidence to the Goldring Inquests in 2015, Ch Supt Duckenfield accepted that he had told Mr Kelly and others a lie and said he apologised unreservedly to the families of those who died for doing so.

7.35 He stated that immediately after speaking to Mr Kelly and Mr Kirton in the PCB, he realised the partial explanation he had given—that supporters had come through a gate—would be open to misinterpretation as he had not clarified that the gate had been opened on police authority.

7.36 If indeed he did realise this, it is notable that he did not seek to correct the impression he had given to Mr Kelly and Mr Kirton. Instead, he offered a very similar explanation shortly after in the SWFC boardroom.

7.37 This was a different account to the one he gave to the Taylor Inquiry. There, he accepted that he may have misled Mr Kelly and Mr Kirton, but suggested it was because he was in shock. He added under further cross-examination at the Inquiry that he had acted "in good faith". He then claimed that he had not told them the police had opened the gate because he "was concerned about the crowd situation, and I didn't want the public at large, via the media or by casual conversation, to become aware… of the opening of the gates by police officers, and the disaster."

7.38 In 2019, Ch Supt Duckenfield faced a retrial for manslaughter relating to the disaster. His barrister said that his client's admission at the Goldring Inquests that he had lied had been taken out of context and had been made with the benefit of hindsight.

7.39 On 22 November 1989, WMP recorded a complaint that Ch Supt Duckenfield "was deceitful and intentionally misled senior police officers and members of the public regarding his command and control of police officers on the day." Part of this related to the explanation he gave to the FA and SWFC officials.

7.40 WMP investigated the complaint and concluded "That Chief Superintendent Duckenfield misled Jackson, Kelly and Kirton seems clear, that he did it deliberately or deceitfully is not supported by the evidence available."

7.41 The PCA, which was the national body that oversaw complaints against police officers at the time, disagreed with this opinion and recommended that SYP should bring disciplinary proceedings against Ch Supt Duckenfield for the lie. These proceedings never took place, as Ch Supt Duckenfield retired early from police duty due to ill health.

7.42 When the IOPC began its investigation in 2012, the complaint was reopened, using new powers that the IOPC had requested to allow it to reinvestigate matters that had been dealt with by its predecessors. Having reviewed the evidence, the IOPC found that Ch Supt Duckenfield would have faced a case to answer for gross misconduct, if he had still been serving. This was on the basis that he knowingly made false, misleading or inaccurate oral statements in the PCB and the SWFC boardroom by suggesting that Gate C had been forced open by supporters, when he knew that he gave the order for the gate to be opened.

Investigating the sources of media stories

7.43 There is a range of evidence to indicate that police officers spoke to the media about the disaster.

7.44 On Sunday 16 April, the SYP press log recorded an enquiry from Bob Westerdale, a journalist at the *Sheffield Star*, who said that he had "info from an unnamed officer who said the trouble was caused by 4000 drunken Liverpool supporters." According to the press log, the SYP press office did not comment.

7.45 On Monday 17 April, among the extensive media coverage of the disaster, several newspapers published quotes from police officers—none of whom were named. For example, in *The Independent*, an officer was reported as saying: "I know my back will be covered in bruises. It's been kicked all afternoon by Liverpool supporters while I've been trying to tend the injured."

7.46 *The Times* included the comment: "Fellow officers were punched and kicked as they carried a dead girl, about nine years old, from the ground." As the youngest person who died in the disaster was a boy aged 10, and the youngest woman who died was 15, it is not clear who this officer was referring to.

7.47 The SYP press log that day recorded queries from journalists at the *Sheffield Star* and *The Sun* asking for police comment on various allegations of misbehaviour by supporters; both reportedly asked about the allegation that officers had been urinated on. The press office did not comment on the allegations.

7.48 In its City Late edition (published mid-afternoon), the *Sheffield Star* named Supt Marshall as the police officer who had opened a gate at the stadium. The front-page article stated that he had made the decision "fearing a wall was seconds away from collapsing on hundreds of fans" outside. The article quoted an unnamed "high-ranking" colleague and an "officer at the scene", both of whom offered support for Supt Marshall. Neither was quoted as commenting on the behaviour of supporters. However, the article did include references to some fans being "the worse for drink" and arriving late.

7.49 The comments in support of Supt Marshall were repeated in the *Daily Mail* on 18 April. The paper also included quotations from PC Middup, who was the SYP Police Federation representative. He strongly criticised the behaviour of supporters, stating that "they were arriving tanked up on drink", and that: "Even as our lads were giving the kiss-of-life to victims they were being spat upon and pelted with coins." The same article also quoted an unnamed chief inspector, who stated: "I have no doubt that a major contributory factor in the disaster was excessive drinking."

7.50 In its first edition of the day, published around lunchtime, the *Sheffield Star* included an article headlined: 'Fans in drunken attacks on police'. The article claimed: "Emergency workers were attacked and even urinated on by drunken fans". One "high-ranking officer" was quoted as saying: "Some were like animals: drunk and violent". The same quotation concluded: "People were picking coins off the floor as victims lay needing help."

7.51 The same day, White's News Agency issued a news feed consisting of three stories, all of which included allegations about supporter behaviour. Such feeds were made available to newspapers and other media outlets to reuse for a fee. The first article in the feed quoted three unnamed officers. In the second piece, an unnamed officer stated: "People were picking up coins which had fallen from victim's pockets as they lay on the floor", and one "high-ranking officer" was quoted as saying: "Some of them were like animals, they were drunk and violent." These words were almost identical to one of the quotations in the *Sheffield Star*; however, the White's feed split the quotation between two officers. The second story also quoted PC Middup, using quotes very similar to those featured in the *Daily Mail* that morning.

7.52 The third story in the news feed was an extended quote from Irvine Patnick, Conservative MP for Sheffield Hallam.

7.53 In its West End Final edition that evening, the London *Evening Standard* published the material from White's, largely verbatim.

7.54 At 6.30pm, the SYP press office received the first of a series of queries from journalists regarding a report they had received from an agency about supporters attacking the police. According to the press log, each caller was referred to WMP, which had by this time been given responsibility for investigating the disaster.

7.55 At 9pm that evening, both PC Middup and Mr Patnick featured in a BBC News broadcast. Both made comments about the behaviour of supporters that were similar to the quotes that had already been attributed to them in newspaper coverage.

7.56 At 10pm, Mr Patnick was featured in an *'ITN News'* broadcast, again repeating the allegations. He stated that he had spoken to officers who had been attacked.

7.57 On Wednesday 19 April, several national newspapers published articles that appear to have been strongly based on the White's news feed of the previous day. These included *The Times,* the *Daily Express*, the *Daily Mail* and the *Daily Mirror.*

7.58 The paper that gave the stories the greatest prominence was *The Sun*, in a now notorious article headlined 'The Truth'. The key difference between *The Sun*'s coverage and that of other papers was that, rather than couching the stories in the language of allegations, *The Sun* published them as facts—emphasised by its headline. It also added two aspects that were not in the White's feed: a further allegation and a quote from PC Middup, suggesting that *The Sun* had requested a comment from him.

7.59 Though media coverage of the disaster continued, the intensity reduced after this. It is clear that these initial stories were the most influential in terms of public opinion and caused the greatest distress.

7.60 The IOPC sought to identify the sources of the stories and in particular the quotes. Aside from official statements made in press conferences by CC Wright, the only police officer who was named as commenting on the behaviour of supporters was

PC Middup. He was first quoted on the subject in the national papers on the morning of Tuesday 18 April. Other quotes were attributed variously to "officers who had been on duty", "senior officers" and "experienced officers".

7.61 There were two similar comments, both attributed to unnamed chief inspectors. In the *Daily Mail* on 18 April, a chief inspector was quoted as saying: "I have no doubt that a major contributory factor in the disaster was excessive drinking." Then in an article from a different paper—which appears to be the *Sheffield Star*—an unnamed chief inspector was quoted as stating: "I am convinced excessing drinking was a major contributory factor."

7.62 In this second article, the chief inspector was described as having "emerged from the temporary mortuary." There were two chief inspectors known to have been in the temporary mortuary. Based on the strong similarity between these comments and words he has used in other accounts, the IOPC has identified that Ch Insp Sumner was the most likely source of these comments. This clear similarity led to a complaint about Ch Insp Sumner speaking to the media in this way so soon after the disaster. The IOPC has upheld this complaint, as in speaking to the media in this way Ch Insp Sumner did not deliver the level of service the public would expect.

7.63 Despite asking dozens of officers, as well as over 100 journalists, IOPC investigators have not been able to identify any other officers who spoke to journalists. No officer has admitted being an unnamed source. Even those officers who have given accounts, as recently as the Goldring Inquests, describing high levels of alcohol consumption among supporters, have flatly denied speaking to the media in the immediate aftermath of the disaster.

7.64 None of the *Sheffield Star* journalists interviewed by the IOPC said they knew where the original allegations regarding supporters' behaviour came from. Several journalists from other media outlets referred to stories and rumours about supporter behaviour beginning to circulate after the disaster. However, none of journalists interviewed by IOPC investigators were willing or able to identify a police source. Apart from calling the SYP press office, very few even recalled speaking to a police officer.

7.65 A common view among the journalists interviewed was that, at the time, they trusted police officers to tell them the truth and did not question what officers had told them. However, most would seek corroboration from at least one other source—potentially, though not necessarily, another officer—before proceeding with a story. This was certainly the view of journalists at both White's and the *Sheffield Star.* Once a quote was published by another news outlet, others would feel able to reuse it without seeking corroboration themselves.

7.66 Two individuals have acknowledged their role in sharing stories with the media: PC Middup and Mr Patnick.

7.67 In a statement to the IOPC, PC Middup confirmed that he had made all the comments attributed to him. He explained that, in engaging with the media in relation to the disaster, he simply repeated what officers had told him. He added that he had not checked whether their accounts were true before sharing them. In fact, the IOPC has found evidence that he did seek to get some of the details confirmed at a Police Federation meeting on 18 April, where according to the minutes, he specifically "asked for the names of people who were abused because the Inquiry will want to know them." This was after he had first spoken to the media.

7.68 Mr Patnick's own notes from the time show that on the evening of the disaster, he went to the Niagara Police Sports and Social Club, which had been opened as an informal meeting point for officers. While he was there, Mr Patnick spoke to a group of SYP officers who made various allegations about the behaviour of Liverpool supporters. These included reports of officers being assaulted and urinated on by supporters. At the end of the conversation, Mr Patnick was asked by the officers to speak up for them and to tell Parliament what had happened.

7.69 Mr Patnick's notes state that he "was advised by senior officers to take what had been said 'with a pinch of salt.'" However, Mr Patnick subsequently repeated several of these stories to the media.

7.70 Further, on 20 April 1989, Mr Patnick wrote to Lord Justice Taylor, whose inquiry had been announced. He explained that he had deliberately spoken to the media about the behaviour of Liverpool supporters: "Eventually after being sickened by the 'myths' that had sprung up about the disaster I repeated the story in part to the media in order to correct the rumours circulating the police officers had related to me." He added: "I am not aware of names ranks or numbers of the officers but do believe they were telling me the truth."

7.71 Following the publication of the HIP Report, Mr Patnick issued a statement, acknowledging that he had repeated to the media information that he had been given by officers. He apologised for not questioning the accuracy of that information. Mr Patnick died shortly after the IOPC investigation began and investigators did not have an opportunity to interview him.

7.72 There is some evidence to indicate that Mr Patnick did seek to check the accuracy of what he had said. On 12 July 1989, Peter Moxon of White's sent a letter to Mr Patnick including extracts from "sworn statements" made by witnesses. The IOPC has established that these were in fact not signed and sworn statements, but accounts written on plain paper from a small number of police and ambulance officers, apparently sent in response to a request from Mr Patnick. The extracts included references to officers being attacked, spat at and urinated on by supporters. One officer also alleged that he had seen supporters stealing.

7.73 Mr Patnick responded on 27 July 1989 thanking Mr Moxon for the accounts. He noted they "actually confirm everything you stated". It is not clear whether Mr Patnick was referring to what was stated in the content of the news feed or what may have been stated in separate conversations.

7.74 The IOPC has not been able to establish how White's received the accounts. Mr Moxon could not recall it. However, it is unlikely that White's had received the accounts by the time it sent out the news feed that included allegations around supporter behaviour. The feed was sent on 18 April 1989; most officers had not completed their accounts by that date.

7.75 No one who provided a statement to the IOPC—from SYP, WMP and SYMAS officers, to solicitors working for any of these organisations—has indicated in any way that they passed the accounts to White's or even that they were aware that it was done.

7.76 The evidence available to the IOPC gives the strong impression that both Mr Patnick and PC Middup simply repeated stories they had been told, without checking them.

Where were allegations about supporter behaviour first published?

7.77 As set out in paragraph 7.45, the first media reports that raised allegations of supporter misbehaviour were published on 17 April. However, it was on 18 April that the allegations escalated, with both the *Sheffield Star* and White's producing stories with similar details.

7.78 The IOPC sought to establish which of the two outlets had been the initial source of these stories.

7.79 Assuming the *Sheffield Star* followed its normal publication times—and no evidence has been found to suggest it did not do so on 18 April 1989—its article 'Fans in drunken attacks on police' would have been available from early afternoon, or possibly even late morning.

7.80 For White's, sending news feeds to the nationals was (and remains) a central part of its business. However, it did also sell stories to the *Sheffield Star.* Therefore, it is possible that the story in the *Sheffield Star* could have been based on a White's news feed. However, the evidence examined by the IOPC suggests this is unlikely.

7.81 Firstly, the White's news feed was built up over the course of the day. The initial feed, consisting of just one story, was issued on the morning of 18 April. According to White's, the second and third parts were then produced in the afternoon. These would, therefore, have been added **after** the *Sheffield Star*'s first edition—which included the article—was printed.

7.82 Secondly, in their statements to the IOPC, the White's journalists indicated that they had not done much investigative work around the disaster in the immediate aftermath. The reason was that the majority of their clients—the national media—had sent their own reporters to Sheffield and so did not need the services of a press agency.

7.83 By contrast, one of the journalists whose name appeared on the *Sheffield Star* article 'Fans in drunken attacks on police' recalled producing the article. He told IOPC investigators that it took some time to research and develop. Rumours had been circulating about supporter behaviour, so he and a colleague were instructed to interview local residents and workers near the ground. They sought to substantiate claims before the paper was willing to print the article.

7.84 The White's journalists who gave statements to the IOPC did not have any recollection of speaking to local residents. However, it does appear that White's did have some contact with police officers in this period.

7.85 On 12 June 1989, White's sent a memo to the news editor of the *Evening Standard* regarding the news feed it had sent out on 18 April 1989. The *Evening Standard* had been one of the first papers to print the allegations made in the feed.

7.86 In the memo, White's provided an explanation of how the agency came about the information contained in the feed: "all the allegations in the stories we filed were made, unsolicited, by ranking officers in the South Yorkshire force to three different experienced senior journalists who are partners in this agency."

7.87 The memo further explained that the first claims were received on the night of the disaster, when an officer told one of the journalists about being punched and urinated on. The following day, another of its journalists met by chance with a different officer who said they had witnessed bad behaviour by supporters. At that stage, White's felt there was not enough confirmation to send a story making such serious claims.

7.88 However, when a third officer reiterated the allegations, White's felt it was appropriate to send the story out.

7.89 There were five journalists at White's at the time who fitted this description of 'experienced senior journalists'. Two had died before the IOPC investigation began. The IOPC interviewed the other three. None recalled the memo, and none said they were one of the journalists to whom unsolicited allegations were made.

7.90 However, all three stated that if they did know the names of any officers who had spoken to the media, they would have been more than willing to disclose them to the IOPC. They commented that the story had damaged the reputation of White's, and they also all felt that any right the sources may have had to anonymity had been lost by the fact that the stories had been false.

7.91 This raises the possibility that officers spoke to both the *Sheffield Star* and White's. As noted, the IOPC was not able to identify the officers quoted anonymously. No officer admitted being the source of these quotes. However, it strongly appears that some officers spoke to the media and commented on the behaviour of supporters. A crucial part of the IOPC investigation was therefore to consider whether any of these comments were inappropriate or inaccurate.

Examining the evidence around allegations about supporter behaviour

7.92 The IOPC examined the evidence around each of the allegations about supporter behaviour that were reported in the media.

7.93 Again, the focus was to look at whether the allegations were based on comments made by police officers and if so, whether there was evidence to support the comments.

7.94 In most cases, even where the reports appeared to indicate that police officers may have been the source of the allegation, the evidence of disruptive supporter behaviour was—and still is—very limited.

7.95 For example, WMP sought to investigate the allegation about supporters coming to the ground without tickets by including a question on the standard questionnaire it used for Liverpool supporters about whether they had got an advance ticket for the game and whether they still had it.

7.96 On 12 June 1989, WMP sent an update on the issue to the Taylor Inquiry team, based on a review of 1,699 questionnaires WMP had completed with Liverpool supporters. Of these, 136 (8%) said they had travelled to Sheffield without a ticket for the Liverpool section. When questioned, 42 said they bought a ticket from a tout. A further 46 said they bought a ticket near the ground, without specifying from whom, while 36 entered the ground without a ticket. WMP applied these figures to the total number of tickets available for Liverpool supporters and suggested that alongside the 24,000 Liverpool supporters with tickets there would have been 2,088 without. This was at best a

miscalculation: WMP found that just 36 of the 1,699 entered the ground without a ticket, equivalent to 2.1%, which if applied to the maximum attendance would have amounted to 212 supporters entering without tickets.

7.97 WMP did not provide any information about how this compared to other all-ticket games. Further, it would be logical that those who bought tickets from touts would not have then attempted to enter the ground without a ticket.

7.98 Detailed analysis by the HSE, carried out in preparation for the Popper Inquests in 1990, concluded that the total number of people on the Leppings Lane terraces on the day did not exceed the maximum allowed capacity of 10,100. It established that 7,494 supporters had entered the Leppings Lane terraces via the turnstiles; the HSE estimated a further 2,020–2,480 came through Gate C when it was opened at 2.48pm and 2.52pm. This indicates that fewer than 10,000 Liverpool supporters entered the terraces in total, undermining the suggestion that the crowd was swelled by people without tickets.

7.99 Similar gaps or uncertainties exist around other allegations reported in the first few days. For example, several newspaper reports claimed that police officers had been attacked by supporters as they attempted to rescue people from the crush. Though the IOPC found references in a number of officers' original accounts to being struck in some way, by the time these officers gave accounts to Operation Resolve or the IOPC they were in general less definite that they had been attacked by supporters, as opposed to simply being jostled in the rescue effort. A comprehensive analysis of video footage and photos taken on the day found very little that depicted or even suggested supporters were attacking police officers.

7.100 WMP sent a list of 34 witnesses to the Taylor Inquiry who claimed they had seen officers being spat at. These included some supporters and other eyewitnesses as well as officers. In several cases, the alleged spitting took place outside the ground, or in other places away from the rescue effort. Three of the witnesses specifically noted that the spitting was by Nottingham Forest supporters rather than Liverpool supporters; one PC stated that he was spat at by supporters of both sides.

7.101 It is understood that it was not uncommon for football crowds at the time to spit at police officers. Further, it would not have been a cause of the disaster, nor would it have hampered any rescue efforts.

7.102 One of the stories in the White's news feed focused on allegations of stealing. An anonymous officer was quoted as saying: "There was a lot of pilfering going on while the bid to save lives was taking place." The story included the claim that Liverpool supporters were "picking the pockets of victims", which was then repeated in *The Sun.*

7.103 At the Police Federation meeting on 19 April 1989, two officers were reported as saying that one of those who died in the disaster had "numerous wallets" in his possession. This was apparently accepted by the meeting as evidence of stealing among the Liverpool supporters. However, this allegation was comprehensively dismissed at the Goldring Inquests, by reference to a police log which listed the property of each of those who died. None had more than one wallet in their possession.

7.104 No police force or other investigation has ever received any complaint from a family member of someone who died in the disaster about theft from their loved one.

7.105 The central allegation about the behaviour of supporters was that a large number were under the influence of alcohol. Here there was, and remains, a clear divide in the evidence.

7.106 In broad terms, supporters have consistently stated that the overwhelming majority of fans did not drink to excess and that there was nothing unusual or remarkable about the level of drinking by supporters before the game. By contrast, a significant proportion of police officers have consistently stated that the level of alcohol consumption was much higher than normal for a football match.

7.107 There is insufficient evidence from any other source to say with certainty which of these perceptions was correct. However, perhaps the pivotal point of the media coverage was the inference that excessive drinking had been a factor in the disaster—if not as a direct cause, then at least aggravating the situation in some way and making the rescue effort harder.

7.108 This claim was rejected as early as the Taylor Interim Report in August 1989, which suggested that officers had overstated the impact of alcohol as a way of explaining the loss of police control. Further investigations, including most recently the Goldring Inquests, did not find evidence to suggest that alcohol consumption was a factor. The jury at the Goldring Inquests concluded that there was no behaviour on the part of football supporters which caused or contributed to the dangerous situation at the Leppings Lane turnstiles. Similarly, the IOPC has not found any evidence to suggest that the behaviour of supporters caused or contributed to the disaster.

No evidence of an organised media campaign

7.109 While the available evidence indicates that some officers did speak to the media, the IOPC has not found evidence that this was done in an organised way, or at the instruction of SYP senior officers.

7.110 In fact, there is evidence on two occasions of senior officers specifically instructing colleagues **not** to speak to the media.

7.111 On 19 April 1989, the day *The Sun*'s article was published, an entry on the SYP press log stated: "With immediate effect no South Yorkshire Police Officer will make any statement or comment to members of the media about the incident at Hillsborough football ground on Saturday 15 April 1989 without the Chief Constable's **express** permission and approval." An instruction to this effect was circulated throughout SYP that day, suggesting it may have been in response to the media coverage, including officers' comments, that morning.

7.112 Then on 29 April, DCC Hayes circulated a memo reminding all officers that no one was to speak to the press without the express permission of the Chief Constable.

7.113 These instructions were in keeping with SYP's Standing Order 31B (Media Liaison), which stated that "members of the Force, other than authorised, must not supply information to media enquiries on police matters". This Standing Order instructed that in the case of criticism of the police or matters with which the Police Authority was likely to be concerned, "the supply of information to the media… will be restricted to chief officers." It is reasonable to suggest that officers of all ranks would have known that the Hillsborough disaster was one such matter.

Media coverage relating to an interview with CC Wright

7.114 The final topic considered under this term of reference related to media coverage that followed an article based on an interview CC Wright gave to the *Sheffield Star* in February 1990. This was after the Taylor Inquiry had published its Final Report and CC Wright had announced he would be retiring on 1 May 1990.

7.115 CC Wright was quoted in the article as suggesting that he didn't understand the Taylor Inquiry's finding that supporters' alcohol consumption had not contributed to the disaster. He was also quoted as saying "a different picture" would emerge at the forthcoming inquests.

7.116 After the interview was published by the *Sheffield Star*, it formed the basis for articles in several national papers too. CC Wright also gave an interview to *The Times.* SYP received three complaints about CC Wright's comments from family members of people who had died in the disaster. The complaints all suggested that CC Wright was abusing his position in relation to his access to the media; that his remarks could prejudice the forthcoming inquests; and that the comments about a "different picture" emerging appeared to be related to allegations of high levels of alcohol consumption among supporters.

7.117 These complaints were investigated in 1990, as part of WMP's disciplinary investigation. CC Wright was interviewed by the investigating officers; he stated that the journalist had linked two distinct and unrelated points he had made, to create a slightly different meaning in the article.

7.118 The journalist was also interviewed and provided a full transcript of his conversation with CC Wright. This strongly supported CC Wright's account. The transcript showed that CC Wright did say that he expected new evidence to emerge at the forthcoming inquests but did not say that this new evidence related to alcohol, as the article had indicated.

7.119 The complaint investigation concluded: "There is nothing in the words used by Mr Wright which can be construed as inaccurate, unfair, irresponsible or unjust" and there was "no evidence that Mr Wright was intending to influence the Inquests or any other proceedings".

7.120 The IOPC re-examined this complaint, and found the transcript supports CC Wright's assertion that his comments were made as separate points and had then been linked in the article.

7.121 Nonetheless, making comments that in any way cast doubt on the Taylor Inquiry conclusions was ill-timed ahead of the Popper Inquests and could be seen as an attempt to undermine the Inquiry's conclusions. His actions were insensitive, and when invited to withdraw his comments, he declined—indicating he did not necessarily disapprove of the manner in which they had been reported.

7.122 The IOPC therefore concluded that CC Wright's actions in relation to the articles could be deemed to have breached the discreditable conduct standard, and that he would have had a case to answer for misconduct, if he had still been serving.

7.123 These articles were the final stage in a series of interactions between CC Wright and the media, from the press conference on the evening of the disaster onwards. There, he had asserted that his officers would be vindicated, inferring from the outset that he did not believe the police were to blame, despite his acknowledgement that Gate C had been opened on police instruction. Over the following months, he consistently

expressed to colleagues a view that supporters were in some way to blame for the disaster. When he gave the interview to the *Sheffield Star*, and another to *The Times* at around the same date, he expressed reservations about the Taylor Inquiry finding that alcohol consumption by supporters had no effect on the events. He also made some veiled procedural criticisms, relating to the way the Taylor Inquiry heard evidence.

7.124 These remarks were insensitive, cast at least some doubt on Lord Justice Taylor's conclusions and could have had the effect of prejudicing the inquests. Having considered all of these interactions, the IOPC view was that CC Wright therefore would have had a case to answer for gross misconduct, on the grounds of discreditable conduct.

8. SYP's engagement with MPs after the disaster

What was investigated?

Under the term of reference covering SYP's engagement with the media and MPs in the aftermath of the disaster, the IOPC investigated:

The interactions of police officers with the press and politicians, in particular:

a) whether any police officer was involved in the passing of inappropriate or inaccurate information to a journalist, including whether any police officer was involved in passing written accounts to the press

b) whether any police officers passed inappropriate or inaccurate information to any Member of Parliament—whether individually or at meetings. This will include investigation of the actions of Chief Inspector Norman Bettison in visiting Parliament and the evidence he presented, its content and subsequent use by others

c) whether the briefing which was given to the Home Secretary and Prime Minister on the day after the disaster contained any inaccurate or inappropriate information

d) whether the evidence demonstrates that such interactions were directed or encouraged by SYP

This chapter focuses on parts b and c. Some interactions with MPs, in relation to what they then said to the media were covered in chapter 7, along with issues under part a.

What was found?

- **Despite wide-ranging enquiries, it has not been possible to establish what SYP officers told the then Prime Minister, Margaret Thatcher, when she visited Hillsborough Stadium the day after the disaster.** Key witnesses have provided very different accounts of what was said.
- **At a meeting with Michael Shersby MP, the then parliamentary advisor to the Police Federation, in October 1989, some officers described the behaviour of supporters in more critical terms than they had done in their original accounts.** This was in the context of an attempt to address a perceived imbalance in the Taylor Interim Report, which some officers described as a whitewash.
- **MPs who attended an SYP video presentation in Parliament about the disaster felt that the force was trying to present its side of the story.** None felt it changed their understanding of events.

Significant new evidence

The IOPC obtained three versions of a similar video, all of which fulfil the description of the video shown at both the meeting with Mr Shersby and the presentation in Parliament. The videos were provided by different sources. The IOPC has analysed these; two are identical and the third is a few minutes longer and has a different voiceover. The IOPC has not been able to confirm which was shown on either occasion.

In addition, the IOPC has taken statements from several MPs and former civil servants who attended one or more of the meetings under investigation for this term of reference.

8.1 After the IOPC announced its investigation into the aftermath of the Hillsborough disaster, it received a number of complaints relating to police interaction with MPs. These came from supporters who had been at the game and survived the disaster, and from family members of those who died, and focused on three events.

- The visit of the then Prime Minister, Mrs Thatcher, to Sheffield the day after the disaster, and what information officers gave her and her advisers during it.
- A South Yorkshire Police Federation meeting on 3 October 1989, where numerous police officers told Mr Shersby that they had been prevented from giving evidence about supporter behaviour to the Taylor Inquiry. At the time, Mr Shersby was the parliamentary advisor to the Police Federation for England and Wales. At the meeting, these officers (who were not named in the meeting notes) recounted their experiences on the day of the disaster. Several expressly stated that they hoped Mr Shersby could use their accounts in parliamentary debates relating to the disaster.
- A visit to Parliament by Chief Inspector Norman Bettison (Ch Insp Bettison) of SYP on 8 November 1989, where he gave a video presentation to 12 MPs about the disaster. Complaints referred to both the act of going to Parliament in this way, and the content of the video.

8.2 The three incidents above were all referred to in the HIP Report. The central allegation around them was that on each occasion, SYP officers were seeking to influence MPs' understanding of the disaster and to draw attention to the behaviour of supporters.

8.3 The IOPC investigated each incident further, interviewing as many of those who were present as possible—including the police officers involved—to gather their recollections. In each case, investigators sought first to establish what information officers gave to MPs, as a step to assessing whether this was inappropriate or inaccurate.

8.4 Ten current or former MPs provided statements; a further four responded to the IOPC by email or telephone to state they had no recollection of the specific incident. In addition, the IOPC contacted and, where appropriate, took statements from civil servants and MPs' staff who were identified as potentially having relevant information regarding this strand of the investigation. These included press officers and advisers to Mrs Thatcher.

The visit of the Prime Minister

8.5 Mrs Thatcher travelled to Sheffield by helicopter on the morning of 6 April. The agenda for her visit included a briefing from SYP, then visits to the stadium and the hospitals to thank staff and speak to the injured and their families. She arrived in Sheffield at around 11.45am, accompanied by the then Home Secretary, Douglas Hurd, and left at around 4.45pm.

8.6 The HIP Report contains a suggestion that when briefing the Home Secretary and Prime Minister, SYP attempted to blame supporters for the tragedy. This suggestion appears to be based on two factors:

- the HIP's review of an early draft of the Home Secretary's statement to Parliament about the disaster
- comments made by Sir Bernard Ingham, the Prime Minister's Press Secretary, in the aftermath of the disaster

8.7 Any information given by senior SYP officers would be expected to form an important part of the Home Secretary and Prime Minister's understanding of the disaster. The IOPC sought to investigate whether the briefing given by SYP to the Home Secretary and Prime Minister on the day after the tragedy contained any inaccurate or inappropriate information.

8.8 The early draft of the Home Secretary's statement included the words: "The Chief Constable of South Yorkshire told us that shortly after the start of the match there was a surge of spectators on the Leppings Lane terrace which crushed many at the front against the safety barrier." It also referred to the behaviour of Liverpool supporters outside the stadium, saying that police officers had needed to use "loudhailers to urge the crowd to be patient"; as the crowd increased, "some supporters started to climb the walls and turnstiles." While the draft statement indicated that they did so to escape the crowd pressure outside the stadium, this could be read as a criticism of supporter behaviour.

8.9 In the final version of the Home Secretary's statement, the reference to being given information by the Chief Constable was removed, and the description of a surge crushing spectators against the barrier was phrased as a factual explanation of what occurred. The comments about the use of loudhailers and supporters climbing walls were retained.

8.10 The IOPC has identified that there are strong similarities between the Home Office Statement and a written update sent from CC Wright's office to the Home Office at 9.30am on 16 April 1989—before Mrs Thatcher's arrival in Sheffield. This appears to have been an initial briefing to duty officials at the Home Office.

8.11 It is understandable that SYP provided an update to officials and that the Home Office used this as the basis for drafting a statement. The Home Office, in both its early and final versions, added more information; it also expressed sympathy for those affected and thanked those who helped in the rescue attempt. These details were not in SYP's written update.

8.12 As Press Secretary to Mrs Thatcher, Sir Bernard accompanied her when she visited Sheffield the day after the disaster. On multiple occasions, he has stated that while there, the police told them that the disaster had been caused by the actions of "tanked-up" supporters. For example, in a letter sent in 1996 to a man whose friend had died in the disaster, Sir Bernard wrote: "I believe that there would have been no

Hillsborough disaster if tanked-up yobs had not turned up in very large numbers to try to force their way into the ground. I visited Hillsborough the day after the disaster and I know what I learned then."

8.13 In a 2014 statement to the IOPC, he said: "We were told that a huge crowd had assembled there late, some of whom I was told were 'tanked up'." He did not specify who told him this.

8.14 There are no minutes available of the briefing Mrs Thatcher received from officers. Several of those involved in the meeting with Mrs Thatcher had died before the IOPC investigation began, including CC Wright and Mrs Thatcher herself.

8.15 However, the evidence from others present offers a very different perspective to Sir Bernard's. Mr Hurd stated to the IOPC: "There was no hint at the time of what became *The Sun* story 'it was all the fault of the Liverpool fans.' I didn't know about it until I saw the story – I had never heard that story." He added: "On the day of our visit I don't think that I heard anything about how the fans behaved from anyone on the day of the disaster."

8.16 Dominic Morris was the Private Secretary for Home Affairs at the time and also accompanied Mrs Thatcher throughout the visit. He told the IOPC he had no recollection of officers making any reference to alcohol or the behaviour of supporters.

8.17 Photographs show Mrs Thatcher visiting the Leppings Lane terraces. Three uniformed senior officers can be seen with her, including Ch Supt Duckenfield (with back to camera) and Ch Supt Mole (next to Mrs Thatcher). CC Wright was known to be present and may be the obscured officer, standing to Mrs Thatcher's right.



Figure 8A: Mrs Thatcher's visit to the terraces, Sunday 16 April 1989 (Source: NewsCorp/The Times Group)

8.18 A number of journalists were also present during Mrs Thatcher's visit, and some toured the ground with her. Investigators asked them for their recollections; none remembered any comments from the police about supporters. The IOPC also asked officers who were, or may have been, present if they could recall what had been said; none could.

8.19 All available AV footage has been scrutinised. IOPC investigators also examined a range of papers and diaries related to the period. These included:

- Mrs Thatcher's diaries
- Lord Hurd's diary, which he handed to investigators when interviewed
- Sir Bernard Ingham's papers, which are held by the Churchill Archive Centre in Cambridge as part of its Thatcher Archive

8.20 Despite these wide-ranging efforts, it has not been possible to confirm the details of the discussions between SYP and Mrs Thatcher and her advisers on the day after the disaster.

The meeting with Mr Shersby

8.21 By contrast, there was considerable detail of the meeting with Mr Shersby, on 3 October 1989. Minutes show it was organised by the Police Federation and that, along with Federation representatives including PC Middup, several senior officers were there, including DCC Hayes.

8.22 From the start, it was made clear to attendees that the purpose of the meeting was "to draw out information that would be helpful to Michael Shersby when Parliament came to debate the Hillsborough disaster."

8.23 Two months earlier, the Taylor Interim Report had been published. The report clearly rejected the views of police witnesses to the Taylor Inquiry that the behaviour of supporters—particularly in relation to allegations of large-scale drunkenness—was a contributory factor. Lord Justice Taylor wrote: "I am satisfied on the evidence, however, that the great majority were not drunk nor even the worse for drink."

8.24 In early September 1989, Mr Shersby met Mr Hurd to discuss various policing matters. Notes of that meeting recorded that Mr Shersby "had heard that morale in South Yorkshire had taken a great knock as a result of Lord Justice Taylor's interim report", and that he had been invited to visit SYP.

8.25 On 3 October, the Police Federation meeting began with a video presentation to Mr Shersby, led by Ch Insp Bettison. This was intended to provide some context about the disaster. According to meeting notes, the video lasted 29 minutes and included, among other things, a history of football disasters, the layout of the stadium and a comparison of the crowd in 1988 and 1989.

8.26 While it was being played, DCC Hayes and Ch Insp Bettison, among others, added further comments relating to previous games and pinpointed specific points in the footage. There were also discussions about the impact the disaster had had on officers and an acknowledgement that supporters had helped in the rescue effort.

8.27 However, the notes show that about halfway through the morning session, the tone of the discussions changed from concerns for officers to condemnation of supporters. For example, Ch Supt Mole said the behaviour of supporters in 1989 "was the worst seen". As Ch Supt Mole had only arrived at the ground once the rescue effort was almost

complete, this comment could not have been based on his own experience. Other officers strongly stated that the Taylor Interim Report had overlooked key aspects of police evidence about supporters' behaviour.

8.28 Tony Judge was Publicity Director of the Police Federation nationally and Editor of *Police*, the Federation journal. He was also present at the meeting. At the end of the morning session, he was recorded as saying "evidence that was not given in the Taylor Report should come out", and then that "we should plan with Michael Shersby the counter attack."

8.29 In the afternoon, individual officers were invited to give their account of the disaster. These officers were, for the most part, not named in the meeting notes; instead, they were referred to as "Officer A", etc. The majority of their accounts included references to supporters being drunk and aggressive or abusive. Officers identified in the notes as A and B reported extreme drunkenness; Officers C and E differentiated between what they called genuine supporters and "yobbos". Officer G suggested that when supporters arrived at Sheffield train stations "at 10 or 11 am all you could smell was beer."

8.30 Officers repeatedly stated that they could not understand why the Taylor Inquiry had rejected evidence about alcohol when they themselves had seen so much being consumed. Several officers specifically mentioned that they hoped Mr Shersby would use their account in parliamentary debates around the disaster.

8.31 This discussion was facilitated by Ch Insp Bettison, who began by drawing officers' attention to some positive comments from the Taylor Report: "If you thought Lord Justice Taylor's Report was unfair – paragraph 253 of the Report: 'Most Officers did all they could. Many supporters paid tribute', paragraph 278 'Over many years the South Yorkshire Police have given excellent service to the public', paragraph 279 'Aggravated by hostility to rescue victims'."

8.32 He then added: "you have the opportunity to present more balance to the Report: fit those paragraphs much more in context."

8.33 Through close comparison of what was said at the meeting with officers' written accounts and transcripts of evidence, the IOPC was able to identify six of the officers who spoke at the meeting and asked them what they recalled of it. One was medically unfit to be interviewed, and two told the IOPC they had no recollection of the meeting. Two did recall it and said that they were invited to speak openly, so they did.

8.34 At the meeting, one of these officers said: "Before the crush I took a wheelchair through because there was no other way in. As we turned round to get out, the crush was so bad we could not move. We asked for horses to come across to stop them pushing. The horses were kicking people back to stop them pushing. Liverpool have been exonerated from this Inquiry because it would be the death of Liverpool Football Club."

8.35 The IOPC has not found evidence of witnesses referring to being kicked by police horses, though one supporter complained to Operation Resolve that a particular police horse was not being adequately controlled. No mounted officer has stated that their horse kicked fans.

8.36 In his comments to the meeting, the other officer identified by the IOPC contrasted the behaviour of the supporters who had travelled to Sheffield by special train—who he described as "decent – no yobbos"—with the scene he saw at "the coach park where Liverpool supporters were being disgorged." He said: "It was crowded outside supermarkets, urinating in streets. There were so many of them, it was ridiculous.

The amount that came in the last 15 minutes was like a human tide. The camera was situated looking down Leppings Lane. But they came over the bridge too—no shots of them over bridge but there were just as many people coming over the bridge. They were carrying 4 packs, 6 packs, anything they could get hold of. There was a genuine reluctance to go into the ground."

8.37 The IOPC compared the comments this officer made in the meeting with his initial written account made after the disaster and with his initial statement to the IOPC, where he described his experiences on the day. In neither of these did he refer to supporters urinating in the streets or carrying "4 packs, 6 packs, anything they could get hold of." While he did say, in both his written account and his first statement to the IOPC, that supporters were drinking before the game and that some seemed reluctant to head into the ground, on both occasions he described the supporters he met as "good-humoured" and, in his written account, he said they were "well-behaved".

8.38 The tone of his comments in the meeting with Mr Shersby—with terms like "a human tide"—therefore appears quite different to his initial account and to the statement he gave to the IOPC.

8.39 Three significant actions followed this meeting. The first was that, when Mr Shersby spoke during a debate in Parliament on the Football Supporters Bill on 30 October 1989, he said that "at the match at which the disaster occurred 3,500 individuals were determined to get into the ground at short notice. Unfortunately some of them had been drinking too much."

8.40 The second was that on 8 November 1989, Ch Insp Bettison visited Parliament at the invitation of Mr Shersby, where he showed a group of MPs a video.

8.41 The third, also in November 1989, was the publication of an article in the Police Federation magazine that reported on the meeting. The article included several quotes from the meeting about drunken behaviour, though it did not include the names of the officers. It ended with the lines: "if the police version is indeed the unpalatable truth, the Hillsborough Inquiry's interim report has ignored a major cause for concern. If mass drunkenness is to be dismissed as a potential creator of future disaster, how can Taylor be said to have done his job?"

8.42 By the end of November 1989, the *Sheffield Star* and at least five national newspapers had published versions of the story.

8.43 Overall, the evidence examined does suggest that the meeting was set up to encourage Mr Shersby to speak up for the view of the police officers and particularly the Federation members, and that the prevailing view of the officers present was that the consumption of alcohol by supporters, and supporter behaviour, had contributed to the disaster. This view was not supported by other evidence.

8.44 Officers were entitled to share their views, and the Police Federation was entitled to arrange such a meeting. Nonetheless, the evidence indicates that some officers at the meeting exaggerated aspects of their accounts, in a bid to redress what they perceived as an imbalance in the Taylor Interim Report.

Ch Insp Bettison's visit to Parliament

8.45 The visit of Ch Insp Bettison to Parliament a few weeks later was facilitated by Mr Shersby and agreed through SYP senior officers.

8.46 In his first prepared statement to the IOPC, Ch Insp Bettison recalled that after the meeting of the Police Federation on 3 October 1989, Mr Shersby asked DCC Hayes "if the video and plans could be shown to an invited audience of fellow MPs in an informal setting he intended to host." According to Ch Insp Bettison, DCC Hayes subsequently discussed this with CC Wright and then confirmed the visit should go ahead. Ch Insp Bettison stated that DCC Hayes "told me that he wanted me to reprise the presentation and to play it exactly as I had done at the in force meeting."

8.47 He also stated that prior to the initial meeting with Mr Shersby, he had been asked by DCC Hayes "to produce a compilation video to try to convey the breadth and the complexity of the events of the day". He added: "I did produce a video which included a factual account of the aspects of evidence that were presented to Lord Justice Taylor."

8.48 When he gave evidence to the Goldring Inquests, DCC Hayes confirmed he was aware that Ch Insp Bettison had said he had produced the video on DCC Hayes's instruction. DCC Hayes stated that he didn't dispute it but had no clear recollection of it.

8.49 Around 40 MPs were invited, of whom 12 attended. Ch Insp Bettison showed the video and answered questions. In a memorandum to CC Wright after the presentation, Ch Insp Bettison commented that while the MPs had welcomed the input, he did not think any opinions had been changed.

8.50 The IOPC sought to contact the MPs for their recollections. Three had died and four had no specific recollection of the visit or the video; one was in ill health and gave a confused account. The other four all commented in different ways that they felt it was an attempt by the police to put across their side of the story; they also indicated they were not convinced by the video or the police stance.

8.51 If, as may be assumed from Ch Insp Bettison's memo to CC Wright, this was indeed SYP's intention, the evidence indicates that it failed.

8.52 Given the clear evidence of both the memo, and the fact that he authorised Ch Insp Bettison's visit to Parliament, it seems implausible that CC Wright would not have been aware of the content of the video and the fact that its overall angle was an attempt to articulate the police side of the story. In assessing CC Wright's actions in relation to the media and MPs, the IOPC was of the view that his agreement to the video being shown to MPs indicated he approved of its content and tone and amounted to his participation in efforts to minimise SYP's culpability and to deflect blame. This was among the reasons for the IOPC reaching the opinion that CC Wright would have a case to answer for gross misconduct, as stated in paragraphs 7.120–7.124.

Content and versions of the video

8.53 During its investigation, the IOPC has obtained three videos which may have been the ones shown to MPs.

- In September 2012, staff from the Chief Constable's office at West Yorkshire Police (WYP) sent the IOPC a video. The Chief Constable of WYP at the time was (former) Ch Insp Bettison. Having learned that the HIP Report had mentioned that he had shown a video to Parliament, he contacted the IOPC and said he would supply a copy of it. This video lasts for 25 minutes and includes a voice-over which is believed to be by Ch Insp Bettison.
- In October 2013, an SYP employee at Moss Way Police Station in Sheffield found a video and a set of slides in an envelope addressed to Ch Insp Bettison. SYP alerted the IOPC, and the video was handed over to IOPC investigators a couple of days later. This video turned out to be an identical copy of the first video obtained.
- The third video was handed to the IOPC by Ch Insp Bettison during an interview under caution on 11 March 2014. It was in a U-Matic format (a video cassette format used mostly by professional studios and broadcasters in the 1970s and 1980s). This video lasts for 31 minutes and includes a voice-over with a West Midlands accent. A former WMP officer, who worked in the WMP AV unit in 1989, has stated to the IOPC that some of the voice-over was his.

8.54 The two different versions of the video have been analysed in detail by the IOPC. The material covered by them both was broadly similar, starting with an overview of football-related disasters resulting in large numbers of deaths and showing some footage of football hooliganism. Both then provided a description of Hillsborough Stadium at the time, highlighting that some of the features of the ground, such as perimeter fences at the front of terraces, were introduced to prevent hooliganism. Both videos then progressed to footage from the day of the disaster, initially outside Leppings Lane, then showing the terraces, then showing the disaster and elements of the rescue effort, including scenes from the temporary mortuary.

8.55 While there were numerous similarities between the two videos, there were also some important differences. The video with a West Midlands accent was seven minutes longer. It included an extended section of continuous footage from the 1988 Semi-Final, as well as longer CCTV extracts.

8.56 In the video with a voice-over from Ch Insp Bettison, the commentary was far more detailed and included:

- a reference to supporters forcing open a gate at around 2.40pm on the day of the disaster
- several points of direct comparison of the crowd, and how well the police managed it, in 1988 compared to 1989
- a brief reference to the Heysel Stadium disaster, which occurred in 1985

8.57 The voice-over by Ch Insp Bettison also emphasised the direct link between hooliganism and the installation of perimeter fences at all major stadia; later, when discussing the rescue effort, this voice-over referred to "narrow perimeter fence gates." It could be argued that this is a veiled criticism of the stadium design, which was the responsibility of SWFC and, to a lesser extent, its contracted engineers, Eastwood & Partners.

8.58 In his evidence to the Goldring Inquests, Ch Insp Bettison stated that he had used three sources of material to compile the video:

- material that had been shown to the Taylor Inquiry
- some SYP footage from the 1988 Semi-Final
- a police training video called 'Planning for Disaster'

8.59 The IOPC has identified that this latter source was a 1986 Metropolitan Police video called 'Plan for Disaster' and has obtained a copy of it. The material about previous incidents at football grounds, including footage showing hooliganism and the reference to Heysel, is taken from 'Plan for Disaster'. This footage appears at the start of both videos; in the longer version of the video, the Metropolitan Police voice-over is also retained.

8.60 There is no suggestion that at any time either version of the video was intended to be shown to the public.

8.61 The IOPC has not been able to confirm from any of those present which of the videos was shown to MPs, or which was shown at the meeting with Mr Shersby on 3 October 1989.

8.62 In the interview under caution on 11 March 2014, Ch Insp Bettison gave a prepared statement, in which he said the third video was the one he presented at the meeting with Mr Shersby and to MPs. In a later prepared statement to the IOPC, he further explained: "I can be sure of that because I recall that Mr. Shersby had to rent a U-Matic player from an AV company in Uxbridge because my tape had been recorded on such an unusual format."

8.63 He also added in this later statement: "My own commentary was added to a later, edited, version of the original tape. This was requested of me by SYP Training School."

8.64 Ch Insp Bettison was asked about the videos when giving evidence to the Goldring Inquests. There, he stated that he had shown the same version of the video at the meeting with Mr Shersby and in Parliament, and that "the video had no narration". He reiterated under cross-examination that "there was no commentary from me at all", then again said, more generally "there was no commentary."

8.65 When asked by the barrister representing the Police Federation if that meant the video was silent, Ch Insp Bettison replied: "Please forgive me. There were elements of the video material that had been given to Lord Justice Taylor's inquiry that had a West Midlands Police officer's narrative over it. The first iteration of the video that was shown both to the Police Federation and to Members of Parliament had no additional commentary from me."

8.66 Asked when he put his own commentary on, Ch Insp Bettison stated it was in late 1989 or early 1990, to create a training video for SYP match commanders, in line with a recommendation made by Lord Justice Taylor.

8.67 While neither the Taylor Interim Report nor the Taylor Final Report specifically recommends the production of a training video, both emphasised the need for police training. A video could logically and reasonably have been part of SYP's approach to this.

9. SYP's collection of evidence

What was investigated?

The IOPC investigated:

The actions of police officers and those providing legal advice to police officers in relation to the collection of evidence, in particular:

a) the role of the teams led by Chief Superintendent Terry Wain and Chief Superintendent Donald Denton
b) the direction given to officers not to complete notebooks or duty statements
c) the process of obtaining handwritten accounts, and the way some of those accounts were subsequently amended, including:
   i. the actions of officers who agreed to amend their accounts
   ii. the actions of any officer involved in asking them to do so
d) whether amended accounts were put forward on behalf of any police officer which they had not agreed and/or signed
e) whether the amendments were made in an attempt to deflect blame from the police

What was found?

- **Some of the earliest actions by SYP to collect evidence after the disaster involved taking photographs of the stadium and areas around it,** including of rubbish bins at the Leppings Lane end on the day of the disaster. In the days that followed, other officers collected rubbish along major routes that Liverpool supporters may have taken to Sheffield. These actions appear to have been an attempt to gather evidence about alcohol consumption.
- **After the disaster, SYP officers were asked to produce written accounts of their experiences on the day, on plain paper rather than the more familiar approach of producing statements which met Criminal Justice Act 1967 standards.** One of these standards is that statements should be factual and should not include opinions (which are generally deemed inadmissible as evidence). When writing their accounts, officers were invited to include their "fears, feelings and observations" and specifically to comment on "the mood of the fans".
- **There is conflicting evidence about whether officers were instructed not to make entries in their pocket notebooks.** While some recalled such an instruction, many more did not, and the IOPC found numerous pocket notebooks with entries related to the day.
- **Some 327 officers' accounts were amended before they were submitted to WMP and the Taylor Inquiry. This figure was more than 100 higher than previous reviews of the evidence had found.** While some of the amendments were relatively minor, such as correcting spelling or other typographical errors, many resulted in several paragraphs being removed or rewritten.

- **The primary justification given by SYP officers and the force's supporting legal team for the review and amendment of officers' accounts was to remove opinion or hearsay.** While some of the material that was removed did amount to officers' opinions, the IOPC's analysis found that a lot of opinion was left in the accounts.
- **The decision to review the accounts was made after SYP was asked to submit them to the Taylor Inquiry.** SYP had originally asked its officers to provide their accounts as part of its internal investigation into what had happened, with the expectation that WMP would take statements from the officers. However, at a certain point, it was determined that WMP would not take statements from officers.
- **Initially, accounts were reviewed by Mr Metcalf, a solicitor who was acting for SYP in 1989–90**, who sent his suggested changes to senior police officers. SYP largely treated these suggestions as instructions and amended the accounts. Accounts received later on were reviewed by a team of SYP officers.
- **Accounts were sometimes amended without the officers that had written them being told. Some of those who noticed changes that they were not comfortable with were pressured to accept the amended version.** Only one officer has stated that he continually resisted that pressure and did not sign an amended version.
- There was a consistent pattern across all reviewers, including the officers as well as Mr Metcalf, of removing or rewording evidence that appeared to criticise senior officers or suggested there had been chaos or a lack of control. Most strikingly, **every reference to SYP officers monitoring the crowd in the pens at previous games or taking action to close the tunnel which led to the centre pens once they were full, was removed from officers' accounts.** These were potentially key points of criticism of SYP's operation on the day of the disaster.

Significant new evidence

The IOPC obtained a range of new evidence in relation to SYP's collection of evidence. This included:

- three separate videos recorded by members of the SYP Traffic Division on 17 and 18 April 1989, in which they collected empty cans and bottles on main routes to Sheffield that Liverpool supporters could have taken
- more than 8,000 pocket notebooks from relevant periods, of which 359 were found to include entries related to the disaster

- **a telex dated 17 April 1989 and marked from the Chief Constable for the "Information of Chief Superintendents", which included instructions for officers who had been involved on the day of the disaster to "prepare a note in the form of an aide-memoire – not a statement – of their recollections of what occurred"**
- **attendance notes and other documentation held by Hammond Suddards, the firm of solicitors that represented SYP at this stage—this information had been disclosed to the HIP, but only at the very end of its work, so had not been assessed in depth**
- **statements from many of the officers whose accounts were amended, which covered, among other things, their awareness of the amendment process**

9.1 As the force responsible for policing on the day of the disaster, SYP was also responsible for securing evidence in the immediate aftermath of the disaster. However, the evening after the disaster, SYP announced that the investigation of what happened would be taken over by WMP.

9.2 On 17 April 1989, the Government ordered a public inquiry into the disaster, led by Lord Justice Taylor. WMP was appointed to collect evidence for this. On 18 April, senior detectives from SYP—who had been overseeing the evidence collection until that point—met with senior officers from WMP. It was agreed at this meeting that "the limits of the South Yorkshire Police enquiry should be to the preservation of evidence and no further." Within days, WMP had taken over the investigation and suspended all enquiries by SYP officers.

9.3 Despite this, SYP did continue to collect evidence, in part to assist in the compilation of a written submission from the force that was required by the Taylor Inquiry. This submission, known as a 'proof of evidence', is examined in more detail in chapter 10.

9.4 Evidence was collected in various forms, including through written accounts from SYP officers who had been on duty on 15 April. The HIP Report highlighted that these accounts had been produced in an unusual format—on plain paper, rather than as formal signed statements under Criminal Justice Act rules—and that some of them were amended before they were submitted to WMP and the Taylor Inquiry. While this was not the first time that the amendments had come to light (the issue had been discussed during the Scrutiny of new evidence led by Lord Justice Stuart-Smith in 1997), the HIP Report demonstrated that amendments were more frequent and potentially more significant than Lord Justice Stuart-Smith had identified.

9.5 The HIP Report also repeated an allegation that "in contrast to the professional training," SYP officers were instructed not to write about their actions on the day of the disaster in their pocket notebooks. This referred to the fact that standard practice requires all police officers to make notes of key events in their day, such as when they arrest someone or gather any form of evidence. They can refer to their pocket notebook later to help them complete a statement or, in some cases, when giving evidence in court.

9.6 In its referral to the IOPC following the publication of the HIP Report in October 2012, SYP asked the IOPC to investigate the potential criminal offences of:

- "pervert[ing] the course of justice by altering accounts/statements", on the basis that "officers altered their accounts or statements to remove critical or contentious matters"

- "pervert[ing] the course of justice by not making pocket book entries", adding "officers were instructed to make handwritten accounts on blank sheets of paper and not pocket book entries"

9.7 The IOPC investigation into SYP's evidence collection began by conducting an in-depth review of all SYP officers' accounts, comparing the original accounts, the versions that had amendments marked on them, and the 'final' versions submitted to WMP and the Taylor Inquiry. The IOPC also confirmed that the amended versions were used for the Popper Inquests and included by WMP in the file of evidence it prepared for the DPP as part of its criminal investigation. IOPC intelligence analysts then examined the amendments for specific themes and patterns.

9.8 Investigators also sought to build a picture of how the SYP evidence-collection process —in particular the amendment process—had developed. This involved reviewing minutes of meetings, including internal meetings involving SYP officers only and meetings between SYP and Hammond Suddards, the firm of solicitors appointed to advise SYP on responding to the claims for damages (rather than SYP using its in-house legal team). Investigators also examined the extensive correspondence between the organisations, and the documentation gathered by the Stuart-Smith Scrutiny in relation to the amendment of accounts.

9.9 An initial assessment of the evidence indicated that junior officers had little or no control of the evidence collection or amendment process. Senior IOPC investigators therefore decided to focus the investigative effort on those who devised and managed the process. This included not only senior officers but also SYP's legal advisers. Though the IOPC's work is focused on the investigation of police conduct, it is permitted to investigate and evaluate the actions of third parties where these may help to explain the actions of police officers.

SYP's initial actions to investigate and preserve evidence

9.10 Within 20 minutes of the match being abandoned, the senior SYP detective on duty at the stadium, D Supt McKay, telephoned the head of the CID, D Ch Supt Addis, to alert him to the situation. D Supt McKay stated that he agreed with D Ch Supt Addis that no police enquiries could commence that evening, and the priority was identifying those who had died in the disaster.

9.11 However, after the crowd had left the stadium, SYP Scenes of Crime photographers took pictures of litter at the Leppings Lane end of the stadium. These included pictures of the turnstile area and the contents of bins outside the stadium. Time stamps on the photos indicate that they were taken shortly before 6pm on the day of the disaster.

9.12 The most plausible explanation for this action was that SYP wanted to gather evidence of alcohol consumption among Liverpool supporters. However, the photos were of little or no evidential value for this purpose. The litter in the photographs included some empty beer cans, but a similar quantity of empty soft drink cans and other rubbish, so did not support the allegations about alcohol consumption.



Figure 9A: Image of litter outside Hillsborough Stadium, 17.58 on 15 April 1989 (Source: SYP)

9.13 SYP secured no comparative evidence of litter from bins at the Nottingham Forest end, or from other games, to help assess whether there was an unusually high quantity of litter at the Leppings Lane end, or an unusually high proportion of alcohol containers within that litter.

9.14 The IOPC took statements from the photographer who had taken the pictures. He said that on the day he had been instructed on what to photograph by SYP officers. However, his accounts of who specifically had instructed him varied, and the IOPC has not been able to establish a source of the instruction.

9.15 In the first few days after the disaster, there were two other instances of SYP appearing to seek evidence about alcohol consumption.

9.16 At 5.17pm on 17 April, an action was raised on SYP's HOLMES account to "Locate and identify all public houses open and used by fans during morning up to 3pm on date of incident".

9.17 On 21 April, a report was logged on the SYP HOLMES database, which documented that SYP had telephoned pubs near the stadium to establish how many Liverpool supporters had visited, at what times and whether there was any trouble. The report recorded that none of the pubs contacted had experienced any trouble with Liverpool supporters. There was nothing in the report showing who had conducted the enquiries.

9.18 On 17 and 18 April, members of the SYP Traffic Division recorded video footage and took photos on two main routes to Sheffield from the west: the A628 Woodhead Pass and A57 Snake Pass. These were roads that some Liverpool supporters had used on the way to the game.

9.19 The IOPC examined three separate videos taken on these trips by the Traffic Division officers. Each shows officers retrieving empty beer cans and wine and spirit bottles from the roadside and then stating on camera that they had been discarded by Liverpool supporters.



Figure 9B: Still image taken from SYP video, 17 April 1989, filmed on roads to Sheffield (Source: SYP)

9.20 It is not clear how this could be said with any certainty; there was no footage to show Liverpool supporters discarding litter. Further, there was no comparative evidence of how much litter had been present before the Semi-Final.

9.21 Two officers in the Traffic Division produced written accounts of this work on 12 May 1989. Both officers have given statements to the IOPC. One stated that he was instructed to take the footage in a briefing from an inspector on 17 April 1989. He was aware that there were rumours among officers that a large number of supporters had been drunk, and he felt then (and still does) that collecting the cans and video evidence of the litter was a reasonable line of enquiry. He stated he was surprised by the quantity of empty cans they found but acknowledged he had no idea whether this was usual for supporters travelling to a match.

9.22 The other officer recalled that they were both keen to get involved in the investigation into the disaster and the video evidence was collected because of a "general consensus at the time that drunken Liverpool fans had turned up in Sheffield and caused the disaster". He was not certain whose idea it was to collect the video evidence but suggested to IOPC investigators that it may have come from him and his fellow PC; however, he added that he believed their inspector would have agreed to it. He

acknowledged that they did not propose a similar process of collecting video evidence on the routes that the Nottingham Forest supporters would have taken; he also had no idea whether this was a normal level of litter for a major game.

9.23 The IOPC took a statement from the inspector. He could not recall asking his two officers to do this, nor could he recall the rationale for it or even seeing the output.

9.24 Supt Brougham was head of the Traffic Division. He did not recall any instruction being given to film the route and on being shown the footage by IOPC investigators, described it as "a load of rubbish", adding: "it looks like a set up." He also stated: "I think it would have been unlikely that the Constables would have filmed the route off their own back."

9.25 The IOPC has found an action registered on the SYP HOLMES database in response to a message from the owner of a snack bar located in a lay-by on the A628 Woodhead Pass, who wished "to make a statement re the behaviour of the fans."

9.26 Detective Sergeant Mick Oughton (DS Oughton) was instructed to speak to the snack bar owner. It was recorded that the snack bar owner had told the officers about "fans leaving beer cans etc in layby 20 miles from SWFC." However, it does not appear that the officers took a statement from him.

9.27 When IOPC investigators took a statement from DS Oughton, they asked him about this action. He remembered the task but couldn't remember any conversation with the snack bar owner.

9.28 This action is striking because it appears so similar to the accounts of Inspector Clive Davis of SYP (Insp Davis), who told the IOPC, the Goldring Inquests and the media that he attended a briefing on 17 April 1989, led by Chief Superintendent Terry Wain (Ch Supt Wain). According to Insp Davis, Ch Supt Wain had opened the meeting by telling the officers present—mostly from CID—that "we are going to put the blame for this disaster where it belongs on the drunken, ticketless Liverpool fans." Insp Davis said Ch Supt Wain then specifically mentioned that officers were "going to drive down the M62 motorway and we are going to photograph the beer cans which were piled up by the M62."

9.29 The IOPC investigated this and found no documentary evidence of any such meeting. No other officer has said they were there or in any way corroborated Insp Davis's account of this meeting. Insp Davis named three people as being present. One was on leave that day; the others were Ch Supt Wain and Ch Insp Bettison.

9.30 Ch Insp Bettison has strongly rejected Insp Davis's account and stated he began working as part of Ch Supt Wain's team on 19 April.

9.31 Ch Supt Wain himself told IOPC investigators, and the Goldring Inquests, that he was not involved in any way in the SYP response until 24 April 1989. The IOPC has not found any documentary evidence to suggest he started any earlier than that date.

Meetings regarding the collection of evidence

9.32 While there is no documentary evidence of the briefing described by Insp Davis, there are detailed notes of several meetings of SYP officers in the days after the disaster.

9.33 At 9am on 16 April, around 20 officers who had a key role in the policing of the match and/or the immediate police response attended a meeting led by CC Wright.

9.34 CC Wright opened the meeting by setting out his aim: to get a clear understanding of the sequence of events. Building on the discussions he had the previous evening, including a debrief with Ch Supt Duckenfield and ACC Jackson, he stated: "I think I've got a good idea of it now", but added that he wanted to confirm the details.

9.35 According to the notes, his first question was: "Did anything happen before 2.30pm that anybody sees as significant?" The meeting notes then show a consistent pattern throughout, of CC Wright setting out his understanding of the situation then asking others to confirm it.

9.36 For example, at one point CC Wright asked: "Have we got any evidence that there was a delay in traffic that resulted in the Liverpool fans' arrival at the ground being as late as it was?" The assumption here was that a majority of Liverpool supporters arrived late; evidence does not support this, as examined in chapter 4, with some supporters in the ground from an early stage and significant numbers around the Leppings Lane entrance by 2.15pm. Ch Supt Nesbit responded to CC Wright's question to say that by 2.30pm, three major roads near the stadium—Penistone Road, Halifax Road and Langsett Road—"were completely sterile of football traffic."

9.37 Although these were not necessarily the routes that Liverpool supporters would have taken, CC Wright concluded: "there is no evidence whatsoever of the delay in transit of the fans. The fans arrived at the ground vicinity early enough to go in the ground but instead went drinking."

9.38 Some commentators have seen this meeting as a pivotal point in shaping SYP's response to the disaster. However, on closer examination it seems that several of the issues discussed—and the provisional understanding that was reached—had little impact on SYP's subsequent evidence gathering.

9.39 Similarly, the first CID briefing at 12 noon on 16 April ended up having little impact. D Supt McKay instructed his CID colleagues to prepare for "an enquiry the like of which we have never contemplated before." He listed some key groups of witnesses that they would need to take statements from, including all the officers who had been at the ground. However, he stated clearly that this would not start that day.

9.40 Shortly after the briefing, a HOLMES database was set up for the enquiry and the first action raised on it at 1pm on 16 April. There were 25 actions raised in total on that first day. Most were in line with D Supt McKay's administrative focus and included:

- identifying officers who were on duty, via a forcewide questionnaire
- compiling lists of names of stewards and turnstile operators on duty
- collecting and preserving video evidence

9.41 However, IOPC investigators identified one item that stood out; a policy decision, reportedly made as early as 7.55pm on 15 April, that "All officers statements to be registered as officers reports". This meant they would be given the HOLMES code R, rather than being coded as statements (S). This was unusual, because a specific decision was taken at this very early stage—before any actions had even been raised to collect evidence—about how to classify the evidence collected from officers.

9.42 During the briefing, D Supt McKay also instructed CID colleagues: "I would say to you all, anyone who was involved yesterday, after this briefing take time to sit down and make some notes. Is there anyone in this briefing who has made a pocket book brief?

No one. Do not start making pocket book entries. Yesterday was the most traumatic experience of my life and large chunks of it I cannot remember. I am sure it must be the same for many of you."

9.43 This has been taken as central evidence for those who have asserted there was a forcewide instruction to officers not to make pocket notebook entries as normal after the disaster. However, as the next section explores, there is conflicting evidence around this.

9.44 D Supt McKay then attended a meeting of senior officers on 17 April led by CC Wright, which appears to have had more of an influence on SYP's approach.

9.45 This took place after WMP had been appointed to carry out—in the words of the press statement read out by ACC Anderson at 5pm on 16 April—"the gathering and assessment of evidence" regarding "The planning and the operational decisions of South Yorkshire Police officers" around the disaster.

9.46 This meeting covered similar ground to the one CC Wright had led the previous day, in terms of looking at the events leading up to the disaster and the police response. However, the tone of this meeting was markedly different. Instead of purely confirming a chronology of events as he had done the day before, at this second meeting CC Wright challenged the senior officers present to explain potential discrepancies and prepare for the kind of questions an independent investigator might ask. For example, he asked: "Why is it with the same crowd, the same factors, what happened this year to change it? [...] what is the unknown factor?" At one point, he commented: "There was a problem and what were we doing to address it – we seemed to be adding to it."

9.47 Most notably, in terms of some of the evidence subsequently gathered and presented, there were a series of references to the police closing the central tunnel that led to Pens 3 and 4 of the West Terrace once those pens were full.

9.48 The notes show that relatively early in the meeting CC Wright asked those present: "Go back to the control inside the tunnel. Whose responsibility is it there to divert people – anybody?"

9.49 Ch Supt Duckenfield replied: "Inspector White with serials 14 and 15. Specific instructions on the Order at phase 2."

9.50 The reference to phase 2 reflects the fact that the SYP F Division Operational Order—the main planning document for the police operation—divided the operation into three broad phases:

- before kick-off (phase 1)
- during the match (phase 2)
- after the match (phase 3)

9.51 Ch Supt Duckenfield's recollection was accurate: the Operational Order instructed that in phase 2 Serial 14 would "be located in the central tunnel to the Leppings Lane terraces to maintain order as required." However, this meant the officers would only be employed to divert people away from the tunnel once the match had started.

9.52 Shortly after Ch Supt Duckenfield's comment about the duties of Insp White, the meeting notes included the observation: "Top of the tunnel solid with horses – that procedure happened last year."

9.53 CC Wright then asked: "Was there any element of that control put in the Order?" No response was recorded.

9.54 Later in the meeting, there was a discussion about how SYP had responded when the decision was made to open the exit gates to relieve the crush outside. Summing up the discussion, CC Wright observed: "the control of movement of people once they were going through gate C, there was no action taken on that. You were well aware there were contingencies to deal with the filled stand, i.e. the shutting off of the tunnel."

9.55 This comment demonstrates CC Wright's awareness of both a key failing in the police response on the day—that they did not control the crowd coming through Gate C—and of the fact that SYP had at least one established contingency that could have been used. Further, he clearly stated that at least some of the officers present at this meeting would have been "well aware" of such contingencies. There was no direct response or acknowledgement of this recorded in the meeting notes, but no one contradicted him or suggested such contingencies were not available to SYP on the day.

9.56 The last section of the meeting was dedicated specifically to the actions that SYP should take next. CC Wright asked how SYP should proceed. D Supt McKay took the lead in responding and proposed that officers who had been at the game should set down their recollections. CC Wright confirmed this action: "Very good point – all officers at the game to make records of their recollections."

9.57 CC Wright concluded the meeting by stating: "The judicial review which is going to be announced today is going to review the evidence that is gathered and if we leave it to West Midlands to provide the evidence we might not get the broad scope of evidence flowing in. We have to be the authors of most of the information fed in. We have to be active and find the areas where the evidence can be found." These concluding remarks about SYP being "authors" have been viewed by some commentators as an indication of an intent to control the evidence given to WMP.

The instructions SYP gave about producing recollections

9.58 As detailed at paragraph 9.42, in a CID briefing on 16 April, D Supt McKay told the officers present not to make pocket notebook entries about the disaster. The HIP Report highlighted D Supt McKay's instruction as the point when "SYP began to shape the investigation that followed." Others, before and since the HIP Report was published, have suggested that this was a deliberate attempt from SYP to control the evidence that officers gave. The IOPC investigated this issue.

9.59 D Supt McKay has stated that "the decision not to make pocket book entries was mine and the subsequent decision taken by the Force stemmed solely from me and this briefing."

9.60 However, his initial instruction was given only to CID officers. On the main SYP F Division Operational Order for the game, there were fewer than 40 CID officers among the 812 officers on duty on the day, and it is not certain that all of these same CID officers were at the briefing led by D Supt McKay.

9.61 In a joint statement to Operation Resolve and the IOPC, D Supt McKay recalled that during the meeting with CC Wright on 17 April, he saw ACC Jackson prepare "a telex that was sent out to all stations within the Force area and this highlighted that no delayed entries were to be made in pocket books and notes were to be made."

9.62 In a statement to Operation Resolve in May 2015, Police Sergeant Philip Whitlam (PS Whitlam) recalled that a "fax" was circulated on 17 April 1989, instructing officers to prepare an aide-memoire. He subsequently sent a copy of this document to Operation Resolve. It is in fact a telex, marked from the Chief Constable for the "Information of Chief Superintendents."

9.63 The telex was recorded as being sent at 1.24pm on 17 April, which indicates it was produced after the meeting with CC Wright that morning, in which D Supt McKay made the suggestion to obtain recollections. It therefore seems highly credible that this was the document D Supt McKay was referring to.

9.64 The telex advised that all members of the force who had been involved in any way with "the events at Sheffield Wednesday on Saturday 15th April" would probably be interviewed and required to make a statement. It instructed: "In order that there [sic] recollections are as accurate as possible these officers should be seen by a supervisory officer and asked to prepare a note in the form of an aide-memoire – not a statement – of their recollections of what occurred."

9.65 The guidance continued: "This could usefully include not only information about what these officers did but also what they saw, including crowd behaviour." Subsequently, officers received further instructions about what to include in their recollections.

9.66 The instruction in the telex clearly differentiated between an aide-memoire and a statement. However, it did **not** mention pocket notebooks.

9.67 A number of officers have said they received instructions not to make pocket notebook entries. However, they have referred to getting these instructions in many different locations and at different times. For example, some said they were told not to make a pocket notebook entry on Saturday 15 April—so before D Supt McKay's first instruction. Yet other officers who attended the same debrief meetings did not recall being given any instruction to this effect.

9.68 Some officers recalled being specifically instructed to write recollections on plain paper but did not remember being told anything about their pocket notebook. Others stated that they were given no instructions whatsoever about their pocket notebook and completed an entry as normal.

9.69 The IOPC asked SYP and its former officers for their help in recovering pocket notebooks. This was the first time SYP had been directly asked for pocket notebooks related to the disaster. In a search of its archives, SYP found a large number of notebooks that had been stored with no marking or labelling to indicate they were relevant to the Hillsborough disaster.

9.70 A significant number of officers—or their families—also responded and provided the IOPC with notebooks from the relevant time, which they had kept. Some officers who handed pocket notebooks to investigators did this when first interviewed; others looked for notebooks or other relevant documentation at home after being interviewed by the IOPC and contacted investigators when they found relevant material in lofts, cupboards or other spaces.

9.71 In total, 8,407 pocket notebooks were retrieved and reviewed during the IOPC investigation. Of these, 2,338 related to two crucial periods:

- March – April 1988, which covered the previous year's FA Cup Semi-Final between Liverpool and Nottingham Forest, including planning and preparation

- March 1989 – April 1991, which covered the planning and preparation for the 1989 Semi-Final, the day itself, the immediate aftermath and subsequent investigations up to the end of the Popper Inquests

9.72 Across all of these, 359 notebooks included entries related to the day. This is not as many as would be expected if all 1,100+ officers on duty had made pocket notebook entries in line with normal practice and if all pocket notebooks that covered the day had been retrieved. However, it is far more than were previously believed to exist.

9.73 The overwhelming majority of the pocket notebook entries that related to the day itself were factual—simply stating when officers came on duty, where they were deployed and when they came off duty. They provided few details of the events of the day, though some referred to various debriefs that took place. For example, 20 notebooks specifically mentioned a debrief taking place in the North Stand at the stadium. However, there was no relevant information in the notebooks about what these debriefs covered.

9.74 D Supt McKay has provided the explanation that pocket notebooks were simply not a suitable tool for officers to record recollections of such a huge event. However, the HIP Report identified a possible alternative reason. It referred to the fact that in a meeting on 26 April 1989, Mr Metcalf from Hammond Suddards commented that "pocket notebook entries can be called for and must be produced." This meant that if the Taylor Inquiry asked to see any pocket notebooks, SYP would have had to submit them.

9.75 However, this comment was made

- nine days after the date on the fax produced by PS Whitlam
- ten days after D Supt McKay formally instructed CID officers not to make pocket notebook entries
- eleven days after the disaster—on the evening of which several officers have stated that they were told not to make pocket notebook entries

9.76 Any instruction not to use pocket notebooks to record evidence therefore appears to have predated this advice from Hammond Suddards.

9.77 While the evidence around pocket notebooks is unclear, the picture is clearer about what instructions officers were given about their accounts.

9.78 The first instructions were those in the telex on 17 April 1989. The next set of instructions to officers was issued on 26 April, by Ch Supt Wain. He briefed a team of seven detectives to obtain accounts from officers who were deployed in the vicinity of the Leppings Lane end and gave them a document listing five questions that the officers should answer. After basic administrative details, the main two questions were: "What did you see that is in any way relevant to the incident?" and "What did you do?"

9.79 The background to Ch Supt Wain issuing these instructions was that on 24 April he had been given the responsibility for producing SYP's written response to the Taylor Inquiry. The need for such a response—known as a 'proof of evidence'—had been identified by Mr Metcalf at the first meeting SYP had with Hammond Suddards after the disaster, on 19 April. At the request of DCC Hayes, Mr Metcalf had then sent written guidance on what this should cover, setting out six broad topics. In the same letter, Mr Metcalf had also advised DCC Hayes that: "In our view, it will be necessary to have statements from as many as possible of the Officers who were deployed at the ground on that day". He suggested that these statements should cover "when they came on duty, to whom they were responsible, where they were, what they observed and what they did."

9.80 Notably, he also wrote: "As the statements concerned are not required for the purposes of any criminal investigation, there is no reason for them to be prepared on CJA forms and indeed many can, in our view, be 'self-taken', in the sense of simply forming a record of the recollections of the Officer concerned on the points raised above."

9.81 When Ch Supt Wain took on the task of producing the proof of evidence, he asked what statements Hammond Suddards wanted from officers. DCC Hayes initially told him that this was no longer necessary, as WMP would be taking statements. However, after the meeting DCC Hayes followed the matter up with Hammond Suddards.

9.82 Mr Metcalf was on holiday, so DCC Hayes spoke to a junior solicitor, Belinda Norcliffe, who advised him that the Taylor Inquiry would want statements from all officers who had been on duty in the Leppings Lane area, as well as from all officers of inspector rank or above who had been on duty anywhere. This would be in addition to any official CJA statements taken by WMP.

9.83 Following this conversation, Hammond Suddards researched whether SYP officers could produce "self-taken statements". Miss Norcliffe called DCC Hayes later that day to advise him that this would be fine. The Hammond Suddards note of this second call also mentioned that DCC Hayes asked whether it was acceptable for four senior officers—Ch Supt Duckenfield, Supt Murray, Supt Greenwood and Supt Murray—all to refer in their accounts to the same timeline of events that SYP had produced by using photos and video footage.

9.84 According to the note, Miss Norcliffe replied that this was fine because it was SYP footage, and it was not in conflict with the evidence that was likely to come out at the Taylor Inquiry. She added that if Counsel advised otherwise at the meeting on 26 April, then the officers' accounts could be amended. This was the first point at which the possibility of amending accounts was raised. No evidence has been found to suggest that DCC Hayes questioned or challenged it.

9.85 The instructions Ch Supt Wain issued on 26 April reflected the guidance from Hammond Suddards to that point. However, at a meeting later that day, William Woodward QC, the barrister appointed to represent SYP at the Taylor Inquiry, suggested that officer accounts could be broader in scope: "You also ought to be aware that the information you give us is privileged so you should encourage anybody giving evidence to put in his feelings, his worries etc."

9.86 In statements to the IOPC, both DCC Hayes and Mr Metcalf identified this as a significant change.

9.87 Following this meeting, the instructions to officers were revised and further questions were added. Several variations of the revised instructions have been found but the essence is the same: in the versions dated after this meeting, officers were asked to comment on issues such as crowd behaviour and the mood of the supporters, and to include their fears, feelings and observations.

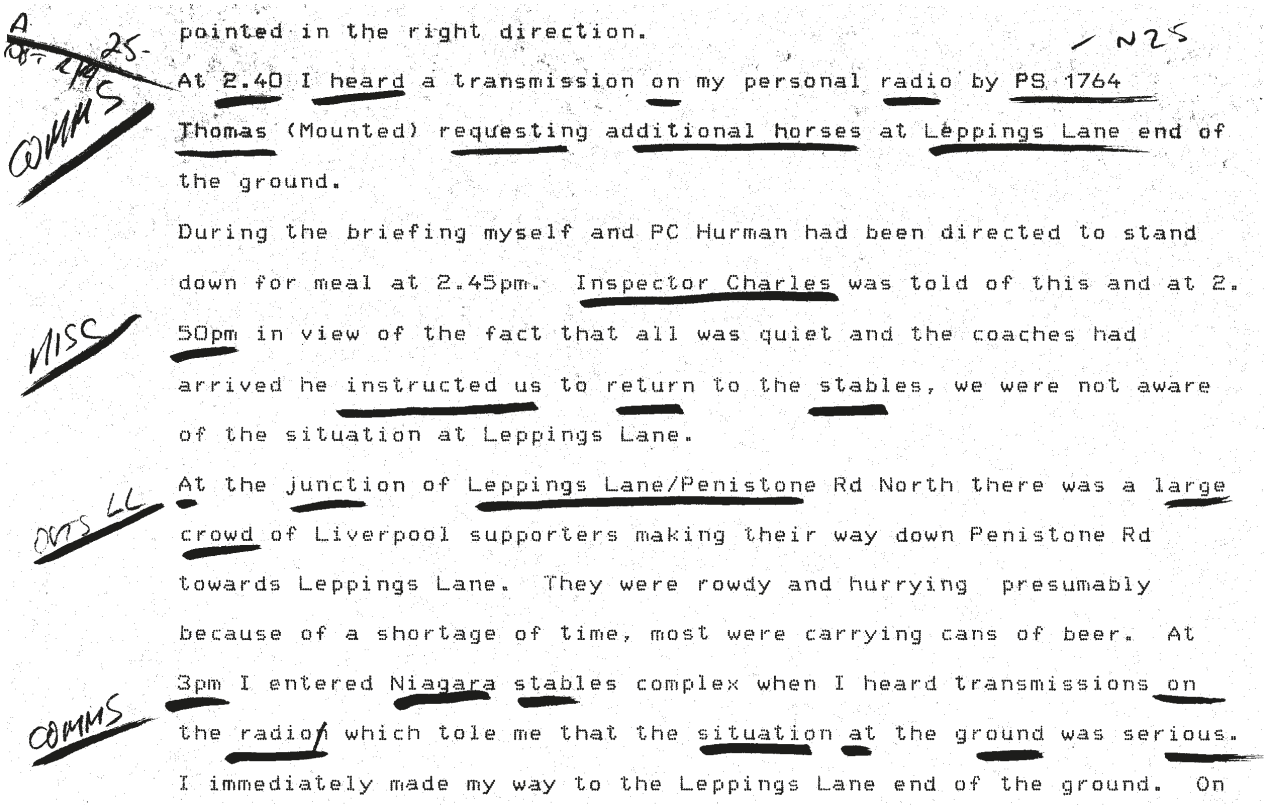
9.88 In addition, on 27 April, DCC Hayes issued a telex, informing all divisions that he had instructed a team of officers, under the command of Ch Supt Wain, to prepare the proof of evidence for the Taylor Inquiry. He asked all officers who had been on duty at the game and had not yet provided an account to produce written accounts. Due to the very short timescales for production of this proof of evidence, he requested the cooperation of all staff in this—noting that, if necessary, officers should be released from normal duties to complete their accounts as soon as possible.

9.89 Towards the end of the meeting on 26 April, DCC Hayes asked Mr Woodward: "The main players in this are doing their own accounts. Is that O.K. or would you rather someone take their statement?" Mr Woodward responded: "It couldn't be better. They can put all the things in that they want and we will sort them out."

9.90 According to the meeting notes, Mr Woodward did not elaborate on what he meant by "sort them out". However, in the context, it would appear to suggest the possibility of revising the accounts the officers submitted in some way, to address any potential issues the legal team foresaw. This then seems to be the second time that the legal team raised the possibility of changing officers' accounts. Like the first, it went unchallenged by SYP.

9.91 Based on the available evidence, including witness statements taken from several officers involved in the process, the IOPC has built up a broad picture of how SYP collected the accounts and what they did with them.

- Officer accounts were formally received into the MIR and registered on the HOLMES database as reports rather than statements, with an identifying number.
- The handwritten versions were typed up and again stored on HOLMES.
- The typed versions were reviewed and marked up for indexing. This is a standard process in an MIR, where the readers mark points in the document that relate to key investigative themes or topics. The indexers then update the document record on HOLMES to show that it contains information relating to these themes. The database can then be searched thematically.



pointed in the right direction.

At 2.40 I heard a transmission on my personal radio by PS 1764 Thomas (Mounted) requesting additional horses at Leppings Lane end of the ground.

During the briefing myself and PC Hurman had been directed to stand down for meal at 2.45pm. Inspector Charles was told of this and at 2.50pm in view of the fact that all was quiet and the coaches had arrived he instructed us to return to the stables, we were not aware of the situation at Leppings Lane.

At the junction of Leppings Lane/Penistone Rd North there was a large crowd of Liverpool supporters making their way down Penistone Rd towards Leppings Lane. They were rowdy and hurrying presumably because of a shortage of time, most were carrying cans of beer. At 3pm I entered Niagara stables complex when I heard transmissions on the radio which tole me that the situation at the ground was serious. I immediately made my way to the Leppings Lane end of the ground. On

Figure 9C: Indexing marks on an officer's account (Source: SYP Archive)

9.92 A detective sergeant who was a member of the team under Ch Supt Wain stated to the IOPC that "Ch Supt Wain always read the documents first and then passed them to whoever the matter related to, depending on which area of concern the item related to. He read everything without exception."

9.93 The detective sergeant also noted that from an early stage, the topics highlighted by the team in officer accounts typically related to "criticisms of senior management, loss of control, lack of communication and lack of leadership."

WMP's request for written recollections

9.94 On 28 April 1989, Lord Justice Taylor held a preliminary hearing for the Inquiry at Sheffield Town Hall. The hearing set out his expectations for the Inquiry. Lord Justice Taylor stated: "I emphasise that during the first phase of the Inquiry what is required is factual evidence as opposed to mere comment or non-expert opinion."

9.95 The following day, ACC Jones, who was leading WMP's work for the Taylor Inquiry, wrote to CC Wright that he had "been directed by Lord Justice Taylor to invite senior police officers who were involved at Hillsborough on Saturday 15 April 1989 to submit, in writing their recollection of the events prior to and during the match." He listed six officers from whom recollections were sought. He did not specify that comment or opinion was not required.

9.96 SYP swiftly conveyed this request to its lawyers. A handwritten file note from Hammond Suddards indicated that Ch Supt Wain phoned the same day and explained the development. After further conversations between DCC Hayes and Mr Metcalf, on 2 May, Mr Metcalf met with some of the senior officers to review their accounts. In a short note of the meeting, Mr Metcalf recorded: "I made various suggestions for alterations to their statements, the principal change being that in respect of ACC Jackson, who had not included any of the details of the planning of the match."

9.97 In what appears to be a direct consequence, ACC Jackson submitted a ten-page account, plus an appendix. This was shared with WMP, who recorded it as his statement.

9.98 On 7 May, ACC Jones wrote to CC Wright again, advising him that the Taylor Inquiry had now requested written recollections from a large number of SYP officers, to be drafted in line with "the same criteria as for the senior officers before." The following day, Detective Chief Inspector Malcolm Ross of WMP (DCI Ross) sent Ch Supt Denton a list of 122 SYP officers from whom recollections were required.

9.99 According to a Hammond Suddards attendance note, Ch Supt Wain and Ch Supt Denton jointly telephoned Hammond Suddards and spoke to Miss Norcliffe about WMP's request. She noted they were "concerned" as some of the accounts they already had from officers on the list "go beyond mere fact." According to the note, Ms Norcliffe advised them that "as the statements already taken were provided for Legal Advisors, this would not necessarily be a problem, that all the statements would have te [sic] be vetted before release and consents from all Officers would be required."

9.100 Having confirmed this with Mr Metcalf, she then telephoned Ch Supt Wain back to advise him that the best course of action would be "for us to read through every single statement requested that we already had, to ok the ones that should be released and to suggest alterations possibly to others."

9.101 This was therefore the third point at which the legal team suggested that officers' accounts might need to be amended. Again, there was no recorded response from SYP.

9.102 On 9 May, Ch Supt Denton sent Mr Metcalf a bundle of accounts, with the specific acknowledgement: "You agreed to vet the initial batch of those statements." The decision to send accounts to Hammond Suddards for vetting was communicated promptly within the SYP teams involved in the collection of evidence. On 10 May, Ch Supt Wain instructed the SYP MIR that "nothing currently in our possession will be released to W/Mids until it has been vetted by our legal representatives."

9.103 It is important to acknowledge that WMP's request meant that officer accounts would now be used for a very different purpose: whereas SYP had asked for them to inform its production of a proof of evidence for the Taylor Inquiry, they were now being treated as primary evidence by another police force.

The first amendments

9.104 On 10 May, the first batch of accounts was returned to Ch Supt Denton with suggestions for amendments made by Hammond Suddards. They were sent back as three faxes and included comments that words may be missing or that spelling should be checked or corrected, alongside broader suggestions such as: "We should like him to review the comment on page 10, first paragraph, relating to the apparent lack of organised Police effort".

9.105 There were a number of requests to check facts. In three cases, it was suggested that the final comment should be removed; in one (the account of Insp White), the fax suggested the removal of a section of several paragraphs that the officer had written under the heading "additional points arising."

9.106 In total, across the three faxes, Hammond Suddards suggested changes to 28 of the 68 accounts reviewed at this stage. In his first prepared statement to the IOPC, Ch Supt Denton recalled receiving the first faxes and noting that Mr Metcalf was "suggesting fairly significant amendments to a number of the recollections before release, such as the removal of opinion, ambiguity and over-descriptive language." He stated: "It was immediately apparent that, on Mr. Metcalf's advice, substantial amendments to many of the recollections would be required before they could be released to WMP."

9.107 Despite this, the IOPC has found no evidence to indicate that Ch Supt Denton challenged any of these proposed amendments and nor did any member of his team. The 'suggestions' were treated as instructions and acted upon.

HAMMOND SUDDARDS

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OUR REF. PCM/PAB YOUR REF. DD/AT DATE 10th May, 1989

Dear Sir,

Hillsborough

We have commenced checking the self-taken statements and will be faxing comments as checking proceeds.

We have the following comments to date. Where the name of an Officer is mentioned without further comment, this indicates that we have checked the statement and would not object to its release as drafted.

1. Serial No. 13

1.1 Inspector Bullas

We would suggest alteration of comments in page 3 to amend descriptive language to a more factual basis, i.e. reference to large number of people, rather than river of people, etc.

1.2 Sergeant Burman

We think that this statement should be re-drafted on a factual basis, removing the entirety of the comment on the final pages of the statement.

Figure 9D: Extract from first fax sent as part of the review process (Source: Home Office)

9.108 In both his evidence to the Goldring Inquests and his first prepared statement to the IOPC, Ch Supt Denton described a standard process he and his team used in implementing the amendments suggested by Mr Metcalf. The following summary is drawn from Ch Supt Denton's evidence.

- Ch Supt Denton and DCI Foster reviewed the faxes sent from Hammond Suddards.
- DCI Foster would then retrieve copies of the relevant original accounts.
- Either DCI Foster himself, or another member of the team, determined what wording needed to be changed, annotated the original account accordingly and handed the annotated version to typists to retype.
- The amended versions were then sent back, via various detective sergeants, to the officers who had originally produced them. These officers were asked to review the amended accounts and sign them; they were not necessarily told what had been changed.

9.109 Over the following days, this process was adopted for all accounts that SYP had gathered by that point. In total, 426 accounts were sent to Hammond Suddards for review: these included the accounts of almost all the officers who had been deployed at the Leppings Lane end, whether inside the stadium or outside the entrance, or in other key roles on the day. The lawyers—predominantly Mr Metcalf—suggested amendments to 172 of these.

9.110 Though only the amended versions were sent to WMP, SYP retained the original accounts **and** the amended versions. In some cases, it also retained a printed copy of the account marked for amendment, with changes written on by hand before the amended version was typed up.

9.111 While Ch Supt Denton has accepted "full supervisory responsibility" for the amendment process, including sending accounts to Mr Metcalf and receiving his responses, the evidence supports his assertion that he did not personally make any amendments. DCI Foster has confirmed he was at the heart of actually making the amendments but also added that two other officers were "involved in carrying out the amendment process in accordance with the legal advice received."

9.112 Having looked into the process in detail, the IOPC found evidence that one of these officers played a predominantly administrative role in the process. However, the other, Detective Inspector Philip Jones (DI Jones), signed or initialled handwritten notes on 106 officers' accounts. These included notes implementing amendments suggested by Hammond Suddards as well as, in 16 cases, further suggested amendments, apparently from DI Jones himself.

9.113 In a statement to Operation Resolve in March 2014, DI Jones stated that at some point after the disaster, D Ch Supt Addis gave him a bundle of around 12 accounts on which suggested amendments had been marked up. DI Jones said he was told "to contact the officers, interview them and delete certain parts of their reports." DI Jones stated to Operation Resolve that he did not know who had suggested the changes but that he was instructed to "have them remove any criticism of senior officers and criticism of the radio communications". He stated he believed he had been asked to do this because DCI Foster was away.

9.114 When IOPC investigators interviewed him and pointed out there was evidence that he had amended more than 12 accounts, DI Jones accepted that he had been involved in amending more than 12 accounts but stated: "I was acting in accordance with legal advice and under the direction of senior officers."

9.115 Both DCI Foster and DI Jones have stated that they amended accounts in accordance with legal advice. However, for 94 of the accounts that were amended, there is no record of advice from Hammond Suddards. Instead, the IOPC has established that from around 16 May—the day after the Taylor Inquiry hearings started—SYP reviewed and amended officers' accounts in-house, without sending them to Hammond Suddards.

9.116 In total, 736 accounts were reviewed by the in-house team of officers: predominantly DCI Foster, DI Jones and one other. The amendments made through this process were similar to those recommended by Hammond Suddards.

9.117 The possibility of SYP reviewing accounts in-house was first discussed on 10 May. According to a file note made by Hammond Suddards, ACC Anderson telephoned the solicitors to discuss the fact that WMP had now asked for accounts from around 600 SYP officers. These were officers that had been on duty at the Semi-Final, but not at the Leppings Lane end.

9.118 Mr Metcalf commented that while they could follow the same process as previously, Hammond Suddards "would be under considerable time difficulties and would not be able to process these prior to the 22nd or even the 29th of May." In response, ACC Anderson proposed that these officers should be asked to provide a statement that "sticks to factual matters alone", and that these "would then be vetted by the Police themselves."

9.119 The accounts of this new group of officers were reviewed and amended by Ch Supt Denton's team, rather than Hammond Suddards; the solicitors were only contacted if Ch Supt Denton's team had specific queries.

9.120 For a brief period, this process ran concurrently with the vetting of the previously requested accounts, which was being conducted by Hammond Suddards.

9.121 A range of documentary evidence shows that from an early stage, WMP and the Taylor Inquiry team were aware that SYP had adopted a vetting process for officers' accounts—though the IOPC has not established who informed them or when. The prime concern from WMP appears to have been that this could delay the delivery of accounts to the Taylor Inquiry team.

9.122 On 15 May, the Taylor Inquiry opened and Andrew Collins QC, Counsel to the Inquiry, gave a preliminary statement in which he explained that "At this stage only witnesses who can give factual evidence will be called" and added: "This is not the stage for witnesses to give evidence of their opinions." However, he added that "this does not of course mean that the Inquiry will ignore the opinions of those who wish to put them forward" and suggested that these could be offered in writing.

9.123 This stance was confirmed in a letter from David Brummell of the Treasury Solicitor's Department, who was part of the Taylor Inquiry team, to ACC Jones on 7 June. The letter was sent after an SYP officer was asked questions at the Taylor Inquiry relating to his original account, which had been sent to WMP by mistake, rather than the amended version.

9.124 Mr Brummell dismissed ACC Jones's concerns about this, commenting: "The main difference between the initial and final versions of the South Yorkshire Police Officers' statements is that any expressions of opinion were (as I understand it, on the advice of Mr. Woodward) removed from the final version." He added: "As I understand it, Andrew Collins' view is that there is absolutely no reason for excluding such expressions of opinion when they touch on matters relevant to the Public Inquiry and that, in the circumstances, there is no objection in principle to written statements containing such opinions being submitted to the Inquiry."

9.125 While this reaffirmed that opinions did not need to be removed, WMP had already been alerted to the possibility that some material changes were being made to accounts. On 22 May, an SYP officer telephoned DCI Ross to complain that his statement had been altered.

9.126 DCI Ross informed ACC Jones, who in turn wrote to CC Wright at SYP. The letter began: "I thought I would advise you discreetly that we have had two approaches from separate sources suggesting omissions have been made from officer's recollections."

9.127 The IOPC has found no evidence to suggest that either WMP or SYP sought to stop the amendment process or look into the issue. Instead, it appears to have been the catalyst for SYP to issue an internal message, titled 'The Hillsborough Inquiry – Update II', which was specifically addressed to "officers of the South Yorkshire Police submitting evidence to the West Midlands Police". It referred to the fact that officers' accounts had been amended and acknowledged that some officers had expressed concerns about this. It explained that the amendments were "necessary" and had been made "to remove conjecture and opinion and to leave only matters of fact."

9.128 The crucial consequence of the amendment process was that WMP only received the amended accounts, so any further actions it took or analysis it conducted could only have been based on those versions. Its investigation was based on the information SYP chose to give it. Similarly, the Taylor Inquiry team could only call witnesses to give oral evidence based on the amended accounts; there may have been information in the original accounts that would have been relevant to the Inquiry, but this was not available for consideration.

Nature and scale of the amendments

9.129 The IOPC's investigation has established that, via the two amendment processes, a total of 327 SYP officers' accounts were amended. This was 133 more than identified in the HIP Report and amounts to approximately 1 in 4 of all SYP officer accounts relating to the day.

9.130 Of these amended accounts, 297 were sent to WMP.

9.131 The IOPC analysed all the amendments in depth, including

- looking at the amendments thematically
- examining how closely the amendments that SYP made as a result of the first amendment process reflected the advice from Hammond Suddards, which in practice in almost every case meant Mr Metcalf
- comparing the amendments made in the second review process, conducted wholly by SYP officers, to those made in the first, based on input from Hammond Suddards

9.132 In addition, the IOPC re-examined the accounts that were **not** amended, to establish if any included the kind of content that was removed from or amended in other accounts. This was to assess the consistency and rigour with which the amendment process was applied.

9.133 The suggestions provided by Mr Metcalf included the following:

Type of suggestion	Examples drawn from different accounts
Corrections of fact, grammar, spelling, or style.	• on the last line of p3, we think the word "not" is a misprint for "riot". • We think that the quoted serial number 31 is a mistake for 32.
Direct or indirect questions, typically to seek clarification.	• We wonder if there is a word missing from paragraph 5 on page 9. • Comment at page 3 as regards lack of discernible comment from match control: is he saying that there were no messages at all, or that there were messages, but they were too distorted to hear?
Suggestions that a particular word or sentence should be amended. Sometimes, Hammond Suddards provided a possible replacement.	• I would suggest substitution of the words "extreme urgency" for "panic" on p4. • Suggest remove last sentence
Suggestions that sections should be reconsidered or reviewed.	• Insofar as the references to communications difficulties represent comment, rather than part of the narrative, these could perhaps be reviewed. • Suggest he may wish to review the final paragraph.
Observations based on comparisons with other accounts.	• Could we check whether the reference to 1.15pm on page 2 should really be to 2.15pm which would be more consistent with the other evidence. • His perception of the crowd position at page 5 do seem at odds with most other officers but, obviously, this should not be altered if it is his clear recollection.
Suggestions that a section could be removed.	• Suggest this ends at "…Mexborough", i.e. first paragraph on page 8. • suggest this ends at off duty on page 3.
Hammond Suddards' opinion.	• We should like him to review his criticism of the briefing so as to ensure that this is not exaggerated (page 1). Bearing in mind that the statement is to be submitted to the Public Enquiry and will be on record as such, he may like the opportunity of reviewing some of the language used, although we would not wish to insist on this being changed if he is happy with it. • I am not particularly happy about the comment on page 4 about the packing of the terraces. I should like to omit this, unless it has already been accepted in the statements of both Murray and Mr Creaser, copies of which I do not have to hand.

9.134 The comments received resulted in amendments ranging from changing a single word or phrase (for example, "panic" to "extreme urgency") to substantial cuts or changes. Some of these were of minimal consequence: for example, in response to the suggestion to end the account at "Mexborough", three paragraphs were cut. This was the account of a police sergeant who had been on duty: the three paragraphs detailed the officer's return to his home police station and the response of his colleagues over subsequent days.

9.135 In other instances, potentially significant information was removed. The suggestion that an account could end at "off duty on page 3" resulted in the deletion of the following sentence: "At the time of the incident there seemed to be no communication between the officers directly involved on the ground and officers in the control room and no senior officer could be seen to be in charge of directing officers at the Leppings Lane end." While it could be argued that the first half of this paragraph was comment or speculation—in that the officer said there **seemed** to be no communication—the second half described what he saw (or didn't see).

9.136 In the accounts that were amended in-house, some of the marked changes were extremely similar to those suggested by Hammond Suddards. For example, on one account the phrase "a sound of panic" was changed to "a sound of urgency"—an almost direct repeat of a wording change cited in the table above.

9.137 Of the 327 amended accounts, in 85 cases, the amendments were purely corrections to spelling and grammar or matters of style.

9.138 The stated rationale for the review and amendment process was the removal of opinion and comment. Of the 172 suggestions for amendment made by Mr Metcalf, 16 specifically referred to text in the officer's account being "comment"—thus inferring it should be removed or amended—and others were described as including "hearsay", "impressions" or in two instances "personal and graphic" recollections.

9.139 The amendments SYP made based on these comments frequently went beyond the removal of opinion—for example, deleting aspects of officers' recollections of events both at the 1989 Semi-Final and at previous games. The amendments also went beyond the correction of information, with changes that removed certain details often altering the meaning of a sentence.

9.140 Having established the full extent of the amendments, the IOPC then refined this analysis, looking at the amendments made in relation to six themes, agreed with the CPS as a useful means of analysing them for the purposes of demonstrating to a jury the extent and impact of the amendment process.

9.141 Content that referred to communication issues—such as problems with police radios—was amended in 40 accounts (31 on the basis of suggestions from Hammond Suddards). Typically, the amendments involved changing generic comments (for example, that radios weren't working) to individual ones (that the officer's radio wasn't working). However, the IOPC identified at least 80 accounts where comments about communication issues were not amended.

9.142 Comments about aspects of police planning and tactics, including pre-match briefings, an apparent shortage of officers and a lack of coordination in the rescue effort were amended in 31 accounts, but left unchanged in 13.

9.143 References to the failure of police control outside Leppings Lane were amended in 29 accounts but not amended in 45. A common theme among the amendments related to the decision not to delay the kick-off.

9.144 There were 63 accounts from which criticisms of senior officers and/or police command and control were removed or reworded, typically to remove comments that suggested a lack of leadership or direction. However, the IOPC also identified 49 accounts where criticisms of the senior officers or overall police command and control were not changed.

9.145 References to the police having contingency plans to close the tunnel to the centre pens of the West Terrace in the event of overcrowding, or having previously taken action to do so, were removed from all five accounts in which they appeared.

9.146 Comments that indicated SYP had any responsibility for monitoring safety in the pens—including any actions to monitor the capacity of the pens at previous matches—were removed from all eight accounts where they appeared.

9.147 By reviewing the amendments in detail, the IOPC has established that there was a high degree of consistency between the amendments suggested by Mr Metcalf and those made by the SYP team. The evidence also indicates that particular care was taken to remove references to SYP being responsible for monitoring safety in the pens or taking steps to control access to the centre pens by closing the tunnel. These were potentially pivotal points; if SYP accepted any such responsibility or acknowledged it had previously taken action to close the tunnel, this could indicate that the force had failed to fulfil these responsibilities on the day of the disaster. As is examined in the next chapter, references to both topics were also removed from the written proof of evidence that SYP submitted to the Taylor Inquiry.

9.148 The amendments to the accounts and proof of evidence were made after these two topics were discussed in detail in meetings between SYP and its legal team—notably at the meeting on 26 April 1989 referred to in paragraphs 9.84–9.90.

9.149 In this meeting, the lawyers and DCC Hayes advocated a position that SYP was not responsible for safety in the pens or controlling access to the tunnel, arguing that no such responsibility was documented anywhere.

9.150 However, Ch Supt Mole stated that there was a known contingency among senior officers to close the tunnel when the pens were full—although he subsequently added that it was only a contingency and may never have been used. This appeared to align with the views expressed by CC Wright, in the meeting on 17 April, when he had commented: "you were well aware there were contingencies to deal with the filled stand, i.e. the shutting off of the tunnel."

9.151 While this responsibility was not documented in the Operational Order, in a court case a few years previously, SYP had argued that it should be paid by football clubs for policing matches, because they were undertaking special police services beyond maintaining law and order: namely, taking responsibility for safety on the terraces. In evidence to the court, SYP officers had described how they did this. SYP won the case, known as *Harris v Sheffield United*. In meetings between SYP and its legal team, there were repeated references to the case; on 26 April, Mr Woodward even read from the case transcript at one point.

9.152 It is important to note that in the case, SYP was only seeking payment for policing the normal 'home' league and matches of clubs in the South Yorkshire area, not for matches when a stadium was being used as a neutral ground, such as FA Cup semi-finals. This was reflected in the meeting when DCC Hayes noted that the 1989 Semi-Final was not within the contract SYP had with SWFC.

9.153 However, when giving evidence in court, none of the officers who testified stated that the responsibility for safety on the terraces only applied to scheduled home games for clubs in South Yorkshire. Further, none of those present at the meeting on 26 April questioned the relevance of the case, or its applicability to the policing of Hillsborough Stadium on the day of the disaster.

9.154 Amending accounts to remove references to monitoring safety on the terraces therefore appears a material change to the evidence that SYP officers had given. It meant that SYP presented a more consistent argument to the Taylor Inquiry, but an incomplete one. For example, the amendment to the account of Insp White involved the removal of a 200-word section describing his "practice over the years" to climb the steps of the PCB so that he could monitor the build-up in the pens. The same change removed Insp White's explanation of some practical considerations around tunnel closure, which included the comment: "Although on rare occasions in the past I have used the gates nearest the concourses to control flow away from the tunnel around to the south pen."

9.155 Insp White was recognised by SYP colleagues as one of the officers with the most experience of policing the Leppings Lane end. This description of how he had monitored the pens and closed the tunnel in the past was simply removed from his account, so the information was not available to WMP or the Taylor Inquiry.

Officers' awareness of the amendment process

9.156 Very few officers recalled being asked to amend their accounts themselves. Instead, most said they were presented with a typed version of the account and asked to read and sign it.

9.157 The majority of officers did sign the amended accounts, effectively giving their approval to the changes. Some stated they did so in full knowledge of what had been changed and why.

9.158 Other officers stated that they were aware that their accounts had been reviewed but had signed the amended versions without checking them thoroughly. When shown the amended versions, they were surprised at the extent of the changes.

9.159 A further group stated they were not told about the amendments at all before being asked to sign the typed version of their account.

9.160 One such officer was Police Constable Gary Cammock (PC Cammock). A series of handwritten notes on a copy of the fax from Hammond Suddards show that there was some discussion with PC Cammock about proposed amendments to his account (see figure 9E).

9.161 The first note was dated 7 June 1989 and stated that PC Cammock had been seen and had agreed to the deletion of some swear words, as suggested by Hammond Suddards. However, the note continued: "he is not inclined to alter his criticism of the briefing." This referred to comments PC Cammock had made about the main briefing given to all SYP officers on duty at 10am on the day of the disaster. He described the microphone system as "next to useless" and said he and others round him "could hear very little of what was actually said." He added that this led to officers having to check the operational orders "to see exactly what we were supposed to do." Hammond Suddards had suggested he review this.

9.162 A second note on the same fax was made by DCI Foster on 8 June. It instructed that the account should be retyped as amended. There is no indication that there was any further discussion with PC Cammock before this.

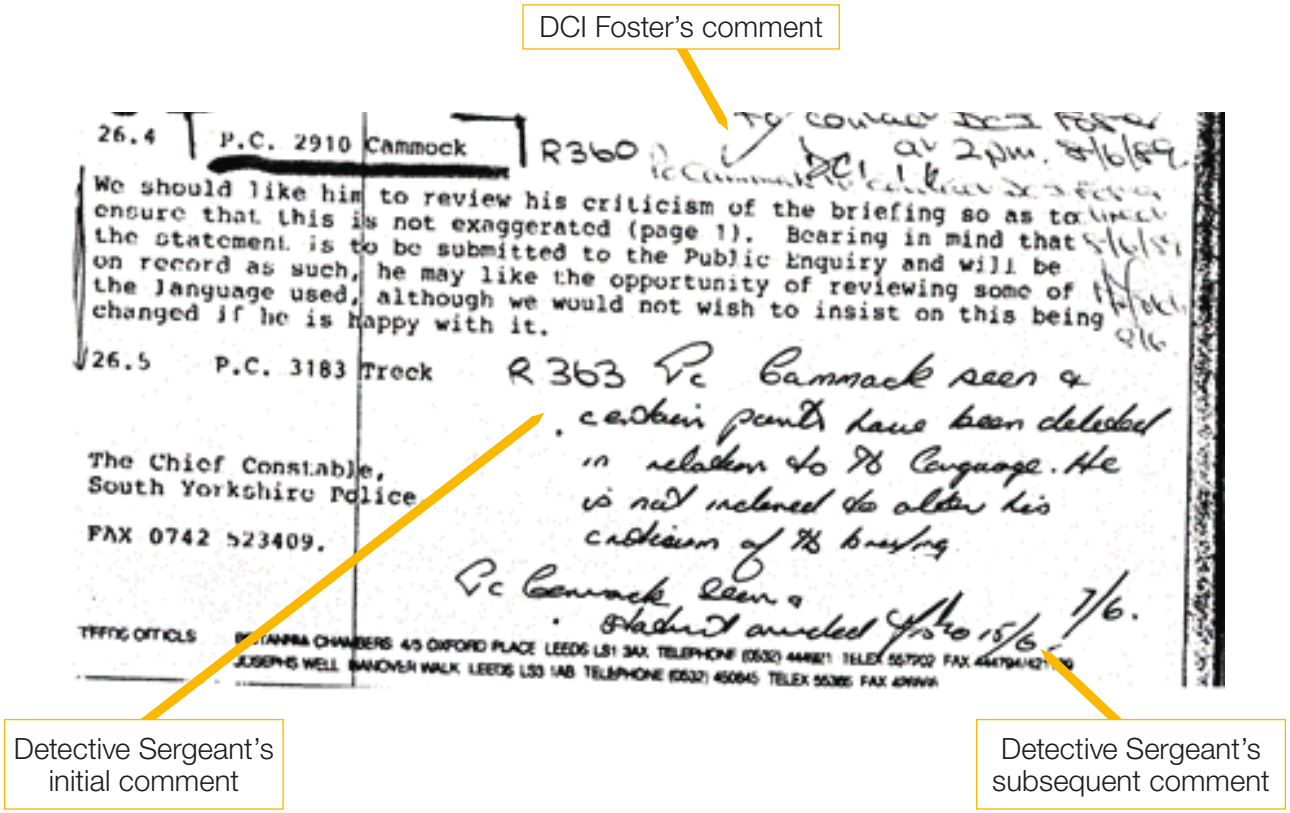


Figure 9E: Notes made by SYP officers regarding the amendment of PC Cammock's account (Source: SYP Archive)

9.163 PC Cammock told the IOPC that he did not remember being asked to sign an amended version, nor being spoken to by any senior officers regarding his account. When shown a version of the account with changes marked on it, PC Cammock acknowledged he had initialled the deletion of swear words but stated: "I do not think I would have agreed to that paragraph [regarding the briefing] being removed."

9.164 Some officers who signed amended accounts have since gone on record to say they were pressured into doing so.

9.165 They described different degrees of pressure being placed on them, ranging from being threatened with transfer or dismissal, to one officer being told that if he didn't agree to the amendments, his account would not be submitted to the Taylor Inquiry.

9.166 Two of the officers said that after refusing to accept the amendments, they were sent to see DCI Foster. A third believed he had seen a different senior officer, but DCI Foster separately stated he had made the amendments to this third officer's account. DCI Foster recalled meeting some officers regarding their accounts but denied putting pressure on them.

9.167 A fourth officer said that he was called in to see Ch Insp Beal and that one of the others who had refused to accept the amendments was there at the same time as him.

9.168 Ch Insp Beal accepted he "may have been tasked to speak with officers about amending statements" but said this would have been on legal advice. In a later statement to the IOPC, he directly denied having met this fourth officer.

9.169 While the evidence is inconclusive in relation to Ch Insp Beal's alleged interaction with this fourth officer, Ch Insp Beal accepted—during the Goldring Inquests—that he had been involved in the amendment of a specific set of accounts. These were the accounts of four communications officers who had been in the PCB at the ground on the day of the disaster.

9.170 The amendments to all four accounts were proposed by Mr Metcalf in a fax sent to Ch Supt Denton on 19 May 1989. Mr Metcalf noted that the officers had "slightly different perspectives as to exactly what happened in relation to the communications problems." He suggested that they should "be seen again to go through their recollections of this crucial period."

9.171 This only happened in one case, of a civilian communication officer. The other three accounts were amended by Ch Insp Beal, without him contacting the officers who had produced them. None were aware that their accounts had been amended; two felt the changes were minor. The last of the group had more substantial amendments made to his account but told the IOPC that the new text actually clarified the situation.

Explanations for the amendment process

9.172 Mr Metcalf, Ch Supt Denton and DCI Foster were all interviewed by the IOPC under caution in relation to their role in amending officers' accounts. Mr Metcalf provided a prepared statement to the IOPC and did not answer investigators' questions, as is his legal right.

9.173 In the prepared statement, he explained his rationale in reviewing the accounts was "to keep the statements as factual as possible, to clarify inconsistencies or ambiguities within statements and between other statements, to remove comment and irrelevant or otherwise inadmissible evidence, to tone down intemperate language, and to allow the witness to present the whole of their admissible evidence." He accepted that in following this rationale he may, on occasion, have inadvertently suggested the removal of some factual content but emphasised this was not his intention. He further stated that his review comments were advice, not instructions. In a later response to the IOPC, he highlighted numerous instances where he had not suggested the removal or amendment of comments that appeared to criticise senior officers or that referenced communication difficulties on the day.

9.174 While reiterating that he did not at any point intend to remove any facts from officers' accounts, Mr Metcalf stated to the IOPC: "I am willing to accept that in a small number of cases my exercise of judgement could be criticised." The IOPC's evidence indicates that this significantly underplays his role. At his recommendation, factual information was removed repeatedly, following a consistent pattern: in particular to remove any reference to SYP having previously taken action to control access to the centre pens or close the central tunnel. While it may have been beneficial or desirable to SYP to put forward a set of accounts without inconsistencies, this did not assist with the Taylor Inquiry's role of understanding how the disaster had occurred.

9.175 Ch Supt Denton also exercised his right not to answer investigators' questions. In a prepared statement provided to the IOPC at the start of the interview, he accepted "full supervisory responsibility" for the amendment process. However, in this statement he

said that "amendments of the recollections were undertaken purely to ensure that they complied with the advice of the legal advisors and the requirements of formal witness statements for legal proceedings".

9.176 At the Goldring Inquests, Ch Supt Denton was asked for his views on some of the amendments. He accepted that in a couple of instances, facts had been removed and should not have been but argued that this was the result of errors of judgement and not anything more intentional.

9.177 DCI Foster provided a prepared statement to the IOPC and answered investigators' questions. He confirmed he was the person mostly responsible for implementing amendments to officers' accounts but consistently stated that he was acting in line with legal advice. When investigators asked him how that applied to the accounts that SYP reviewed and amended in-house, rather than through Hammond Suddards—a review process he had been central to—DCI Foster stated that he was following the broad principles and direction set by the legal team.

The trial of Mr Metcalf, Ch Supt Denton and DCI Foster

9.178 The extent and consistency of the amendment process led the IOPC to refer several individuals who had been involved in overseeing or implementing the process to the CPS, for decisions on whether they should face criminal charges of perverting the course of justice and conspiracy to pervert the course of justice.

9.179 Having reviewed the evidence, the CPS announced that Mr Metcalf, Ch Supt Denton and DCI Foster would be charged with perverting the course of justice. The three men went on trial on 19 April 2021. However, on 26 May 2021, having heard arguments from legal experts for the prosecution and the defence, the judge, Mr Justice William Davis, ruled that the defendants had no case to answer.

9.180 This was because the offence they were charged with was perverting the course of justice in relation to the amendment of officer accounts presented to the Taylor Inquiry. Before the trial, a different judge (Sir Peter Openshaw, who had been the judge in the trial of Ch Supt Duckenfield and Mr Mackrell) ruled that as the Taylor Inquiry was a non-statutory departmental inquiry, it was not a course of justice. The case against Mr Metcalf, Ch Supt Denton and DCI Foster therefore required the prosecution to demonstrate that the amendment of officers' accounts that were submitted to the Taylor Inquiry could also have affected the Popper Inquests or the subsequent criminal investigation conducted by WMP—both of which were courses of public justice. The judge concluded that the prosecution had failed to demonstrate this.

9.181 Of the 68 amended accounts that were submitted by the CPS, Mr Justice Davis identified just four where he believed the amendments were significant enough to potentially mislead and therefore support a charge of perverting the course of justice, if the Taylor Inquiry had been a course of justice. However, he acknowledged that a key part of the prosecution case related to the consistency of the amendments and the impact this had on the overall body of evidence SYP presented.

Conduct matters investigated

9.182 The IOPC also recorded and investigated several conduct matters relating to SYP's collection of evidence. These focused on the actions of senior officers involved, including Ch Supt Denton and DCI Foster, but also CC Wright, DCC Hayes, ACC Anderson, Ch Supt Wain, Ch Insp Beal and DI Jones. The main allegations related

to the officers either overseeing, or being directly involved in, a process to amend accounts, removing factual information which would have been of significance to the Taylor Inquiry. In some cases, officers were also alleged to have pressured colleagues to amend their accounts.

9.183 Having reviewed the evidence in the conduct report, the IOPC's opinion was that DCI Foster would have had a case to answer for gross misconduct, in relation to the allegation that he directly or indirectly brought undue pressure to bear upon those SYP officers who refused to make changes to their original accounts.

9.184 However, none of the officers would have had a case to answer for misconduct in relation to the amendment of accounts.

9.185 Though the evidence clearly showed there was a deliberate and concerted effort to amend the accounts—and that officers up to CC Wright were aware that amendments were being made—there was not (and still is no) duty of candour that applied to non-statutory public inquiries, such as the Taylor Inquiry. This meant that, as long as they did not mislead the Taylor Inquiry, there was no obligation for police officers, or any other party, to disclose information which might undermine the version of events they had portrayed or wished to portray, unless they were specifically asked for it.

9.186 In simple terms, officers and, by extension, the force were legally entitled to present their best case within these parameters.

9.187 However, it could also be suggested that there was a greater public interest in enabling the Taylor Inquiry to thoroughly examine all the causes of the disaster. By amending accounts, as part of presenting its best case, SYP did not act in that public interest.

9.188 This is one of the reasons the IOPC welcomes the introduction of a new, stronger statutory duty of candour for all public officials, including the police, as set out in the Public Office (Accountability) Bill.

10. SYP's presentation of evidence to the Taylor Inquiry

What was investigated?

The IOPC investigated:

The evidence that was put forward on behalf of SYP, or by individual officers, to the WMP investigations, Lord Justice Taylor's Inquiry, the contribution proceedings, and the inquests, or in the immediate aftermath of the disaster, considering:

a) whether any police officer gave or produced evidence that was inaccurate, false or deliberately misleading (or was involved in attempts to do so)

b) whether such evidence contained inaccurate, misleading or irrelevant criticism of supporters' behaviour

c) whether the 'Wain Report' was an accurate and complete picture of the evidence

d) whether any police officer was party to, or directed the production or selection of, evidence that was inaccurate or misleading, including irrelevant criticism of supporters' behaviour and evidence regarding operational police tactics/actions to control supporters

This chapter focuses on the evidence presented to the Taylor Inquiry only, looking at the written submissions from SYP and the oral evidence given by individual officers.

What was found?

- The IOPC has found clear evidence **the 'Wain report' was an internal draft of the proof of evidence SYP was required to provide to the Taylor Inquiry and was edited substantially by the legal team before submission.** This is a different sequence from that proposed in the HIP Report which suggested that SYP expanded its proof of evidence to create the Wain report.
- **The proof of evidence did not include any information about SYP being involved in monitoring safety in the pens, or about previous police tactics to control access to the centre pens at the Leppings Lane end by closing the central tunnel.** There had been references to both of these topics in the Wain report.
- **The widely reported claim that supporters deliberately burned a police horse with cigarettes outside the stadium was not true.** Detailed investigation found no evidence to support the claim; when this was put to a key witness, he changed his account of what had happened.
- Before senior officers gave evidence to the Taylor Inquiry, most attended a meeting with Mr Metcalf, where **those present agreed some "appropriate answers" that they could use in response to some of the expected questions.** In some cases, officers then used these appropriate answers in their evidence, even where they included information the officer could not have known at the time.

- **In their evidence to the Taylor Inquiry, several SYP senior officers stated, to differing degrees, that they had no knowledge of police actions to close the tunnel at the 1988 Semi-Final (or on other occasions) and that they did not see the police as having responsibility for monitoring the pens. This contradicted what some of them had said at internal meetings.**
- **In SYP's closing submissions to the Taylor Inquiry, delivered on 6 July 1989, there was no mention whatsoever of past actions to close the tunnel.** This submission was written by the legal team, and SYP did not have sight of it before it was submitted.

Significant new evidence

The IOPC took statements from many of those involved in the production of SYP's proof of evidence and from several officers who gave evidence to the Taylor Inquiry. In some cases, this required multiple requests, culminating in agreement that written statements could be provided without interview, where the witness was in poor health.

As part of its investigation into the allegation that supporters had burned a police horse, the IOPC appointed an expert witness in equine health, who provided a comprehensive report.

10.1 In his Interim Report, Lord Justice Taylor made some deeply critical remarks about the quality of evidence SYP had provided to his inquiry. At paragraph 280, he commented that—with some exceptions—senior officers had been "defensive and evasive witnesses." He then extended this criticism at paragraph 285, writing: "It is a matter of regret that at the hearing, and in their submissions, the South Yorkshire Police were not prepared to concede they were in any respect at fault in what occurred."

10.2 Reflecting that "the police case was to blame the fans for being late and drunk, and to blame the Club for failing to monitor the pens", he concluded: "Such an unrealistic approach gives cause for anxiety as to whether lessons have been learnt. It would have been more seemly and encouraging for the future if responsibility had been faced."

10.3 It has since been alleged that the evidence presented by SYP and its officers was not just unrealistic, as Lord Justice Taylor described it, but deliberately misleading.

10.4 The HIP Report commented that a document known as the 'Wain report', because it was produced under the direction of Ch Supt Wain, "placed significant emphasis on ticketless fans, alcohol and crowd behaviour." The HIP Report showed that such emphasis was, at best, disproportionate. It also called into question the accuracy of some of the material in the Wain report, which it suggested was SYP's main written submission to the Taylor Inquiry.

10.5 There were also questions raised in the HIP Report about the accuracy of the oral evidence some senior officers gave to the Taylor Inquiry.

10.6 Having reviewed the material cited in the HIP Report and received a referral from SYP that acknowledged the concerns about it, the IOPC made the evidence presented by SYP one of its terms of reference. The IOPC also received some complaints, from family members of some of those who died and from some supporters who were at the game, about the written and/or oral evidence given by certain officers. These were investigated under this term of reference.

10.7 The core of this strand of the investigation was to examine the evidence that was presented by SYP to the Taylor Inquiry, from written submissions to the Inquiry transcripts, and to compare this to other evidence. That included accounts given by officers at other times, to establish if there were any significant differences, and looking at a wider range of material, including photographs and video footage from the day of the disaster, to assess if anything said in evidence was inaccurate.

10.8 To investigate the accuracy and completeness of the Wain report, the IOPC conducted a close comparison of the three different versions of the proof of evidence that were in the archived material held by the investigations. By looking at documentary evidence—in particular meeting minutes and correspondence between senior SYP officers and SYP's appointed solicitors, Hammond Suddards—investigators were able to clarify the sequence in which the three versions were produced and gain a greater understanding of who had been involved in drafting the various iterations. This was corroborated as far as possible through interviewing the senior SYP officers involved in producing the Wain report and members of the legal team.

10.9 The evidence clearly showed that the Wain report was the second internal draft of the document that would eventually become the proof of evidence, provided to the legal team on 9 May 1989. It was 288 pages long and included extracts from 81 officers' accounts. The section covering the events of the day of the disaster amounted to over 100 pages. It was then radically edited by the legal team, to just 122 pages, and submitted to the Taylor Inquiry on 12 May. The extracts from officers' accounts had been removed and the section on the events of the day reduced from over 100 pages to just seven, with no details whatsoever of events beyond 12 noon.

10.10 This sequence of events is different from that set out in the HIP Report, which suggested that the substantially longer Wain report was produced **after** the shorter version had been submitted. This is significant because it means that, rather than 'expanding' its case with more information, as the HIP Report suggested, SYP (via its lawyers) actually reduced it prior to submission.

10.11 The fact that the Wain report was not presented as evidence to the Taylor Inquiry means that it is primarily of investigative interest in understanding the development over time of SYP's proposed evidence to the Inquiry.

Development of the proof of evidence

10.12 On 19 April 1989, in the first meeting between SYP and Hammond Suddards after the disaster, Mr Metcalf told those present, including DCC Hayes, ACC Anderson and Ch Supt Denton, that the force would be expected to submit a proof of evidence to the Taylor Inquiry. Though there was no official requirement to do this, it was what a (non-police) party represented by Mr Metcalf had done during a previous public inquiry.

10.13 There was some discussion among the officers present about what should be covered in the proof of evidence. DCC Hayes concluded this topic by stating that SYP had little experience of public inquiries and asked Mr Metcalf for some guidance on what should be included. Mr Metcalf suggested some broad headings during the meeting, which he confirmed in a letter to DCC Hayes the following day. These were:

"1. The South Yorkshire Police: history, geographical area, manning and organisation.

2. The policing of sporting events: the statutory and common law background to Police involvement.

3. The approach of the South Yorkshire Police to the policing of major sporting events: the history of such operations and the current standing operational orders.

4. The specific background to Police involvement in the match to be played at Hillsborough on 15th April.

5. Details of the manpower and organisation for the match.

6. The events which occurred."

10.14 In the letter, Mr Metcalf also advised DCC Hayes: "In our view, it will be necessary to have statements from as many as possible of the Officers who were deployed at the ground on that day".

10.15 At some point between 19 and 24 April, DCC Hayes appointed Ch Supt Wain to take responsibility for production of the proof of evidence. Ch Supt Wain was, at the time, divisional commander of the Rotherham division of SYP. He was a highly experienced officer who had worked as a detective, led major investigations and run major incident rooms. He had also been match commander for a large number of football matches. At the Goldring Inquests, DCC Hayes confirmed he had specifically chosen to delegate the task of producing the report to Ch Supt Wain as he saw him as "an extremely good communicator, an extremely good administrator."

10.16 At a meeting in DCC Hayes's office on 24 April 1989, this responsibility was confirmed. DCC Hayes instructed Ch Supt Wain and his team to have a draft report ready for a meeting with the legal team on 26 April.

10.17 The minutes recorded that, by the time of the meeting, Ch Supt Mole had already produced initial drafts of content relating to headings 4 and 5 and Ch Insp Beal, who was not present at the meeting, had begun drafting the content for heading 3. The other headings were then allocated to different members of the team.

10.18 At the meeting on 26 April, Ch Supt Wain gave the first draft of the proof of evidence to Mr Metcalf and Mr Woodward. He advised all present that the document had been "hastily pulled together" and pointed out: "We have not taken any evidence yet with which to back up the comments contained herein." However, he said that they "should be able to validate it given time."

10.19 He added that "Parts IV and V in particular ought at this stage to be treated with care." These were the sections relating to the background to the police operation for the 1989 Semi-Final and the events of the day; SYP had produced the document in five sections, rather than adhering to the six Mr Metcalf had recommended.

10.20 The minutes recorded Mr Woodward describing the document as "magnificent".

10.21 There were two major topics of discussion during the meeting. Firstly, the lawyers asked whether the police were responsible for monitoring the capacity of the pens and closing the tunnel to the centre pens of the West Terrace if capacity was reached. This was with reference to the case of *Harris v Sheffield United* (see paragraphs 9.151–9.153). As detailed in chapter 9, Ch Supt Mole stated that there was a known contingency among senior officers to close the tunnel when the pens were full; both DCC Hayes and the legal team sought to confirm whether this was documented anywhere.

10.22 The second major topic was that Mr Woodward asked the officers present what had changed between the 1988 FA Cup Semi-Final between Liverpool and Nottingham Forest at Hillsborough Stadium and the parallel game in 1989. After Ch Supt Mole detailed some specific changes that had been made to the Operational Order, DCC Hayes stated: "Now there were other changes and I think this is what Mr Woodward wants. People tell me for example, that they had never seen at other similar football matches to this one so many non-ticket holders arriving, so much alcohol brought to the football matches, and therefore having to be consumed or disposed of at the turnstiles."

10.23 ACC Anderson and Ch Supt Wain then gave examples of stories they had heard from officers about Liverpool supporters' consumption of alcohol. None of these three officers—DCC Hayes, ACC Anderson or Ch Supt Wain—had been on duty at the game, so all were relying on information they had received from those who had been present, which they all acknowledged during the meeting.

10.24 Following this meeting, the draft proof of evidence was updated substantially to become the document known as the Wain report. Both the topics discussed at the meeting on 26 April were covered in detail, but in a way that did not replicate the full breadth of the discussions.

10.25 For example, on the subject of closing the tunnel, the Wain report overlooked Ch Supt Mole's comments at the meeting and only included references that indicated it was not a safe or appropriate tactic. It also included several references to the roles and responsibilities of SWFC stewards, including a comment that "over the years, the clubs [sic] attention has been drawn to the fact that stewards were not performing their duties to the full."

10.26 Some 15 paragraphs were allocated to a discussion of the case of *Harris v Sheffield United*. Towards the end of the section, the Wain report made clear that the 1989 FA Cup Semi-Final was not covered by the contractual agreement that had been in place with clubs following the conclusion of the case.

10.27 In part 4 of the Wain report, relating to police planning for the 1989 Semi-Final, there were multiple negative references to the behaviour of football supporters generally, plus some specific references to previous matches involving Liverpool.

10.28 There were also multiple points of comparison between the 1988 game and the 1989 one—including comprehensive details of changes in the number of officers on duty at the two games.

10.29 In the very first draft of the proof of evidence, part 5 consisted of a chronological summary of the events of 15 April 1989, from 2pm to 3.33pm. In the Wain report, part 5 was over 100 pages long and quoted extensively from 81 officer accounts. Full versions of these accounts were also included in an appendix.

10.30 In a section with the subheading "Events to 2.30pm", numerous quotes were included from officers about supporters drinking large amounts of alcohol and/or attempting to enter the ground without tickets. Some of these were potentially misleading. For example, in an extended quote from Supt Marshall describing supporters "drinking openly", he commented: "all of the fans I encountered were Liverpool supporters". This arguably gave the impression that only Liverpool supporters were drinking. However, as he was on duty at the Liverpool end, it was in fact no surprise that he only encountered Liverpool supporters.

10.31 The subsection on the emergency response also included several accounts where officers referred to their efforts being hampered in some way by the actions of supporters under the influence of alcohol.

10.32 At the Goldring Inquests on 20 April 2015, Ch Supt Wain was directly asked about the reasons behind the inclusion of this material, and whether it stemmed from discussions at the meeting with the legal team on 26 April 1989. He confirmed that was the case and that he had picked up "a concern among senior officers to ensure that any evidence about changes in fan behaviour was highlighted".

10.33 At the Goldring Inquests, the barrister representing Ch Supt Wain pointed out that of the 81 accounts appended to version B of the proof of evidence, 31 officers stated they had witnessed the consumption of alcohol and a further 29 either referred to the effects of alcohol on supporters or made other observations about the involvement of alcohol. This therefore appeared to support Ch Supt Wain's assertion—both at the Goldring Inquests and in his prepared statement to the IOPC—that the focus on alcohol consumption in the proof of evidence reflected the evidence of the SYP officers.

10.34 However, it overlooked the fact that SYP had control over which accounts it chose to include. According to dates on SYP's HOLMES account, up to and including 8 May 1989, some 429 officer accounts (including seven statements) had been registered. There is no clear explanation of how the 81 accounts used were chosen.

10.35 Having reviewed all these accounts, the IOPC has established that 44% of them included a reference to Liverpool supporters behaving in a way that could be seen as negative. By comparison, 72% of the accounts referred to in part 5 of the Wain report referred to negative supporter behaviour. This indicates that the accounts SYP selected for inclusion over-represented these issues.

10.36 These topics were then reintroduced in a section under the subheading "Observations", which was written in a different style to the rest of part 5. As the subheading suggested, it was mostly comment; however, it did not accurately reflect the evidence of the preceding sections. More significantly, the section as a whole squarely pointed the finger at supporters, with a series of observations that had not been substantiated in the evidence included as part of the Wain report, or since. Examples of this were:

- "Saturday 15 April 1989 was a warm and sunny Spring day, which should have provided the perfect atmosphere for a major sporting attraction. Instead, however, it would appear that many visiting spectators used this as an opportunity to find local public houses and off licences where they could purchase and consume alcohol, to the extent that in so doing their arrival at the stadium was seriously delayed."
- "The situation was exacerbated by the obvious influx of a large number of Liverpool supporters who did not have a ticket."

- "Despite substantial police resources which had been allocated for the event, senior officers found themselves suddenly and unexpectedly overwhelmed by several thousand spectators who had converged on the Leppings Lane entrance within a few minutes of the designated time for kickoff, many of whom being the worse for drink embarked upon a determined course of action, the aim of which was to enter Hillsborough Football Stadium at all cost; irrespective of any danger to property or, more importantly, the lives and safety of others."

10.37 Strikingly, the Observations section was introduced with the comment: "the Chief Constable is content to make a number of observations which he feels may be pertinent to the Committee of Enquiry". This firmly placed the responsibility for these observations on CC Wright.

10.38 On 9 May, the 288-page Wain report was given to the legal team. In a phone call before the legal team received it, ACC Anderson told Mr Metcalf that the draft was two inches thick. Mr Metcalf replied that "this was not too bad and that if we could cut it down to 1 inch thick with just a few crucial documents included as appendices to the report itself, then I would be really quite satisfied." Having seen the draft, Mr Metcalf spoke to ACC Anderson again later that day and informed him that they intended to edit part 5, which would "be limited to factual comment up to about 2.00pm" on the day of the disaster.

10.39 The legal team edited the document extensively. The submitted version included no officer accounts. Clear points of comparison between the 1988 and 1989 Semi-Finals, such as differences in officer numbers, were mostly removed, as was the section on *Harris v Sheffield United.* The references to supporter behaviour on the day were cut, but some earlier references to previous matches involving Liverpool supporters were retained. Most notably, the section on the events of the day was cut from over 100 pages to just seven, and ended at 12 noon, when the turnstiles opened. The submitted version included the following explanation: "With a view to avoiding comment prejudicial to the Enquiry this background material does not seek to cover the tragic events which followed thereafter."

10.40 The majority of the observations were removed from the version submitted to the Taylor Inquiry, leaving only a section of three paragraphs, with a very different tone:

"The South Yorkshire Police has been deeply involved with the tragic events which occurred on Saturday 15 April 1989. Police officers and civilian personnel involved in the operation have been deeply grieved by the death and suffering which they witnessed on an occasion which should have been an enjoyable sporting event. Many have had to seek professional counselling.

"For those most directly involved, memories and a deep sense of sorrow will remain with them for the rest of their lives, particularly those officers who tried so desperately to save the lives of men, women and children.

"The Force extends it sincere condolences to the relatives and loved ones of those who died."

10.41 By the time the Wain report was handed to the legal team, there had been some significant developments in terms of the evidence that the Taylor Inquiry had requested from SYP. Notably, the accounts of the SYP officers on duty now had to be submitted to the Taylor Inquiry—a decision that led to the review and amendment process described in the previous chapter. This may explain why the legal team removed references to officers' accounts from the proof of evidence.

10.42 At the Goldring Inquests, Ch Supt Wain acknowledged he was responsible for the proof of evidence, regardless of its authorship. Under cross-examination, he also accepted that the document he had overseen was potentially misleading.

The accuracy of officers' accounts submitted to the Taylor Inquiry

10.43 More than 700 officers had their accounts submitted to the Taylor Inquiry. In the course of its investigation, the IOPC received specific complaints about the accuracy of the accounts given by seven officers. In two further cases, the IOPC identified material that raised questions about the accuracy of the evidence the officers concerned had presented.

10.44 Each of these instances is covered in a complaint or conduct report, and the complainants and officers concerned have been informed of the outcomes.

10.45 This section summarises some of these, where the matter under investigation is relevant to the overall understanding of the disaster and specifically to allegations that police officers exaggerated or fabricated stories about the behaviour of supporters.

10.46 Though normally a plain clothes officer, Detective Constable James Oakes (DC Oakes) was on duty at the 1989 FA Cup Semi-Final in uniform. He was part of a serial of officers stationed inside the turnstiles at the Leppings Lane end and was close to exit Gate C when it was opened. After the match was halted, DC Oakes assisted in the rescue effort.

10.47 He produced an initial account dated 17 April 1989 that is the source of the complaint against him. In this account, DC Oakes described his experiences on the day, from 8.30am until a post-incident debrief in the North Stand. He referred to attempting to resuscitate two supporters. He wrote that as he tried unsuccessfully to resuscitate one of these two, the supporter "was vomiting beer."

10.48 When this victim's blood alcohol level was tested during the post-mortem, it was found to be zero, a point emphasised by Dr Popper during the original inquests.

10.49 However, the comments made by DC Oakes became the subject of a formal complaint from the family, that the account was fabricated and that it had been drafted in a way that conveyed the impression that supporters were drunk.

10.50 For health reasons, DC Oakes could not be interviewed by the IOPC or called to give evidence at the Goldring Inquests. However, after a lengthy period of correspondence, he agreed to provide the IOPC with a written response to the allegations.

10.51 In the written response, DC Oakes explained the reasons he believed the supporter had vomited beer but acknowledged that this was incorrect and stated he regretted that this comment had caused undue distress to the family.

10.52 In response to the allegation about the overall tone of his account, DC Oakes commented that everything he wrote was "what I believed to be true and not influenced by anyone else." The account included references to supporters being intoxicated, attempting to enter the ground without tickets and being aggressive outside the ground. Many other SYP officers also made similar comments in their accounts; DC Oakes's account does not stand out as giving markedly more emphasis than others to such comments.

10.53 There were two specific points he mentioned that were not supported by other evidence; these were a comment that he saw two supporters being arrested for selling forged tickets, which did not appear in any arrest records, and another that he saw a supporter pick up a match programme from next to someone who had died.

10.54 Police Constable David Scott (PC Scott) was a mounted officer on duty outside the Leppings Lane entrance. BBC cameras recorded him swinging his arm and striking a Liverpool supporter in the crush before the game. This footage was shown on news reports in the days following the disaster. In his original written account, PC Scott explained that he had acted to protect his horse from supporters who were threatening to burn it with cigarettes. He added that when he inspected his horse later, he found lumps on its back legs and said the horse's coat appeared singed.

10.55 His account was supported by the statement of Phillip Webb, a farrier who looked after SYP horses. Mr Webb stated that he had seen multiple circular burn marks on the horse. Both repeated their claims in subsequent statements.

10.56 The injuries to the horse were accepted as fact by the Taylor Inquiry. WMP investigated complaints about the actions of PC Scott and sought, unsuccessfully, to identify the supporter who had been struck. No disciplinary proceedings were recommended, but PC Scott received management advice about his future actions.

10.57 However, after PC Scott's account and Mr Webb's statement were published online by the HIP, the IOPC received a complaint that they may have been exaggerated. The complainant suggested that if the injuries were as bad as claimed, the horse would have needed veterinary treatment, but there was no record of any such treatment. He also suggested that SYP would have taken photos of the injuries; again, there were none.

10.58 To investigate the complaint, the IOPC reviewed the video footage of the incident involving PC Scott but did not see any signs of the horse being in distress, as might be expected if it was being burned. Investigators then took statements from other members of SYP's Mounted Section. Though some recalled hearing about a horse being burned, none had seen the injuries. The SYP press log showed that the head of the Mounted Section had expressly denied that a horse had been burned but said it had been threatened.

10.59 The IOPC appointed an expert witness—a professor specialising in equine surgery—to review the evidence and explain how a horse might react if it was burned. She stated she would expect a horse being burned multiple times to show signs of distress, such as kicking out or swishing its tail. She saw no video evidence of either. To assess the likely impact of a cigarette burn on a horse's skin, she conducted a series of tests (with all appropriate consents) to the body of a horse that had recently been euthanised. These included applying a lit cigarette to the horse's skin: it did not result in the kind of marks that Mr Webb had described.

10.60 The IOPC then reinterviewed PC Scott and Mr Webb. When shown some of the evidence that the IOPC had gathered, Mr Webb changed his account and stated that he was not sure if he had actually seen any burn marks. He said it was possible he had made the statement to WMP because he was disgusted at what he had heard from PC Scott about the burns, rather than having seen them himself. PC Scott made no further comment.

10.61 The IOPC also established that PC Scott and Mr Webb knew each other socially; PC Scott attended Mr Webb's wedding.

10.62 The claim that supporters burned a police horse with cigarettes was a damaging allegation that painted a picture of supporters being either sufficiently cruel to deliberately cause the injuries, or sufficiently insensitive as to not realise that they were doing so. The evidence gathered by the IOPC indicates this alleged incident did not take place.

10.63 Based on the evidence gathered, in June 2017, the IOPC referred PC Scott and Mr Webb to the CPS, requesting a decision on whether both individuals should be charged with the criminal offences of perverting the course of justice and conspiracy to pervert the course of justice. In December 2017, the CPS announced that no charges had been authorised against either individual. The decision was challenged under the Victims' Right to Review Scheme. The evidence was reviewed by a different prosecutor, who upheld the CPS decision.

10.64 The evidence was also set out in a separate complaint report. Having reviewed it, the IOPC's view was that, if he had still been serving with the police, PC Scott would have had a case to answer for gross misconduct, for falsehood or prevarication.

Evidence given by senior officers at the Taylor Inquiry

10.65 The Taylor Inquiry was set up to establish what happened during the disaster and its causes, with a view to learning lessons that could prevent such events from happening again. It was a departmental inquiry, rather than a statutory public inquiry, meaning it was not a court, or course of public justice, and did not operate in that way. Unlike at a criminal trial, witnesses did not have to swear an oath before they gave evidence.

10.66 Nonetheless, in his opening speech, Mr Collins, Counsel to the Inquiry, set out a "hope that all who are involved in this Inquiry appreciate it is vital that an accurate account be given even if that involves admissions of errors." He added that "the avoidance of any such disaster in the future is more important than the justification for what occurred on this occasion."

10.67 In total, 60 SYP officers were called to give evidence to the Taylor Inquiry, ranging from PCs who had been on duty at the Leppings Lane end to senior officers. This meant that SYP accounted for more than a third of all the witnesses called.

10.68 Concerns have repeatedly been raised about the accuracy and completeness of the evidence some of these officers gave. As set out at the start of this chapter, the Taylor Interim Report expressed the view that senior officers had been "evasive and defensive" in their evidence. It further stated that the quality of the evidence given by police officers "was in inverse proportion to their rank".

10.69 The focus of the IOPC's investigation was around the accuracy of the evidence and whether any officer sought to deliberately mislead the Taylor Inquiry. In particular, the IOPC looked at the evidence that senior officers gave in relation to two broad topics: supporters' behaviour and police tactics and actions to control the supporters.

10.70 Investigators identified a high degree of consistency in the evidence senior officers gave to the Taylor Inquiry in relation to whether:

- SYP was responsible for monitoring the fullness of the pens
- SYP had previously closed the tunnel leading from the concourse at the Leppings Lane end to the centre pens of the West Terrace (Pens 3 and 4)

- SYP had previously deployed cordons of officers on the approach to the Leppings Lane entrance to check supporters had valid tickets for the game

10.71 However, when some junior officers gave evidence, they offered different perspectives; some described previous police actions to close the central tunnel, including at the 1988 FA Cup Semi-Final at Hillsborough Stadium.

10.72 The evidence the senior officers gave appeared to contradict what they had said in internal meetings.

10.73 For example, as set out at paragraph 10.21, at the meeting on 26 April, Ch Supt Mole stated that there was a known contingency among senior officers to close the tunnel when the pens were full. He was the first SYP officer to give evidence to the Taylor Inquiry on 24 May. He was asked about the tunnel closure at the 1988 Semi-Final, where he had been match commander, but said: "I have no recollection of closing the tunnel in 1988." In reply to further questions, he then stated: "I have no information of anyone putting a serial or barrier across that tunnel."

10.74 This prompted Lord Justice Taylor to intervene and ask: "You are saying nobody closed off the tunnel in 1988?" Ch Supt Mole replied: "I am aware of that suggestion, and I have made enquiries and can find no confirmation of that. I certainly have no recollection, and those Officers who were present have no recollection of it."

10.75 By the time Ch Supt Mole gave evidence, SYP had recorded on its HOLMES database a significant number of officer accounts that had mentioned the tunnel being closed at the 1988 Semi-Final. References to tunnel closure had been removed from some accounts by this date. This calls into question the extent and rigour of the enquiries Ch Supt Mole claimed to have made about the issue.

10.76 When he gave evidence to the Taylor Inquiry, Supt Greenwood was asked how he would respond to the centre pens of the West Terrace becoming full. He suggested he would have simply alerted the PCB and stated: "I did not know of the arrangement in terms of what would happen if they got full." He was then asked if he had any idea what action he would have expected to be taken as a result. He replied: "No, because we had never reached that stage."

10.77 However, a range of evidence shows that both before and after the disaster, Supt Greenwood drew colleagues' attention to the crushing incident on the West Terrace at the 1981 FA Cup Semi-Final at Hillsborough Stadium.

10.78 In his evidence on 31 May and 1 June 1989, Supt Murray was asked whether he had thought it would be necessary to block the tunnel when Gate C was opened on the day of the disaster, allowing large numbers of supporters in over a short space of time. He said he never considered it and denied any knowledge of the tunnel being closed at the 1988 Semi-Final.

10.79 Supt Murray was asked whether any officers "were concerned to keep a watch on the filling of Pens 3 and 4 of the Leppings Lane terrace?" He replied: "There was no one who had a specific duty as such." He was not asked directly what his own duties regarding the filling of the pens were.

10.80 Insp White was on duty on the inner concourse at the Leppings Lane end, a role he had performed many times before. At the Goldring Inquests, he recalled that when he received a copy of the Operational Order for the 1989 Semi-Final, he had gone to see Supt Murray. He said that Supt Murray told him that he should not follow the approach he had previously taken to filling the pens in a sequential fashion and instead

should leave all pens open and allow supporters to find their own level. He added that Supt Murray said "that he, up in the control box, was in the best position to see if anything was developing in those pens." Insp White repeated this point twice more in his evidence.

10.81 Ch Supt Mole, Supt Greenwood and Supt Murray were all highly experienced officers, who had worked at Hillsborough Stadium many times, at high-profile and ordinary matches. Yet when giving evidence to the Taylor Inquiry, they broadly indicated that the police had no responsibility for monitoring the pens and were either evasive in answering questions about past practice to close the tunnel or flatly denied any knowledge of it having taken place in 1988.

10.82 This denial or omission appears to echo the removal of references to tunnel closure from the SYP proof of evidence submitted to the Taylor Inquiry and from SYP officers' accounts.

10.83 If these senior officers had acknowledged that SYP had previously closed the tunnel when the pens were full, it may have indicated a significant failure on the day of the disaster: the failure to follow past practice and prevent supporters from entering full pens.

10.84 It was therefore of considerable significance when some more junior SYP officers giving evidence to the Taylor Inquiry described precisely the practice of closing the tunnel—echoing the evidence that had been given by some supporters. On 5 June 1989, Ch Insp Creaser, another officer with a lot of experience policing matches at the stadium, stated that he believed the tunnel had been closed at the 1988 Semi-Final. He later explained that though he had not been involved on that occasion, there were "several times when I have taken that action", including at the 1987 FA Cup Semi-Final.

10.85 Ch Insp Creaser also told the Taylor Inquiry that the reason he knew the tunnel had been closed at the 1988 Semi-Final was because he had "seen sight of a statement of a former Sergeant Higgins" which mentioned this. This referred to Police Sergeant Trevor Higgins (PS Higgins).

10.86 The Taylor Inquiry team had not seen the account of PS Higgins but requested to. Over a month later, on 7 July, a member of the team reminded Hammond Suddards that the account had still not been provided. Documents show that the account was sent to Hammonds Suddards for review on 9 June and returned with suggested amendments on 12 June. There were then two further reminders from the Taylor Inquiry team before the account was delivered on 12 July. Many other accounts were delivered to WMP and the Taylor Inquiry in this period.

10.87 The evidence suggests that SYP did not forward the account of PS Higgins with due expediency. By the time it was delivered, the Taylor Inquiry was no longer hearing oral evidence, so there would have been no chance to call PS Higgins as a witness.

10.88 Nonetheless, two other officers referred to previous tunnel closure in their evidence and a third account was read to the Taylor Inquiry, from a police constable who stated he had closed the tunnel at the 1988 game, following an instruction from another officer. However, the police constable could not remember who that officer was.

10.89 Given this evidence, SYP's legal representatives informed the Taylor Inquiry team that the force accepted that the tunnel had been closed in some way at the 1988 Semi-Final. However, in subsequent written submissions SYP maintained that the tunnel had been closed in 1988 by junior officers acting on their own initiative—not

at the instruction of senior officers. This, SYP argued, explained why it had not been mentioned in the SYP Operational Order and why senior officers were not aware it had taken place.

10.90 In his Interim Report, Lord Justice Taylor concluded that, given how full the centre pens were, "the tunnel should have been closed off whether gate C was to be opened or not. The exercise was a simple one and had been carried out in 1988." However, he commented: "Unfortunately, the 1988 closure seems to have been unknown to the senior officers on duty at the time."

10.91 Several supporters who had been at the 1988 Semi-Final gave evidence to the Taylor Inquiry that in 1988 SYP had deployed cordons of officers, some distance from the Leppings Lane turnstiles, to check that supporters had tickets. Those who did not have tickets were turned away. According to the evidence given by supporters, this process:

- prevented those without tickets from approaching the turnstiles—thus reducing the total number of people in the turnstile area
- controlled the flow of supporters down Leppings Lane

Therefore, the use of cordons helped avoid a build-up outside the turnstiles. Some supporters said that they were surprised not to see cordons in place at the 1989 game.

10.92 This was supported by the evidence of an assessor employed by the FA, who told the Taylor Inquiry that at the 1988 Semi-Final he saw police officers checking tickets at two points. When asked if this had been "a formal system of filtering people", he said he was not certain.

10.93 Ch Supt Mole was asked about this issue, including by Lord Justice Taylor, who pointed out that there was a good deal of evidence that supporters had been asked to produce their tickets in 1988. Ch Supt Mole suggested this was simply a by-product of the fact that there had been a steady flow of supporters towards the turnstiles, which allowed officers to ask people for tickets. He stated: "that might be the misperception that someone has of what was taking place."

10.94 Both ACC Jackson and Supt Marshall suggested at the Taylor Inquiry that operating a cordon system would be difficult. Supt Marshall told the Taylor Inquiry that "an enormously strong Police presence" would have been required to filter the crowd effectively on Leppings Lane.

10.95 ACC Jackson stated: "I mean what you would require in a situation like that is certainly several hundred Police Officers to try and form some cordon to prevent the people crushing up to the turnstiles."

10.96 This comment was strikingly similar to the wording that had been agreed as an "appropriate answer" at a meeting between Mr Metcalf and ACC Jackson, Ch Supt Duckenfield and Supt Murray on 22 May. This meeting had been set up to talk through the "main points of criticism".

10.97 In relation to the use of police cordons outside the ground, the appropriate answer developed at the meeting was: "To have had any effect on the chaos which developed at Leppings Lane, something like 400 more Officers would have been needed, with a view to forming impenetrable cordons to block off both ends of the Lane and to send out sallies of Officers to disperse the crowds."

10.98 Another appropriate answer agreed at the meeting was that the arrival of supporters en masse would have reduced the potential effectiveness of cordons: "Any action taken to filter or slow down the movements of the crowds would only have caused problems elsewhere. As it seems that some three to four thousand people arrived between 2.30 and 2.50p.m., if some sort of block had been put on to allow, say, only one thousand through, the other two thousand would have had to be either contained or dispersed, with consequent nuisance and problems to local residents or even with the possible consequence of their moving down Pennistone [sic] Road, to confront supporters of Nottingham Forest."

10.99 In his evidence to the Taylor Inquiry, ACC Jackson stated: "From what I could see, they arrived in the last fifteen minutes, about 4,000 people." This number had not been cited in his initial written account. In response to a subsequent question, he added: "the situation in Leppings Lane would be extremely difficult because of the topography and the residents. You would start pushing the crowd then back on to the main road, back into the residential area, and probably back to the flashpoint, I should imagine, where Notts Forest fans were coming."

10.100 ACC Jackson stated at the Goldring Inquests that he was in the Directors' Box at the stadium by 2.40pm. The Directors' Box did not offer a view of outside the stadium. It is therefore not clear how he could have seen the situation outside the Leppings Lane entrance in the last 15 minutes before the game, when he claimed he saw 4,000 supporters arriving.

10.101 The meeting at which the appropriate answers were agreed was one of various occasions where SYP officers received support from the legal team, before they gave evidence to the Taylor Inquiry. Part of the stated reason for this was that a public inquiry was unfamiliar territory for police officers who were accustomed to criminal trials.

10.102 It is normal procedure for officers to receive some support and preparation before cross-examination. Solicitors or more senior officers might advise them of questions they may be asked and identify potential issues or discrepancies in their evidence. However, the evidence set out by the IOPC suggests that SYP's preparation for the Taylor Inquiry went further than this, with senior officers and a member of the legal team preparing and agreeing "appropriate answers" to likely criticisms. In one instance, this resulted in a witness using an appropriate answer as the basis for his evidence to the Taylor Inquiry, even though other evidence tends to indicate he would not have been able to give that account from his own personal experience.

10.103 The Taylor Inquiry was not a court. There was no legal requirement for officers, or any other witnesses, to provide the whole truth, as long as they did not mislead. Therefore, there was no bar to the use of agreed appropriate answers, as long as these answers were not inaccurate or misleading.

10.104 Nonetheless, it was certainly contrary to the spirit of the Taylor Inquiry and its intent and could be seen as an attempt to limit the evidence SYP put forward to the Inquiry.

SYP's closing submissions to the Taylor Inquiry

10.105 After the oral hearings of the Taylor Inquiry were complete, all parties were invited to produce a final written submission. Mr Woodward wrote the closing submissions on behalf of SYP and on 29 June 1989, SYP sent him some documents that they believed he may find helpful. These included the Observations that formed section 5.18 of the Wain report, and a memo sent by Ch Supt Wain to CC Wright on 16 June 1989, including suggestions for what should be in SYP's closing submissions, based on a review of the Inquiry transcripts.

10.106 On 6 July, the legal team made a 31-page submission on behalf of SYP. It was accompanied by an additional statement from Superintendent David Chapman (Supt Chapman), which Ch Insp Bettison helped obtain.

10.107 Supt Chapman's statement specifically addressed evidence given on 29 June (the last day of the oral hearings) by Douglas Lock, the head of security at SWFC.

10.108 Mr Lock had stated to the Inquiry that SYP and SWFC had an agreement that the police were responsible for crowd control and safety on the West Terrace at Hillsborough Stadium. He asserted that this agreement had been in place since 1982, when Mr Lock was a superintendent with SYP. According to Mr Lock, the agreement was a result of a discussion involving himself, Ch Supt Herold (who was then the SYP match commander for high-profile games at Hillsborough Stadium), Supt Chapman and the then SWFC Secretary, Mr England. Mr Lock said he then adopted this same approach when he was in charge of policing the ground, adding he had "rubber-stamped" an agreement that had been made by his predecessor, Supt Chapman. He further stated that this same agreement "was subsequently carried on by Mr. Freeman and also Mr. Murray."

10.109 The additional statement from Supt Chapman that was included as part of SYP's closing submissions wholly refuted this. It denied not only the existence of any agreement with SWFC but also that Supt Chapman had been present at any meeting that matched that described by Mr Lock.

10.110 The first page of SYP's main closing submission included an apparent criticism of the way the Inquiry had been conducted: "At the Inquiry no rules of evidence prevailed, no sworn testimony was given (and once the Advocates had become accustomed to such licence), leading questions became the order of the day, hearsay upon hearsay was invited and opinion and speculation was canvassed."

10.111 It suggested that, due to the speed at which the Inquiry had taken place and the fact that WMP's investigations were ongoing, "it may be unsafe, even if were considered possible, to come to what might strictly be described as findings of fact."

10.112 However, the closing submissions then presented information as facts which had either yet to be proven or had been proven wrong. For example, under the subheading "Non ticket holders", SYP's closing submissions claimed that there was a "significant and substantial element of non-ticket holders" at the game. This did not align with analysis conducted by the HSE for the Taylor Inquiry, which found that the total number of supporters who had entered the ground through turnstiles A to G and Gate C was at the very most just 14 more than the number of tickets available; the more likely figure was actually lower than the 10,100 capacity. Evidence has not emerged through any subsequent investigation to prove there were large numbers of supporters at the game without tickets.

10.113 The closing submissions also repeated the suggestion, rejected by the Taylor Inquiry, that there had been "concerted action" among some supporters to try to gain entry to the ground, and commented: "the very notion that something was planned or organised to defeat the Police and embarrass them into having to open the gates was, in the early stages of this Inquiry, dealt with perhaps somewhat dismissively and treated as fanciful by Counsel for the Inquiry. Clearly it is not a matter upon which it might be expected evidence would be readily, if ever, available. However, belatedly it has to some degree emerged and it is submitted that the notion of a plan by some to foment difficulty and disorder cannot be airily dismissed."

10.114 The IOPC has established that there were no similarities between the memo from Ch Supt Wain to CC Wright, which was then shared with the legal team, and a memo sent from Ch Supt Duckenfield to Ch Supt Wain on 13 June 1989.

10.115 Ch Supt Duckenfield's memo had included a series of recommendations to prevent or manage future crowd crushes at Hillsborough Stadium. Though not specifically analysing the causes of the disaster, his recommendations addressed some factors which have since been identified as contributing to the disaster. These included:

- the unequal allocation of turnstiles to the respective sets of supporters
- the physical layout of the Leppings Lane end
- improved signage, including a suggestion of a "large electronic indicator, similar to an electronic score-board, equipped with flashing lights so that fans queuing can be given, visually, up to date information regarding delays or police messages and, whatever the noise, this can be seen clearly by all queuing or waiting in Leppings Lane."
- greater use of loudhailers and Tannoys

10.116 Ch Supt Wain's memo similarly included recommendations around reviewing signage, turnstile allocation and the use of Tannoys and loudhailers.

10.117 When reviewing the memo, IOPC investigators noted that its tone is highly lucid, and the recommendations appear to show some insight into the causes of the disaster. This makes a notable contrast to the more hesitant answers Ch Supt Duckenfield gave in his evidence to the Taylor Inquiry.

10.118 Evidence examined by the IOPC indicates that the closing submissions were written by the legal team—primarily Mr Woodward—and that SYP did not even see it before it was sent to the Taylor Inquiry on 6 July, despite a request from CC Wright to Mr Metcalf to view it. On 12 July 1989, Mr Metcalf and Mr Woodward met CC Wright and DCC Hayes. An attendance note of the meeting, written by Mr Metcalf, recorded that the officers were very pleased with the closing submissions.

Assessment of SYP's presentation of evidence against the terms of reference

10.119 As the evidence summarised has shown, significant questions remain about the accuracy and completeness of the evidence presented by SYP and by individual officers to the Taylor Inquiry. These questions are not predominantly concerned with the evidence individual SYP officers gave about supporters' behaviour. Given the evidence now available, and the gaps in that evidence, it is neither possible to verify nor wholly disprove officers' accounts and testimony about issues such as supporters' alcohol consumption.

10.120 The question of whether the evidence presented by officers about supporter behaviour was relevant is a complex one to answer. The material considered in this and other chapters strongly indicates that many SYP officers believed supporters' behaviour—and in particular the amount of alcohol consumed—was relevant to an understanding of the disaster. This stance was reiterated at the Goldring Inquests, where officers such as Supt Marshall and Insp Sykes stated that, while accepting there were flaws in police action and indeed their own actions, they still feel the role of the supporters in the disaster should be taken into account.

10.121 It is acceptable for a police force to present the evidence of its officers to an inquiry or external investigation and for that inquiry or investigation to consider it. Logically, the evidence the force presents will be whatever it considers relevant. However, as detailed in the previous chapter, IOPC analysis indicates that SYP sought to amplify the evidence about supporter behaviour.

10.122 This was the case with the claim that a police horse was deliberately and repeatedly burned with a cigarette. This was accepted as fact by Lord Justice Taylor. However, evidence gathered by the IOPC strongly indicates it did not happen and that the officer involved, PC Scott, exaggerated the incident to justify him striking out a supporter. This led the IOPC to the view that the officer would have had a case to answer for gross misconduct.

10.123 While some officers made comments about supporter behaviour when they gave oral evidence, information about supporter behaviour was deleted almost wholesale from SYP's proof of evidence before it was submitted to the Taylor Inquiry. The deletion was made by the legal team and was part of a comprehensive edit made before submission.

10.124 This took place at around the time when SYP was first advised that WMP would not be taking statements from its officers; instead, the recollections of SYP officers would be submitted to the Taylor Inquiry. In such a context, it could be argued that there was therefore no need to include a narrative summary of the recollections in the SYP proof of evidence; instead, the Taylor Inquiry team could simply read the recollections in full.

10.125 The result of the legal team's editing of the SYP proof of evidence was that the submitted version contained no details about events of the day after 12 noon (though these were covered in the officers' accounts). To answer part of the IOPC's terms of reference, this submitted version was not, and cannot have been, a complete picture of all the evidence available to SYP.

10.126 The IOPC's analysis of the different versions has also highlighted that several areas of information that would have been relevant to the Taylor Inquiry were removed from the proof of evidence before submission. Details of the number of officers on duty at the 1988 Semi-Final were cut, making it hard to compare the police preparation for the two games. Also, all references to the possibility of SYP closing the tunnel and having responsibility for monitoring capacity in the pens were deleted.

10.127 When senior officers gave oral evidence to the Taylor Inquiry, they denied that the police were responsible for monitoring capacity in the pens—suggesting instead it was the responsibility of SWFC stewards. In addition, they denied knowledge of past actions to close the tunnel. The IOPC view is that these denials appear to have been coordinated or formed part of an agreed stance.

10.128 In the face of substantial evidence from junior officers, some spectators and SWFC officials that the tunnel was not only closed at the 1988 Semi-Final but also that it was a relatively common practice to do so at league games, SYP and its legal team were forced to accept that the tunnel had been closed at the 1988 Semi-Final. However, they then claimed this was as a result of junior officers acting on their own initiative. Lord Justice Taylor accepted this.

10.129 Overall, the IOPC has found a range of evidence to suggest that SYP did seek to control the story it presented to the Taylor Inquiry, about certain topics. There is a consistency between the amendments made to officer accounts, the material in the proof of evidence and oral evidence given by senior officers. This consistency was not focused on the behaviour of supporters, but rather on the extent of police responsibility.

10.130 However, as set out in other chapters, there was no duty of candour to the Taylor Inquiry, as long as evidence was not misleading. Officers and the force as a whole were entitled to present their best case and not put forward material that could undermine the overall argument SYP and its legal team was seeking to make.

10.131 However, acting in this way was not in keeping with the aims of the Taylor Inquiry, to prevent such events recurring. SYP adopted a highly defensive approach and was selective in what it put forward as evidence, particularly in relation to tunnel closure and monitoring the pens. Though evidence around this came out during the oral hearings, the Taylor Inquiry still could not make safety recommendations based on a full understanding of how the police managed matches at Hillsborough Stadium.

10.132 The written submissions to the Taylor Inquiry were made in CC Wright's name. He was reportedly pleased with the closing submissions sent, which included unsubstantiated claims about the behaviour of supporters.

10.133 CC Wright had the authority to set the direction for the force's approach. He was directly aware of evidence pointing towards police culpability for the disaster. Instead of acknowledging this and seeking to assure the public that SYP would act to prevent any future reoccurrence, CC Wright appears to have sanctioned an approach that sought to deflect blame onto others.

10.134 It was clearly in the public interest that such information should have formed part of the Taylor Inquiry's considerations and not providing it was potentially detrimental to the Inquiry The IOPC was therefore of the view that, CC Wright could be deemed to have breached the Police Disciplinary Code for the offence of discreditable conduct. This was because he permitted and even appears to have endorsed the approach SYP took: one of defensiveness and deflection, rather than transparency. SYP senior officers were aware from an early stage that there was evidence suggesting that the actions of the police had caused, or contributed to, the disaster.

10.135 By contrast, as the Inquiry progressed, it was clear there was limited or no evidence of supporter behaviour being a causative factor. Despite this, SYP persisted in putting forward the case that it was, particularly in its closing submissions; hence Lord Justice Taylor's criticism of the police case as unrealistic. CC Wright had the authority to insist SYP adopted a different position, which was less defensive and did not seek to blame supporters; he made no efforts to do so. If he was still serving, his actions would have resulted in a case to answer for gross misconduct.

11. SYP's presentation of evidence to the Popper Inquests and contribution proceedings

What was investigated?

The IOPC investigated:

The evidence that was put forward on behalf of SYP, or by individual officers, to the WMP investigations, Lord Justice Taylor's Inquiry, the contribution proceedings, and the inquests, or in the immediate aftermath of the disaster, considering:

a) whether any police officer gave or produced evidence that was inaccurate, false or deliberately misleading (or was involved in attempts to do so)

b) whether such evidence contained inaccurate, misleading or irrelevant criticism of supporters' behaviour

c) whether the 'Wain Report' was an accurate and complete picture of the evidence

d) whether any police officer was party to, or directed the production or selection of, evidence that was inaccurate or misleading, including irrelevant criticism of supporters' behaviour and evidence regarding operational police tactics/actions to control supporters

This chapter focuses on the evidence presented to the Popper Inquests and contribution proceedings, and how SYP prepared for both.

What was found?

- After SYP had agreed to pay compensation to those seeking damages in relation to the disaster, it took court action to seek financial contributions from SWFC, Eastwood & Partners and SCC towards the payment. **This approach was advocated by both DCC Hayes and Mr Metcalf, even after newly appointed Counsel Richard Payne QC had suggested SYP was likely to be liable for the majority of compensation payments.**
- **In preparation for the contribution proceedings, a team of officers under Ch Supt Wain was tasked with carrying out a series of actions requested by the lawyers.** These included reviewing the Taylor Interim Report to see if there was anything the force should challenge and re-examining evidence around the 1988 tunnel closure.
- In their evidence to the Taylor Inquiry, four officers had indicated they were aware of previous police actions to close the tunnel to the centre pens. **The team under Ch Supt Wain was instructed to ask these officers to review the transcripts of the evidence they had given to the Taylor Inquiry and, if they felt it had given the wrong impression, provide a statement correcting it.** All four refused.

- **In preparation for the generic hearing of the Popper Inquests, Ch Supt Wain issued an instruction to identify the officers who could provide the best evidence about various aspects of alleged misbehaviour by supporters.**
- **Mr Metcalf described on three occasions the "strategy" he proposed to follow at the Popper Inquests** on behalf of his client, which involved a "low key approach avoiding too much individual criticism" but highlighting "drink induced hooligan behaviour".
- In their evidence to the Popper Inquests, **senior officers again sought to play down the force's responsibility for safety in the pens or at the stadium and to avoid the suggestion that senior officers on duty on the day had failed to take relevant action, such as to close the tunnel.**

Significant new evidence

There were two main sources of new evidence around the Popper Inquests and contribution proceedings. These were:

- **the attendance notes and other documentation held by Hammond Suddards. This information had been disclosed to the HIP, but only at the very end of its work, so had not been assessed in depth**
- **the policy books of ACC Jones of WMP, who had worked closely with Dr Popper in preparation for the generic hearing of the inquests. These had not previously been available**

Background to the generic hearing

11.1 On 18 April 1989, inquests into the deaths at Hillsborough Stadium were opened, and immediately adjourned by Dr Popper. The adjournment was because there was a possibility of criminal proceedings in relation to the disaster. In such situations, it is accepted practice to defer an inquest.

11.2 A criminal investigation began in September 1989, after the publication of the Taylor Interim Report. By March 1990, with the criminal investigation work largely complete, Dr Popper sought the agreement of the DPP to restart the inquests as soon as possible.

11.3 Because the evidence was still under review by the DPP, there were limits as to what could be discussed in front of a jury at that stage. Dr Popper proposed holding the inquests in phases. There would be a series of individual inquests (these have sometimes been referred to as 'mini inquests') to confirm the identity of each of those who died, along with the medical cause of death, and where and when they died. Once the DPP reached his decision about whether anyone should be prosecuted, and potentially after any trials that followed, there would then be a generic hearing examining the circumstances leading up to the deaths. This proposal was accepted by all parties, including solicitors representing the families.

11.4 The individual inquests took place between 18 April 1990 and 4 May 1990. SYP officers were not required to present any evidence at the hearings.

11.5 On 30 August 1990, the DPP announced that no one would be charged with a criminal offence in relation to the disaster, meaning the generic hearing could freely take place. It began on 19 November 1990 and ended on 28 March 1991. It heard evidence from 230 witnesses, including 62 serving SYP officers and three witnesses described as retired SYP officers. The jury returned majority verdicts of accidental death in all 95 cases. Anthony (Tony) Bland died in hospital on 3 March 1993. His death was therefore not considered in the Popper Inquests, nor was that of Andrew Devine, who died in 2021.

11.6 A significant proportion of the officers who gave evidence commented on the behaviour of supporters and in particular about their alleged levels of alcohol consumption. This was despite the findings of the Taylor Interim Report that the great majority of supporters at the game were not drunk, nor even the worse for drink.

11.7 When the Lord Chief Justice announced in 2012 that the verdicts of the Popper Inquests were to be quashed and new inquests opened, one of the reasons he gave was the prominence given to alcohol levels among the Liverpool supporters. Another was the tendency by SYP to blame the supporters, which the Lord Chief Justice described as "disappointingly tenacious".

Background to the contribution proceedings

11.8 In the aftermath of the disaster, claims for compensation were made by some of those who had been injured or bereaved. These included claims from some police officers who had been on duty. They were not only against SYP but also other parties. By mid-August 1989, hundreds of claims had been made.

11.9 No party accepted liability, so it was expected that the claims would proceed to court. However, this meant that civil proceedings might take place before any criminal trials. If any SYP officers were facing prosecution, they could have refused to give evidence at a civil hearing.

11.10 To avoid this problem arising, on 30 November 1989, SYP announced that it intended to settle any "bona fide claims" for compensation out of court—but that it did not accept any liability. A large number of payments were made, at different levels depending on the nature of the claim. These included payments to 16 police officers.

11.11 SYP invited the other parties against whom claims had been made to join the out-of-court settlements. All declined, so SYP issued contribution claims against them, with the aim of requiring them to contribute towards the sums it had paid out.

11.12 The High Court determined that court hearings into the matter should take place in October 1990. The hearings commenced on 2 October 1990. On 5 October, SYP's Counsel requested an adjournment. On 8 October, it was announced that the parties had reached an agreement.

11.13 Though aspects of the civil litigation and contribution proceedings were referred to in the HIP Report, SYP's preparation for them has not previously been examined in depth. During the early stages of its investigation, the IOPC identified from documentary evidence that there was a strong link between the way SYP prepared for the contribution proceedings and the way it prepared for the generic hearing of the Popper Inquests. This led the IOPC to include the contribution proceedings within this term of reference for its investigation, even though the brief hearings meant the amount of evidence presented by any party in court was minimal.

SYP's approach to the contribution proceedings

11.14 Following the announcement in August 1989 of a criminal investigation into the disaster, on 11 September 1989, Hammond Suddards sent instructions to Mr Payne, who had taken over the role of Counsel for SYP from Mr Woodward, who had represented SYP during the Taylor Inquiry.

11.15 The instructions related to the various claims for damages received by SYP. Hammond Suddards requested advice on the likely liability for paying the claims, including how this might be split between the four parties against whom claims had been made: SYP, SWFC, Eastwood & Partners and SCC. Hammond Suddards also asked what further evidence might be needed to increase the share carried by the other parties. Mr Payne was asked for his view on the idea of settling the claims (in other words, paying compensation without going to court).

11.16 Mr Payne responded on 15 September 1989. He advised that, based on the findings of the Taylor Interim Report and the press statement of CC Wright in response to it (in which he said that he and SYP accepted those findings), the likely apportionment of damages in the civil case was about 55% against SYP and 15% against each of the other three parties.

11.17 On 2 October 1989, further instructions were sent to Mr Payne by Hammond Suddards to request advice on the evidence available around responsibility for public safety and the level of liability based on this evidence. In particular, advice was requested in respect of the Taylor Interim Report finding that SYP had "de-facto accepted responsibility for the packing and monitoring of the West terraces".

11.18 On 11 October 1989, there was a meeting at the barristers' chambers where both Mr Woodward and Mr Payne were based. Both attended, as did DCC Hayes and Mr Metcalf. DCC Hayes was recorded as making a point very early in the meeting that while CC Wright had publicly stated his acceptance of Lord Justice Taylor's report, this did not mean SYP accepted everything in the report. He added that "as far as the police were concerned liability remained to be determined in civil proceedings." Further into the discussion, he was documented to be "much concerned" that an admission of de facto (in practice) responsibility would amount to de jure (by law) acceptance for the future.

11.19 Mr Payne pointed out that "to defend the matter at a trial would be difficult in view of the Harris-v-Sheffield United case where SYP asked for money and were awarded money for crowd control." [Underlining in the original meeting notes.] He also pointed out that this case had been concluded just a few years before the disaster.

11.20 The topic moved to a discussion of SYP's potential admission of liability. DCC Hayes was recorded as accepting that there "was some liability on SYP" and that it would be "nonsensical" to dispute it. He added that the legal team "had given the same advice on this point and he [DCC Hayes] accepted it". However, he said the "amount of liability" was still to be decided. Three broad options for SYP were discussed:

- to continue to openly defend themselves against the claims
- to formally admit liability and allow judgment to be entered "with damages to be assessed"
- to come to an agreement with the other parties as to the proportion of blame each party would take, which would remove the need for a court hearing

11.21 It was agreed that at the forthcoming pre-trial review SYP would not offer any admission of liability. However, it was further agreed that if it became clear that a negotiated settlement was not going to be reached, SYP may need to reconsider.

11.22 Following this, on 18 October 1989, DCC Hayes, ACC Anderson, Ch Supt Denton and Ch Insp Bettison attended a meeting with Mr Metcalf, who advised them that Mr Payne had recommended admission of liability at an early stage. This was on the basis that SYP "would, perhaps attract 25% or more of liability in any civil case". He said Mr Payne had further argued that SYP should "admit those aspects of the claims to which we have no defence on the basis that doing otherwise might be seen as weak, indecisive, and flying in the face of Taylor."

11.23 Mr Metcalf was reported as saying that he did not believe "it would be as bad" as Mr Payne had suggested. He argued that non-admission of liability at this stage would provide time to negotiate a settlement with the other parties. The officers also raised the impact that admitting liability would have on force morale.

11.24 At the pre-trial hearing on 26 October 1989, the High Court rejected SYP's application that a civil case should not be allowed to proceed until after the criminal investigation and any trials had finished. A provisional date for hearing the first claims was set for 11 June 1990.

11.25 This led to SYP's announcement in November 1989 that it would settle claims out of court, though the announcement made clear this was not an admission of liability. A large number of payments were made, although as the HIP Report identified, "In cases that concerned the death of children, their parents received no more than the statutory bereavement allowance of £3,500 and funeral expenses." Some families of those who died did not make a claim.

11.26 In the announcement made on 30 November 1989, SYP stated that it had asked the other parties if they would join the force in settling these claims; however, it noted that all had refused to do so.

11.27 SYP subsequently issued contribution claims against all three organisations, asking them to contribute towards the sums it had paid out. They all declined, so again the matter proceeded to court. On 15 December 1989, the High Court determined that contribution proceedings would be held in October 1990.

11.28 The actual court date was confirmed in May 1990, and SYP began to prepare. On 25 May 1990, Mr Metcalf wrote to DCC Hayes to inform him that a date had been set for the contribution proceedings. Mr Metcalf explained that, on the instruction of the Court, "each party is to mark up copies of the interim and final Taylor reports by underlining those aspects of the report which they do not admit for the purposes of trial." Mr Metcalf also wrote that "a small team of Officers would be of great assistance" in preparing for the contribution proceedings.

11.29 On 30 May 1990, Mr Metcalf met DCC Hayes to discuss this further. DCC Hayes agreed to provide a team of officers under Ch Supt Wain to assist and made a list of tasks for the team. The first of these was to review the copy of the Taylor Interim Report that had already been examined and marked up by Mr Metcalf to identify whether there were any further aspects of it which they believed SYP should not accept.

11.30 There was a specific request to review the issue of tunnel closure and in particular the evidence of PS Higgins that at the 1988 Semi-Final he had received orders to close the tunnel. Further notes on this topic read: "Who was on duty at that end of the ground in 1988? What do any of these officers remember of the tunnel closure and alleged

verbal order to do that? It may be that the instruction to close the gate came from the Club. If it can be shown that many stewards were involved then the Club through their agents (stewards) should have known of this and their arrangements subsequently, ie 1989, seemed to have failed to take account of the 1988 experience which increases their liability."

11.31 Though Ch Supt Wain and Ch Insp Bettison were both appointed to the team, the majority of tasks appear to have been performed by Detective Inspector John Cleverley (DI Cleverley).

11.32 In a report to Ch Supt Wain on 2 July 1990, DI Cleverley dealt with the question of if and why the tunnel to the centre pens had been closed by the police at the 1988 Semi-Final. DI Cleverley reported that he had reinterviewed the officers who closed the gates to the tunnel. He wrote that they had indicated that "the instructions to do so came from police sources, not the club so far as they knew." None of the officers he had interviewed were able to identify who these police sources were. He commented: "the operation seems to have been simple and low key, with not much more than three officers involved."

11.33 The evidence identified by DI Cleverley appeared to reduce the possibility of SWFC accepting a greater share of liability in relation to tunnel control, as Mr Metcalf had hoped.

11.34 On 12 July 1990, Ch Insp Bettison provided a written update to DCC Hayes that confirmed the nine tasks had been completed. He also mentioned that on 11 July, he and DI Cleverley had met with Mr Metcalf and identified some further required actions. This correspondence indicates that DCC Hayes and Ch Insp Bettison were both fully aware of the actions being undertaken in preparation for the contribution proceedings.

11.35 Also on 12 July 1990, Ch Supt Wain instructed DI Cleverley to "interrogate the system" to identify the officers who could give the best evidence about issues such as "Unruly behaviour by Liverpool fans", supporters attending without valid tickets and alcohol consumption. This was noted as being in preparation for the inquests, rather than for the contribution hearings.

11.36 When he gave evidence to the Goldring Inquests, Ch Supt Wain was questioned about this request. He stated he had no recollection of it and that he was "shocked" to see it. He said he could only think that it "was a request from the legal team." When Mark George QC, representing some of the families of those who died, described it as "clear evidence of an attempt to denigrate the fans", Ch Supt Wain replied: "I must agree with you."

11.37 On 19 July 1990, Mr Metcalf wrote to DCC Hayes outlining his intention to challenge Lord Justice Taylor's finding that SYP had accepted responsibility for monitoring the capacity of the pens. He noted that while several officers had said "they believed the duty extended only to keeping an eye on the crowd and reacting to any signs of distress…", some officers had gone further. He identified Ch Insp Creaser and three other inspectors, all of whom had stated that they were aware of the police tactic to close the tunnel when the pens were full, or that they had been involved in police action to do so.

11.38 Mr Metcalf proposed that the officers should be asked to review the transcript of their evidence to see whether it gave "the true flavour of what they meant to say." If not, he suggested that they could provide a further statement to clarify. He provided a draft

statement that could be used as the basis for this, which began with the clarification that the officer "did not expect any police officer to be making a deliberate numerical or overall visual assessment of the numbers of fans entering each of the individual pens."

11.39 DI Cleverley approached the four officers as requested. All confirmed they were happy with the evidence they had given, and none made a further statement.

11.40 Having received the responses, on 16 August 1990, Mr Metcalf wrote to Ch Supt Wain stating that it remained his intention not to accept SYP was responsible for monitoring the numbers in the pens, but "realistically, we must face the likelihood of this issue going against us, as it did at the inquiry."

11.41 The approach used by Mr Metcalf, including the pre-drafting of a template statement for officers to complete, led to one of the charges of perverting the course of justice against him. This was considered in the trial of Mr Metcalf, Ch Supt Denton and DCI Foster in 2021.

11.42 On 26 May 2021, the judge, Mr Justice William Davis, ruled that there was no case to answer. He ruled that, in drafting statements for witnesses to sign, Mr Metcalf was acting in accordance with accepted practice, as long as the witness confirmed the information submitted in their name was accurate.

11.43 On 12 September 1990, DCC Hayes had a discussion with Mr Metcalf about the contribution proceedings, the generic hearing and the disciplinary investigations. In his file note, DCC Hayes said that Mr Metcalf "made specific reference to the lack of certified crowd capacity numbers for the individual Leppings Lane pens; the ineffective escape routes; the radial fences; the ineffective barriers; incompetent signing; the failure to close the tunnel; non-ticket holders; the recognition of overcrowding; and, other matters."

11.44 As can be seen, many of these issues cited by Mr Metcalf related to the ground layout—for which SWFC, rather than SYP, had primary responsibility. One related to supporters: the presence of non-ticket holders. Only two could be deemed to relate directly to the police operation: the failure to close the tunnel and the recognition of overcrowding, both of which SYP had already sought to demonstrate were not its responsibility.

11.45 On 21 September 1990, DCC Hayes attended a five-hour meeting with Mr Payne, Mr Metcalf and claims officers from SYP's insurers, Mutual Municipal Insurance. In notes he made following this meeting, DCC Hayes stated that Mr Metcalf had already met with the judge who would preside over the contribution proceedings. According to Mr Metcalf, the judge had "made it clear that on his reading of the evidence available to him at this time, he was of the view that the police were clearly negligent, especially in view of the very clear view they had over the terraces and he was surprised an out of court settlement had not been arrived at yet."

11.46 In his note, DCC Hayes also wrote: "I reacted very strongly against any acceptance that the police had, even de facto, accepted responsibility for monitoring the relevant pens if this was assumed to mean counting in, checking for overcrowding, taking remedial action if this was likely or seen to have occurred, as this would have been impossible." This echoed the stance DCC Hayes had taken from the earliest meetings in preparation for the contribution hearings.

11.47 As the case was settled out of court, these arguments did not need to be made. However, the IOPC identified that they showed a consistent approach from SYP, building from the Taylor Inquiry onwards, in rejecting the suggestion that officers had responsibility for monitoring safety in the pens.

Preparing for the generic hearing

11.48 Similarly, SYP's approach to the Popper Inquests was consistent with aspects of its approach to the Taylor Inquiry.

11.49 With the costs of compensation apparently contained by early October 1990 and the DPP having announced in August 1990 that no officers would be prosecuted in connection with the disaster, two major risks to SYP and its officers were, to a degree addressed. In this context, SYP now appeared willing to take a more confrontational approach at the forthcoming generic hearing (which was to look at the broader causes of death rather than just the medical causes) than it had done in previous legal proceedings.

11.50 At 2pm on 30 October 1990, a 'pre-inquest' meeting took place between DCC Hayes, Ch Insp Bettison, Mr Metcalf, Mr Payne and Patrick Limb (junior counsel working with Mr Payne).

11.51 According to a meeting note, Mr Payne suggested that in his view "unlawful killing is the most likely [inquest] verdict." This was instead of other potential verdicts such as accidental death, natural causes or an open verdict. However, he set out four points that would need to be accepted by the jury to reach that verdict, and indicated he felt that this was not a foregone conclusion.

11.52 He explained that SYP would not be permitted to make a speech or put forward a case to the inquests, so the only available "weapon" was cross-examination of witnesses. He suggested focusing on aspects of the ground layout and provision for spectators; in other words, drawing attention to apparent failings of SWFC.

11.53 Despite this, Mr Payne stated that he "saw no point in attempting to pass blame on any other parties". The note recorded that he then quoted from the judgment in the *Harris v SUFC* case, where he said that "police officers had firmly accepted their role as being one of crowd management."

11.54 Mr Payne was reported as stating that he did not "see the relevance of advancing an argument that it was drunken, disorderly Liverpool supporters who first created the problem for the Police outside the ground."

11.55 Later that same day, a further meeting was documented, at SYP HQ, where the police officers "under threat" attended along with their legal representatives. The term "under threat" referred to Ch Supt Duckenfield, Supt Murray, Supt Greenwood and Supt Marshall, all of whom were at this stage still potentially under threat of prosecution and police disciplinary proceedings and had appointed their own barristers to represent them at the generic hearing.

11.56 According to the meeting notes, Mr Payne again argued against attempting to "shovel blame" onto other parties and said that "the behaviour of the fans outside the ground may not be relevant."

11.57 The officers disagreed. According to the meeting notes, "There was a strong feeling from most parties that this evidence should be gotten-in. It was agreed that Hammond Suddards would be provided with details of those people known to the South Yorkshire Police who might give evidence in this regard".

11.58 The notes of these two meetings indicate a difference of opinion between Mr Payne and the police officers about the overall approach that should be taken. This is significant, insofar as several SYP officers have consistently suggested that they were acting in line with legal advice; the evidence shows that on this subject, SYP rejected the advice of Mr Payne.

11.59 Following the meeting, SYP carried out a series of actions that were related to promoting evidence about the behaviour of supporters. DCC Hayes approached ACC Jones to ask him whether Dr Popper intended to call some of the witnesses SYP had suggested; ACC Jones responded that this was Dr Popper's decision.

11.60 Separately, Ch Insp Bettison attempted to search the HOLMES database for statements from witnesses that included certain "buzz words" related to supporter behaviour and alcohol consumption—though this proved a fruitless task (and one Ch Insp Bettison later described as a "fool's errand").

11.61 On 6 November 1990, Mr Metcalf wrote to DCC Hayes to advise him that Hammond Suddards had looked through the statements and transcripts in accordance with the "various categories of misbehaviour". Mr Metcalf listed 79 SYP officers whose accounts were deemed most relevant to the categories. He invited DCC Hayes to remove any names from the list before submitting it to Dr Popper. Mr Metcalf's letter concluded: "I remain of the opinion that ground inadequacy was the real cause of this disaster and that the events outside, however abominable, should not be the main focus of our attention. Having made that point, if we can get in some solid evidence about drunkenness and drunken behaviour **and** this is fairly reported in the press, then this may do something to alleviate the perception of unfairness which clearly persists with a substantial number of Officers." [Emphasis in original.]

11.62 Of the 79 SYP officers listed by Mr Metcalf, nine were initially selected to give evidence at the Popper Inquests. Eight of these gave evidence, along with two others who had been on Mr Metcalf's list but were not initially selected by Dr Popper.

11.63 As the start of the generic hearing approached, Mr Metcalf set out a "strategy" he proposed to take. He explained this in a meeting with the new Chief Constable of SYP, Richard Wells, on 15 November 1990 and again in a telephone call with Mr Payne on 16 November. In speaking to Mr Payne, Mr Metcalf described a "relatively low key approach without too many attacks, but to bring out the issue of drink related hooliganism so far as possible." Once the generic hearing was underway, Mr Metcalf wrote to SYP's insurers, again describing the strategy in similar terms.

11.64 At the Goldring Inquests, DCC Hayes was asked questions about SYP's preparation for the generic hearing of the Popper Inquests. Under examination by Pete Weatherby QC, who was representing 22 of the bereaved families, DCC Hayes was specifically asked whether "in preparing for the inquests in particular, officers under your command were trying to raise the profile of evidence which blamed the fans". He replied: "Yes, I think that's true."

11.65 Of the 230 witnesses listed to give evidence at the generic hearing, 62 were serving SYP officers and three were retired. In the event, fewer SYP officers were called than had initially been planned: just 49, plus two retired officers. While several of them made comments about supporter behaviour, these were in line with their original written accounts. Though video and photographic evidence has not substantiated officer accounts, it is not possible to verify or wholly disprove their claims. When interviewing officers who gave evidence to the Popper Inquests, the IOPC asked if they stood by what they had said; none suggested they did not.

11.66 Despite the conclusions of the Taylor Inquiry, officers were still asked questions about alcohol consumption and given the opportunity to comment on the behaviour of supporters. Mr Payne asked the majority of these witnesses some questions about alcohol consumption, but so did other barristers.

11.67 Ch Insp Creaser and PS Crawford both gave evidence to the Popper Inquests and reiterated their accounts of police involvement in closing the tunnel at previous matches. PS Higgins was also called to give evidence and said tunnel closure was a standard practice. He could not recall who had given the order at the 1988 Semi-Final.

11.68 The senior officers on duty were all asked about tunnel closure. Ch Supt Duckenfield denied any knowledge of previous tunnel closures. He further suggested that it was not solely a police responsibility to close the tunnel and ensure supporters did not enter the centre pens. He asked: "Don't the fans have a role in this situation when they come through that gate?"

11.69 At the generic hearing, Supt Greenwood was asked: "Did you know at the end of the 1988 match or before the 1989 match began that the tunnel leading to the centre pens may have been or was closed off in 1988?" He replied, "no".

11.70 Supt Murray specifically stated in his evidence to the Popper Inquests that he only learned the tunnel had been closed in 1988 **after** the 1989 Semi-Final and added that was "the first I knew that the tunnel had ever been closed." Pressed on this, he said: "I had no knowledge of the tunnel ever being closed. No one had ever told me it had been closed; no one had ever told me it had been used as any sort of measure to prevent people going down."

11.71 Ch Supt Mole gave evidence to the Popper Inquests over several days. He was asked early on about tunnel closure and replied: "I have never had occasion to seal the tunnel and I have no knowledge of it being sealed in my operational experience."

11.72 The Popper Inquests ended on 28 March 1991, when the jury reached the verdict of accidental death. Though the Taylor Inquiry had found that "the main reason for the disaster was the failure of police control", at the Popper Inquests there was no adverse finding against SYP. This suggests that the evidence presented, selected or produced by SYP officers may have had a material impact on the process and the outcomes.

11.73 What can be said with certainty is that the fact that supporter behaviour and alcohol consumption again came under the spotlight had a devastating impact on the families of those who died and on many of the supporters who had been at the game but survived.

11.74 The evidence examined by the IOPC demonstrates that many officers in SYP felt that the Taylor Inquiry had not considered the impact of supporter behaviour sufficiently and wished to raise it again at the generic hearing. Mr Payne, the barrister appointed to represent SYP at the generic hearing, initially advised senior officers that he did not see this as relevant. However, it was made clear that the match commanders, and others,

felt strongly that the topic should be covered. It appears Mr Payne accepted this and adapted his approach to include a greater focus on supporter behaviour and alcohol consumption—again, in contrast to the arguments made by SYP officers that they followed legal advice. Evidence shows that once this approach was agreed, SYP and Mr Payne took a range of steps to encourage Dr Popper to call witnesses who might provide further details of drunken behaviour.

11.75 While there are questions about the appropriateness of this approach, questions about the accuracy and completeness of the evidence presented by SYP and by individual officers at the Popper Inquests relate primarily to other matters.

11.76 Again, SYP senior officers denied knowledge of past actions to close the tunnel, inferring they could not be held responsible for failing to instruct any officers to close the tunnel at the 1989 Semi-Final. They also rejected the suggestion that SYP was responsible for monitoring safety in the pens. There is clear evidence that these officers attended meetings after the disaster where tunnel closure was discussed. However, it is not possible to establish what knowledge they had at the time of the disaster.

11.77 IOPC conduct reports considered whether any of the officers had given inaccurate or misleading evidence. Having reviewed these, the IOPC was of the view that none had a case to answer. It was not clear that any of them had answered the specific questions they were asked in a misleading way, and because there was no duty of candour, they were not obliged to volunteer any further details.

11.78 The evidence in this chapter has shown that DCC Hayes was adamant that SYP should not accept that it was responsible for monitoring safety in the pens, and that when SYP began to prepare for the contribution proceedings, Mr Metcalf identified this issue as one that the force should challenge.

11.79 At Mr Metcalf's suggestion, a range of actions were coordinated to try to gather evidence that would enable SYP to challenge the Taylor Inquiry's finding. Officers that had given evidence about previous actions to close the tunnel or police responsibility for monitoring the pens—either in their original accounts or at the Taylor Inquiry itself—were approached and asked whether they stood by that evidence. This action was undertaken by DI Cleverley, but with the knowledge and endorsement of DCC Hayes, Ch Supt Wain and Ch Insp Bettison.

11.80 The IOPC investigated the conduct of DCC Hayes and Ch Supt Wain in relation to the contribution proceedings. Having assessed the evidence, the IOPC noted it was legitimate and acceptable for SYP to defend its position and present its best case, to minimise financial liability following the disaster. If doing so would require the force to gather additional evidence, it was legally entitled to.

11.81 The evidence is inconclusive as to whether this approach worked. The out-of-court settlement of the contribution proceedings on 8 October 1990 meant that other parties agreed to contribute £4 million to the costs of paying compensation. SWFC and Eastwood & Partners paid £1.5 million each and Sheffield City Council paid £1 million. In a letter to DCC Hayes on 19 February 1992, Mr Metcalf stated that the total liability was "now estimated at £12 million", noting that "if the estimate is correct then the South Yorkshire Police have taken two thirds of the liability." This proportion was higher than the 55% share anticipated by Mr Payne. Further, it continued to rise: by 1999, it is understood that approximately £19.8 million had been paid in compensation, with no further contributions from other parties. This meant SYP had covered almost 80% of the total sum paid.

11.82 The amounts paid to families varied, with many receiving comparatively small sums that were insufficient to cover funeral costs.

11.83 In June 2021, SYP and WMP announced additional compensation to 601 individuals following a group litigation claim for misfeasance in public office relating to the actions of the two forces following the disaster. The claims had been started in 2015, and compensation was awarded for the trauma and psychological harm as a result of the actions of the police in the aftermath of the disaster, including the investigations that followed. Acting Chief Constable Lauren Poultney of SYP stated that the force offered "an unreserved apology" to those affected by the Hillsborough disaster and its aftermath and acknowledged that "serious errors and mistakes were made by South Yorkshire Police, both on 15 April 1989 and during the subsequent investigations." She added that "The force's subsequent failings also caused huge distress, suffering and pain, both to the victims and their families."

11.84 WMP Deputy Chief Constable Vanessa Jardine also issued a statement, saying: "We deeply regret the harm and distress caused to those affected by the tragedy and although I know it cannot make up for their suffering, working with South Yorkshire Police, we have agreed a scheme to compensate those affected."

12. The checking of blood alcohol levels of those who died

What was investigated?

The IOPC investigated:

The checking of blood alcohol levels of those who died and survivors, and what influence, if any, any police officer may have had on the Coroner's/any other person's decision to do this.

What was found?

- **The IOPC found no evidence to indicate that the decision to test blood alcohol levels as part of the post-mortems following the disaster was influenced by the police.** Dr Popper consistently stated that it was his decision and believed it was the correct one. Most of the pathologists who conducted the post-mortems said they agreed with the decision.
- **Evidence gathered by the IOPC indicates that blood alcohol testing was not, as the HIP Report suggested, an "unusual" or "exceptional" decision.** Official coronial statistics indicate that toxicology testing takes place in around 1 in 5 post-mortems today: by no means a majority, but not rare enough to be deemed exceptional. Blood alcohol was tested in other disasters involving multiple deaths in the era, such as the Herald of Free Enterprise sinking in 1987.
- **The IOPC found no obvious clinical reason why ten of those who received hospital treatment after the disaster had their blood alcohol tested.** The consultant who authorised blood alcohol testing of survivors stated strongly that he had not been asked by police officers to do this.
- **The IOPC has found no evidence that blood alcohol testing was carried out on any other injured patients beyond these ten.**

Significant new evidence

New evidence gathered in investigating this term of reference consisted primarily of statements from Dr Popper and his deputy, six of the ten pathologists who conducted the post-mortems and the toxicologists who conducted the tests. In addition, investigators sought to gain the expert view of other coroners and pathologists on the decision to test blood alcohol levels.

12.1 On 16 April 1989, the day after the Hillsborough disaster, post-mortem examinations began on all of those who had died. These were carried out at the direction of Dr Popper, to assist in the inquests into the deaths. As part of the post-mortems, blood alcohol levels were tested in all cases—regardless of the age of the individual who died. In the context of allegations from the police and others that a large number of Liverpool supporters had been drinking heavily before the match, this testing has become a source of considerable controversy.

12.2 The HIP Report commented that Dr Popper's decision to conduct the testing was "an unusual direction" and stated: "The bereaved and survivors considered allegations of drunkenness had been compounded by the decision to take and publish blood alcohol levels, impugning the reputation of those who died."

12.3 The reference to publishing the blood alcohol levels reflected the fact that each individual's blood alcohol level was read out at two separate points during the individual inquests. The first time was at the overall start of proceedings, where the names and blood alcohol levels of all those who died were read out together. The second time was at the start of the specific inquest into each individual's death.

12.4 The HIP Report also showed, for the first time, that the blood alcohol levels of a small number of injured patients had also been tested. It asked why this had been done.

12.5 In light of the questions posed by the HIP Report, SYP referred the issue of blood alcohol testing to the IOPC to investigate. The focus of the investigation was to establish whether there was evidence to indicate that the decision to test the blood alcohol in all the post-mortems was influenced by the police.

The decision to test blood alcohol levels of all of those who died

12.6 The post-mortem examinations of 94 of those who died in the Hillsborough disaster began at around 9am on Sunday 16 April 1989. They were completed the following day.

12.7 Dr Popper had made initial arrangements for the post-mortems on the Saturday evening. At some point before they began, he determined that full forensic post-mortems should be conducted in all cases. That included the testing of blood alcohol in all cases, including on those aged under 18.

12.8 In the preliminary proceedings to the individual inquests on 18 April 1990, Dr Popper explained that this testing had been done at his direction. He acknowledged that blood alcohol testing was not conducted as a part of every inquest, but commented it is part of "a great number of cases".

12.9 He said he made the decision to authorise the testing because alcohol levels **may** have been relevant to understanding how people died. He added that he made the decision without knowing the ages of all those who had died and determined that it should be a standard part of all of the post-mortems.

12.10 Nothing he said in the preliminary proceedings indicated that any police officer—or indeed any other individual—influenced the decision.

12.11 The IOPC sought to re-examine the decision process, reviewing documentation and taking statements from Dr Popper, six of the pathologists who conducted the post-mortems (the other four had died) and various other members of Dr Popper's team.

12.12 Dr Popper reiterated to the IOPC that the decision had been his, and that no police officer had influenced it. He suggested that the question of whether to test blood alcohol had probably been discussed in his initial meetings with pathologists and the deputy coroner, but he couldn't specifically recall this. He said: "It might have been that one of the pathologists said that we ought to do blood alcohol tests, or I may have spontaneously thought of it myself."

12.13 None of those interviewed by the IOPC who were present in these initial meetings recalled there being any discussion regarding blood alcohol testing—nor of supporter behaviour or alcohol consumption.

12.14 Dr Popper also acknowledged that he was aware, from an early stage, of the suggestion that alcohol could have been a factor in the disaster but could not remember how he knew this or whether anyone said anything to him. He also stated that he thought what he had heard about alcohol was "unlikely not to have had an influence" on his decision.

12.15 Though he knew that some families were upset by it, he felt it had been the right decision, as doing it meant they had been able to answer the question as to whether alcohol had been a factor in the deaths; the testing provided evidence that it had not been.

12.16 In his statement, Dr Popper described the overall sequence of events between when he received the initial call from the police to advise him of the disaster and the start of the post-mortems. This provided an insight into where he went and who he might have spoken to.

12.17 He remembered speaking in depth to only one police officer before the post-mortems began. This was D Ch Supt Addis, with whom he discussed the formal identification process and arrangements for transporting those who had died from hospitals to the gymnasium, then on to the MLC.

12.18 At least four SYP officers mentioned seeing Dr Popper in the gymnasium. However, none of these officers has at any time mentioned speaking to him at this point.

12.19 Dr Popper stated to the IOPC that he had "no recollection of any pressure from the police" in relation to the question of whether blood alcohol testing should be conducted. He added: "I'm as confident as I can be at the present time that I was not put under any pressure to do it."

12.20 No one else interviewed by the IOPC suggested there had been any discussion with police officers about blood alcohol testing. The deputy coroner recalled being present when Dr Popper spoke to some police officers, including CC Wright, but said there was no discussion whatsoever about alcohol or the behaviour of supporters.

12.21 Regardless of how the decision was reached, Dr Popper stated to the IOPC: "I do not recall anybody questioned or disagreed with the decision to do the blood alcohol tests."

12.22 This was supported by the statements from the pathologists who, with one exception, felt it had been an appropriate decision in the circumstances. Several of them suggested they would have been more surprised if they had **not** been instructed to test blood alcohol levels.

12.23 The only pathologist who disagreed said that left to his own devices, he would not have tested blood alcohol levels as he didn't smell any alcohol in the post-mortems that he did. He arrived during the afternoon of 16 April, when the post-mortems were underway, and understood it was a definite instruction.

12.24 He also addressed the question of taking blood alcohol levels from those under the age of 18, commenting: "There was no separate discussion about the decision to take blood alcohol levels from those under the age of 18. One of the patients I examined was 14 years old and I didn't think it was all that appropriate really, I felt slightly uncomfortable doing it."

12.25 Again, this was a different view from the others, who agreed that having decided to test blood alcohol levels of all those who died, there was no need for a separate policy for under 18s.

12.26 While there was a difference of opinion on the appropriateness of testing, there was total agreement on the key issue for the IOPC's investigation: all of the pathologists who provided statements were unaware of any police influence on the decision to test blood alcohol.

12.27 D Ch Supt Addis was asked what he recalled of his contact with Dr Popper. He said: "I did not have any conversation with him regarding post-mortems and I had nothing to do with post-mortems whatsoever." He added: "I had no knowledge of why blood samples was [sic] taken from the deceased and checks on alcohol levels, I wasn't privy to any discussions regarding this."

12.28 Professor Jack Crane was an experienced pathologist who served as an advisor to the Goldring Inquests on pathological issues. After these ended, the IOPC asked him for an expert opinion on the decision to test blood alcohol levels. He provided a written report, in which he said that "In the circumstances of Hillsborough it seems quite reasonable for BAA [blood alcohol analysis] to be carried out on the majority of victims since there was [sic] at least a theoretical possibility that alcohol intoxication could have played a part in the incident."

12.29 He echoed Dr Popper's view that blood alcohol testing had ultimately proved valuable as it meant "the rumour that drunken fans contributed to the disaster could be, and indeed was, able to be refuted". However, he said that conducting blood alcohol testing on the children who had died was "disproportionate and inappropriate".

The way blood alcohol levels were presented at the individual inquests

12.30 The allegation that the decision to test blood alcohol was part of an attempt to discredit Liverpool supporters was reinforced for some by the way the information about blood alcohol was presented at the Popper Inquests. As explained earlier, the blood alcohol levels of all those who died were read out together in the evidence of the toxicologist, Dr Bob Forrest. Each individual's blood alcohol level was then read out again as part of the factual summary given in relation to that individual.

12.31 IOPC investigators asked Dr Popper why blood alcohol levels had been read out twice in this way. Dr Popper could not specifically recall this and suggested "it was merely a matter of convenience".

12.32 Documentary evidence shows that the approach was discussed at a pre-inquest review meeting, attended by some of the solicitors representing the families of those who had died in the disaster. There was no suggestion that any of them voiced any concern about it.

12.33 WMP was supporting Dr Popper in his work. The IOPC therefore examined records of WMP's investigation, such as the policy books of ACC Jones, who led WMP's work for the Popper Inquests. No reference of any sort was found to when blood alcohol levels should or would be read out.

12.34 While presenting the information twice in this way may have been distressing to families, the IOPC found no evidence to suggest it was done in an attempt to discredit those who died, or Liverpool supporters more generally.

Blood alcohol tests on injured supporters

12.35 While the testing of blood alcohol levels of those who died in the disaster had been a contentious subject since the Popper Inquests, the testing of blood alcohol levels of survivors only became public knowledge through two documents disclosed to the HIP.

- The first was a note from Dr Forrest, the same toxicologist who carried out the blood alcohol testing on the majority of those who died in the disaster, to Mr Alan Crosby, A&E Consultant at the Royal Hallamshire Hospital, on the afternoon of the disaster. The document listed 11 names and/or hospital identification numbers of survivors, a date and time, and their blood alcohol levels. For 9 of the 11 individuals listed, no alcohol was detected.
- The second was a document which, under the heading "Alcohol", recorded the number of those who died that had blood alcohol levels over 80mg/100ml (the legal alcohol limit for driving in England, Wales and Northern Ireland) then included the note: "few of those admitted had appreciable levels".

12.36 The IOPC used these documents as the basis to investigate why blood alcohol had been tested in these cases, and to establish if any other injured patients had been tested.

12.37 One of the first things the IOPC established in relation to the first document was that although there were 11 names or identification numbers on the list, it referred to only ten individuals: one was listed twice.

12.38 There was no record of this blood alcohol testing in the medical notes of eight of the ten survivors. The reasons for treatment did not suggest any correlation between those who were tested and the injuries they had or treatment they required: the list of those tested included individuals who had only minor injuries as well as some with more serious injuries.

12.39 IOPC investigators sought to contact each of the ten individuals listed on the note, or their families, to find out whether they knew anything about the testing. Where individuals gave consent, investigators reviewed the respective medical records to ascertain whether there was any common pattern or clinical reason (such as common pre-existing medical conditions) behind their blood alcohol level being tested.

12.40 None was found. Of the ten individuals, four were conscious on arrival; five were unconscious and one semi-conscious. Seven were admitted to intensive care.

12.41 Five of the patients agreed to talk to the IOPC. None of those interviewed recalled having their blood taken while in hospital. None thought that having a blood sample taken was an unreasonable step in their treatment, nor did they think they would have objected to it or questioned it at the time. However, none remembered being asked whether they were willing to have their blood taken for alcohol testing or being told that their blood alcohol level would be tested.

12.42 The IOPC followed a range of routes to establish whether blood alcohol testing had been carried out on any other injured patients. No evidence was found to suggest it had been.

12.43 IOPC investigators interviewed Dr Forrest and Mr Crosby to ask what they remembered of the testing and whether there had been any police influence on the decision to carry out tests.

12.44 Dr Forrest said he was aware, when he did it, that he "was carrying out the tests on people who had been injured at Hillsborough." He said that the tests were authorised by a consultant, and he had no reservations about doing them. He suggested that the consultant may have been intending to write a report or scientific paper on the disaster.

12.45 Mr Crosby who authorised the tests told the IOPC he couldn't remember asking for them but agreed that the request had come from him. He also accepted Dr Forrest's suggestion that it was possible he was considering writing a paper. However, he stated: "there would have been an initial clinical reason" for taking blood samples.

12.46 Crucially for the IOPC investigation, Mr Crosby stated strongly that he had not been asked by police officers to conduct blood alcohol testing and that "A suggestion like that from a police officer would not have gone down too well."

13. Police National Computer checks carried out on those who died

What was investigated?

The IOPC investigated:

The carrying out of Police National Computer checks on those who died and others to establish, if possible, which police force or police officer was responsible for this, the reasons why it was done, and whether it was justified.

What was found?

- **The Police National Computer (PNC) checks carried out after the disaster were done using the original PNC**, which was replaced by PNC2 in 1991. This meant that, unlike PNC2, there would have been no records in the system to show who had conducted the search or produced the printouts.
- **The IOPC has not been able to establish who carried out the PNC checks or wrote the accompanying summary.** However, it has established that the handwriting on the summary did not belong to the solicitor who originally provided these documents to the HIP, or to his client, Supt Marshall.
- SYP standing orders from the time indicate that **carrying out PNC checks on those who died would have been in line with procedure**, so that records could be updated. However, **in the aftermath of the Hillsborough disaster, it appears that the process followed was not in line with SYP guidance.**
- This was confirmed when **in 2014 the IOPC conducted PNC checks on those who died in the disaster and found that records relating to nine of those who died had not been removed, as they should have been.** This has since been rectified, and the National Policing Lead for Information Management apologised to the families of those who died for the oversight.
- **WMP conducted Criminal Records Office (CRO) checks on 94 of those who died.** The IOPC has not found any specific explanation for why or when this was done, nor any evidence of who conducted them.
- In response to the concern that PNC checks had been carried out on someone who claimed compensation after the disaster, **the IOPC conducted a comprehensive search of the archived material to establish whether any form of check was conducted on any other individual. Only one more check was found.**

Significant new evidence

In June 2016, during a search of SYP premises conducted at the IOPC's request, a book of SYP standing orders from late 1989/early 1990 was found. This contained the standing orders around use of the PNC referred to in this section.

The IOPC also contacted former PNC operators at SYP to understand how the PNC was used in 1989 and up to the launch of PNC2.

13.1 The PNC is a national database of information available to all UK police forces and law enforcement agencies. It holds a range of information relevant to policing, such as records of people who have previous convictions, cautions and formal warnings. It also holds information about all UK drivers and the vehicles they own.

13.2 The PNC is used by police officers and some police staff routinely in their daily work, for a range of reasons, but there are strict rules on how it should be used. Looking up whether a person has a criminal record on the PNC is known as conducting a PNC check.

13.3 Documents disclosed to the HIP showed that PNC checks were conducted on some of those who died in the Hillsborough disaster. This information had not previously been public knowledge. The documents, which consisted of printouts from the PNC and a handwritten list of personal data about some of those who had died, had been in the possession of the solicitor who had represented Supt Marshall during the original criminal investigation into the disaster and at the Popper Inquests.

13.4 The documents gave rise to the concern that, in this instance, PNC checks may have been carried out inappropriately or even unlawfully. One reason for this concern was that the checks appeared to have been carried out systematically on a targeted group: those who died in the disaster **and** who had blood alcohol levels over zero. Another reason was that the information had been in the possession of a third party (the solicitor) who, under normal police procedure, would not have had access to PNC data.

13.5 The HIP Report suggested that the checks were carried out in an attempt to impugn the reputations of those who died. In addition, the HIP Report stated that, in response to claims for compensation for injuries sustained at Hillsborough Stadium, "South Yorkshire Police (SYP) undertook criminal records checks on the claimants." In fact, the documents available to the HIP provided evidence that this had happened in one case.

13.6 As there appeared to be a clear breach of accepted practice around the use of the PNC, both SYP and WMP referred the matter to the IOPC to investigate.

Seeking to establish who conducted the PNC checks and why

13.7 The IOPC sought to establish who carried out the checks, why, and how the information had been given to the solicitor. Investigators made several attempts to interview the solicitor, who had indicated he wanted to speak to the IOPC. However, he was in poor health and unable to answer questions. Members of his family, who had worked with him, and other former colleagues spoke to the IOPC and confirmed they had no knowledge of how he had obtained this information. They allowed the IOPC to take further documents from the solicitor's home to review, but these contained no further references to the PNC checks.

13.8 Supt Marshall stated he had no knowledge of, or involvement in, any PNC checks being carried out in relation to the Hillsborough disaster. Investigators did not find any information to suggest otherwise.

13.9 Investigators also compared handwriting on the documents to a sample of Supt Marshall's handwriting. The visual dissimilarities between the two were so apparent to the naked eye that no further comparative analysis was deemed necessary. Investigators asked the solicitor's family if they recognised the handwriting as his. They all agreed it was not.

13.10 The format of the printouts showed that they were from the original PNC rather than from PNC2, which became available to police forces in 1991. This narrowed the time window; however, it also meant that there were no records to show who had conducted the search or produced the printouts. Under PNC2 and current procedure, the name of the officer who conducts a check is automatically recorded and stored.

13.11 IOPC investigators spoke to two former PNC operators at SYP to understand how the PNC was used by the force in 1989 and up to the launch of PNC2. The operators explained that PNC checks were typically conducted by trained staff at a dedicated terminal. As far as they could remember, in 1989 SYP had two PNC terminals in the CRO and an additional two in the Force Control Room. To request a check, officers in the field would call in via radio or telephone. They would have to give their name and collar number, plus the name and date of birth of the subject of the check. The information they requested was recorded on paper logs, along with the date and time the check was requested. The paper logs were kept for 12 months before they were destroyed. In line with this policy, the IOPC has not found any paper logs from the time.

13.12 The IOPC asked SYP officers interviewed if they had any recollection of PNC checks being carried out after the disaster. The only officers who referred to anything of this sort were some of those who had been involved at either the gymnasium or at the MLC in documenting the details of each of those who died in the disaster. They noted that the forms they completed included a tick-box referring to PNC checks. This was not ticked on any of the forms, supporting the accounts of the officers that they had not had access to the PNC when they were conducting this task.

13.13 The IOPC checked all the HOLMES databases used by SYP and WMP in relation to the disaster. There was no record in any of them of an instruction to conduct PNC checks.

13.14 This meant that the IOPC had no further avenues available to establish who conducted the checks or why, or who had provided the solicitor with the information.

SYP's failure to conduct PNC checks in the aftermath of the disaster

13.15 However, the IOPC did find evidence to show that SYP **should** have conducted PNC checks on all of those who died, shortly after the disaster. This is part of a standard process for updating the PNC and removing the records of those who have died from it. Though there is evidence to suggest that some checks were conducted, they were not done systematically and consistently, as they should have been.

13.16 This became apparent when, in June 2014 and with the consent of families, IOPC investigators conducted PNC checks on those who had died in, or as a direct result of, the disaster. If the process had been followed correctly, no records should have been found, as their details should have been removed from the PNC. However, investigators discovered that, as of June 2014, details of nine of those who died had not been removed from the PNC.

13.17 Following the IOPC's discovery, the PNC has now been corrected and the relevant records removed. The IOPC wrote to the families of all those who died, explaining what had happened and offering to inform them if details of their family member had incorrectly remained on the PNC. Separately, the then National Policing Lead for Information Management apologised to the families for this oversight. In a letter, he explained that though he was not able to identify precisely where the process failed, the failure did not appear to have been a deliberate act.

Checks conducted by WMP

13.18 On the main HOLMES database used by WMP, the records for 94 of those who died suggest that CRO checks were carried out. A CRO check is not the same as a PNC check. It does not provide the same level of detail and typically only includes any unspent convictions.

13.19 The IOPC has not found any specific explanation for why or when CRO checks were conducted, nor any evidence of who conducted them or who instructed that they should be conducted.

13.20 This still does not explain how the solicitor obtained the information. There is no record of any direct contact between WMP and the solicitor, and the documents in his possession were PNC printouts, not CRO checks.

13.21 Despite pursuing multiple routes, it has not been possible to ascertain how or why he had obtained this information. The IOPC has not found any legitimate reason for it to have been in his possession.

PNC checks on compensation claimants

13.22 The HIP had found documents that indicated a PNC check had been conducted on a person who made a claim for compensation after the disaster. In its report, the HIP raised the concern that more such checks may have been conducted. The IOPC examined the circumstances around this and sought to establish if any similar checks had been made.

13.23 The disclosed documents showed that solicitors acting on behalf of SYP wrote to CC Wells on 2 March 1995 to request details of the criminal records of a Liverpool supporter who had claimed compensation for loss of earnings as a result of the disaster. The request was

fulfilled by an inspector who was part of the SYP CRO on 15 March 1995 and appears to have resulted in a complaint from the solicitor representing the claimant. A subsequent SYP note indicated that the matter was resolved between the two sets of solicitors, and no further action was required.

13.24 In the circumstances, there is no evidence to suggest that this check was carried out inappropriately.

13.25 IOPC investigators carried out a comprehensive search of the archived material available to the investigations to establish whether any form of check was conducted on any other individual who made a claim for compensation. Only one was found.

13.26 This took place in April 1989, just days after the disaster. It followed the receipt on 18 April 1989 of a claim for compensation against SYP and SWFC for injuries sustained. A document showed that both a PNC check and a CRO check were conducted on the claimant. The document did not explain why these checks were carried out or why a printout of the record was added to the claim file.

13.27 While it is possible that further records have been legitimately destroyed in line with retention policies, there is no other evidence to suggest that there was a decision or intention to conduct PNC checks on survivors of the disaster.

14. WMP's work for the Taylor Inquiry

What was investigated?

The IOPC's terms of reference included investigating:

The conduct of officers involved in WMP's investigations. This will include:

a) the involvement of WMP in the decisions taken about how to gather evidence/ obtain witness accounts

b) whether police officers involved in this investigation put inappropriate pressure on any witnesses to alter their accounts or influence the content of those accounts

c) whether the summaries of evidence WMP presented at the individual inquests were accurate

d) whether there is any evidence of bias in favour of SYP on the part of those involved in or leading the investigation

e) whether any accounts provided were deliberately lost, inaccurately recorded, amended, or mishandled (including not following up on key witnesses)

f) investigating other recorded complaints or conduct matters about the actions of WMP in the gathering or presenting of evidence

WMP's work in relation to the Hillsborough disaster consisted of several different investigative strands: gathering evidence for the Taylor Inquiry, a criminal investigation, a police disciplinary investigation and supporting the Popper Inquests. WMP's work had previously received little scrutiny but was subject to numerous complaints. The IOPC therefore conducted a substantial and wide-ranging investigation that considered each of these strands separately. This chapter focuses on the work WMP did for the Taylor Inquiry.

What was found?

- **In the weeks after the disaster, WMP interviewed more than 3,800 supporters who had been at the match.** This was an extremely challenging task, requiring relatively untrained officers to interview large numbers of severely traumatised witnesses over a short period of time.
- **There were occasions where officers did not show sufficient compassion for witnesses**—particularly those under the age of 18—which undoubtedly added to their already considerable distress. However, the evidence, including from supporters and respondents to the IOPC's witness appeal, indicates that this occurred in a minority of cases only and that, **for the most part, WMP officers undertook this work professionally.**
- Some of the main criticisms of the WMP officers involved in this task were that they focused excessively on supporters' alcohol consumption and that they did not record supporters' accounts accurately. **Though the evidence indicates that there were instances where aspects of accounts weren't recorded accurately, the IOPC did not find evidence that this was a recurring or widespread issue.**

- **Many supporters interviewed by WMP recalled being questioned extensively about their alcohol consumption on the day, and about whether other supporters were drinking.** However, the questionnaires WMP completed with supporters and statements it took included very few comments about alcohol consumption.
- Despite the absence of evidence from supporters about alcohol consumption, **the officers leading the WMP investigation appear to have reached a view that alcohol was a key factor in the disaster, and that the Taylor Inquiry did not consider it sufficiently.** This became apparent in a memo sent from the most senior detective involved, D Ch Supt Foster, to the officer in overall charge of WMP's work, ACC Jones, after Counsel to the Taylor Inquiry had made his closing comments.
- WMP did not interview SYP officers to take statements from them for the Taylor Inquiry. It is not clear that WMP ever committed to doing so, but nor is it clear that, as those leading the WMP investigation have claimed, they were instructed by the Taylor Inquiry to simply gather SYP officers' accounts as evidence for the Inquiry.
- **When WMP senior officers were alerted to the fact that SYP officers' accounts were being amended—in some cases, significantly—before SYP submitted them, WMP did not take action to check the process or stop it.**

Significant new evidence

In investigating the work of WMP, the IOPC had three significant sources of new evidence:

- **The policy books of ACC Jones**, who led WMP's work around the disaster. This was a series of 14 physical notebooks into which were attached detailed, chronological records of ACC Jones's correspondence, telephone calls and meeting notes throughout the investigations. Each entry was numbered, and they appeared to form a continuous record. Some of this material had been previously disclosed to the HIP, and there were other copies of some of the documents elsewhere in the archived material. However, there was also a large volume of material in the policy books that had not previously been considered.
- The **responses to a major witness appeal, conducted by the IOPC in 2013**, inviting people who had any contact with WMP during its initial investigation to contact the IOPC and share their accounts and experiences. This was the largest witness appeal ever conducted by the IOPC and was publicised across a range of channels, including national media and local media in Merseyside, South Yorkshire and the West Midlands. It was also publicised by Liverpool Football Club. Some **1,713 people responded, of whom 1,325 said they had some dealings with WMP.**

- **A set of 165 floppy disks—a digital storage technology used widely in the 1980s and 1990s—relating to the WMP investigation. These were in the South Yorkshire Police Archive, so had been available for review previously; however, they were not examined by the HIP, potentially because they were in a storage format that was no longer widely used. The IOPC employed a specialist company to recover all the material from these floppy disks into a format that could be read by today's computers. Investigators then reviewed the material. While much of the material duplicated existing documents and records, the process did lead to the discovery of some new information, including correspondence between WMP officers that was not recorded elsewhere.**

In addition, the IOPC took statements from more than 100 former WMP officers who had been involved in different aspects of the force's work.

14.1 WMP was the police force responsible for investigating the Hillsborough disaster. Its involvement began on the day after the disaster and continued for almost two years. Its role and responsibilities evolved during this time, meaning WMP ultimately undertook four distinct, though overlapping, strands of work:

- gathering evidence for the Taylor Inquiry from supporters who had been at the Semi-Final, the families of those who died in the disaster, police officers and a range of other witnesses
- a criminal investigation
- a police disciplinary investigation, overseen by the PCA, the national body that oversaw complaints against police officers at the time
- supporting the Popper Inquests

14.2 Though some aspects of WMP's work had previously been reviewed through the Stuart-Smith Scrutiny and the Goldring Inquests, the actions of WMP in relation to the disaster had not previously been the subject of a formal investigation. However, the HIP Report raised questions about the adequacy, integrity and professionalism of certain aspects of WMP's investigations, including that, when interviewing Liverpool supporters in the aftermath of the disaster, officers focused disproportionately on alcohol consumption. Behind these questions was the underlying concern that WMP may have been biased in favour of SYP.

14.3 Recognising these questions and concerns, in 2012 WMP referred the actions of a small number of its officers to the IOPC for investigation. This referral led the IOPC to make the actions of officers involved in the WMP investigations one of the terms of reference for its independent investigation into the aftermath of the disaster. The IOPC subsequently received 118 complaints about the actions of WMP officers. A clear majority of these were related to the way WMP officers had collected evidence from Liverpool supporters. For example, 46 complaints focused on issues around how WMP recorded evidence and whether they had done so accurately. Fifteen were related to an alleged focus on supporters' alcohol consumption. Seven covered WMP interviewing those under the age of 18 in an inappropriate way.

14.4 The IOPC upheld the complaint or found a case to answer in 41 instances.

14.5 It quickly became clear to the IOPC that examining WMP's work as a single entity was neither helpful nor appropriate. The different strands of activity overlapped in terms of their timing but had separate aims and involved different officers. Separating the strands of work provided a degree of clarity in assessing the actions of the WMP officers involved against relevant standards. For instance, it made it easier to examine whether WMP conducted its disciplinary investigation to the professional standards that would have applied at the time, regardless of whether its work supporting Dr Popper was sufficient.

14.6 As well as investigating each strand individually, the IOPC has separated the work into different chapters of this report. This one focuses on the work WMP did for the Taylor Inquiry, covering the period from the day after the disaster, up to the publication of the Taylor Interim Report in August 1989.

The role of the IOPC's witness appeal

14.7 Though the IOPC had access to thousands of archive documents relating to the investigations, there was comparatively little evidence within these documents about how WMP conducted its investigations. To address this, in September 2013, the IOPC launched a witness appeal, inviting people who had any contact with WMP during its initial investigation to contact the IOPC and share their accounts and experiences. This became the largest witness appeal the IOPC had ever conducted. In total, 1,713 individuals responded, of whom 1,325 said they had some dealings with WMP. Many of those who responded had never previously given an account to any inquiry or investigation.

14.8 Every respondent who had contact with WMP was asked if they believed the account they gave to WMP adequately reflected their experiences on the day of the disaster. While over 800 respondents said it did, 490 answered this question "no". These individuals were then asked why: a range of reasons were given, with some giving more than one reason.

14.9 Those who said "no" were contacted again by IOPC investigators who asked for more information about the reasons for their dissatisfaction. Before contacting them, the IOPC investigators examined archived material and the WMP HOLMES databases to retrieve any statement or questionnaire registered by WMP in the respondent's name. Investigators then sent the respondent a copy of these documents or, where the documents had already been published on the HIP website, directed them to the relevant pages.

14.10 In many cases, the dissatisfaction expressed specifically related to the fact that the respondent recalled being interviewed by WMP but had not been able to find any documentation related to them. One reason for this was that, in many cases, the HIP redacted the names of witnesses before publishing the documents. Once they had confirmed that there were documents that related to them, many of these witnesses informed the IOPC that they had no further issues.

14.11 However, over a quarter of those who had engaged with WMP expressed concerns about the behaviour and manner of the officers who interviewed them. Other common concerns raised by respondents were that WMP officers:

- interviewed witnesses, but did not take a formal statement from them
- did not record witnesses' evidence accurately

- appeared uninterested in what the witness had to say
- focused excessively on alcohol consumption
- interviewed witnesses under the age of 18 without an adult being present

14.12 Arising from these concerns, the IOPC received 66 formal complaints relating to these issues. This meant that WMP's approach to collecting evidence from supporters for the Taylor Inquiry was the most common source of complaints related to the Hillsborough disaster.

ACC Jones's policy books

14.13 In addition to the witness appeal, the IOPC also had a second major source of new evidence: the policy books of ACC Jones, who led WMP's work around the disaster.

14.14 This was a series of 14 physical notebooks into which were attached detailed, chronological records of ACC Jones's correspondence, telephone calls and meeting notes throughout the investigations. They also included some policy decisions, often flagged as such, among more detailed entries. Each entry was numbered, and they appeared to form a continuous record of how WMP conducted its work, the decisions made by senior officers and its dealings with other parties, including SYP, the Taylor Inquiry team and Dr Popper.

14.15 The policy books therefore were of considerable importance to the IOPC's investigation into WMP's work.

14.16 The books were provided to the IOPC by ACC Jones in 2013. He had retained them in his personal possession when he left WMP and had not previously made them available to any other party, investigation or review of evidence relating to the Hillsborough disaster.

14.17 Though he had not been specifically contacted by the Stuart-Smith Scrutiny, there is evidence that he was aware of its work and aims. In 2011, the HIP contacted ACC Jones and asked if he had any relevant material for its work. He did not provide the policy books and advised the HIP that "all of the product of my involvement in the investigation" had been retained by WMP.

14.18 He later told the IOPC that when the HIP contacted him, he had forgotten he had them. He further said that the policy books were "my copies of material forwarded to the official Holmes Policy File", adding: "the contents you have probably found are already known to you from the official file." In short, he suggested that the policy books were only duplicates and that the material in them would all have been available elsewhere.

14.19 While the HIP did have access to copies of many of the documents in the policy books, it did not have all of them. Further, when the IOPC restored and examined the HOLMES databases used by WMP for its work around the Hillsborough disaster, it became apparent that ACC Jones had requested that some of the electronic policy files related to WMP's investigation should be deleted from the system. Before doing so, he requested that printed copies were made.

14.20 An officer retaining potentially sensitive material relating to police work in their personal possession, and deleting material from the HOLMES system, are both unusual steps.

14.21 Further, given the allegations of a failure in the direction and control of WMP's investigations noted in WMP's referral to the IOPC, the deletion appeared particularly significant. It was therefore one of the issues raised in the Notice of alleged breach of the Standards of Professional Behaviour the IOPC sent to ACC Jones in January 2015.

14.22 ACC Jones responded to the allegation in a prepared statement to the IOPC. He stated that the deletion of the policy files had been agreed as they contained potentially sensitive and confidential material. However, he provided no further details, such as who this had been agreed with. He also said he did not have the printed copies of the policy entries.

14.23 Given the potential value of the policy files, and the strong indication that they were not the same as the policy books, the IOPC carried out or requested a number of further searches in an attempt to find them, in either digital or hard copy format. This included searches of police premises and obtaining a warrant to search ACC Jones's home. The files were not recovered.

14.24 Though ACC Jones's decision to delete the files was documented and included an instruction to retain hard copies, it was nonetheless highly unusual and leaves a gap in the IOPC investigation. It remains unclear what happened to the hard copies of the policy files.

14.25 The IOPC recorded a conduct matter around ACC Jones's actions and completed an investigation into it. Having reviewed the investigation report, the IOPC was of the view that, if he had still been serving, ACC Jones would have had a case to answer for gross misconduct for discreditable conduct in relation to the deletion of the files, falsehood or prevarication regarding the retention of the policy books and neglect of duty, because he did not advise the Stuart-Smith Scrutiny of the books' existence in 1997.

The appointment of WMP

14.26 WMP first became involved in investigating the Hillsborough disaster on 16 April 1989, when WMP's Chief Constable Geoffrey Dear (CC Dear) was asked by CC Wright to examine SYP officers' planning for the match and operational decisions on the day.

14.27 On 17 April 1989, it was announced that WMP had been further appointed by the Home Secretary to support Lord Justice Taylor in his inquiry into the disaster. Almost immediately after that, WMP was also appointed to support Dr Popper in the inquests. At this stage, no criminal or disciplinary investigation had been started.

14.28 Though the choice of WMP for these tasks was swift, the IOPC has not found any definitive explanation of why WMP was nominated, nor found any evidence to suggest that the decision was biased or inappropriate.

14.29 WMP was a large force with considerable experience of policing major football matches. It had five football grounds in its area, one of which was Villa Park, the venue for the other FA Cup Semi-Final in 1989. Further, CC Dear was a highly experienced officer who had been involved in several high-profile investigations and inquiries and was well regarded by the Home Secretary, Mr Hurd.

14.30 CC Dear and CC Wright did know each other through police circles, but when interviewed by the IOPC, CC Dear stated there was no particular friendship or professional relationship between them. They had not served in the same force at any point, and no evidence has been found to indicate they were close.

WMP's initial steps

14.31 A team of WMP officers first arrived in Sheffield on 18 April 1989. Early steps included securing the stadium as a crime scene, setting up an MIR and meeting with some of the senior SYP officers who had been involved in collecting evidence up to that point. During that morning, CC Dear took part in a press conference with Lord Justice Taylor, which explained the remit of the Inquiry and WMP's role in it.

14.32 At 2pm, ACC Jones recorded a policy decision that "the limits of the South Yorkshire Police enquiry should be to the preservation of evidence and no further." He then expanded on that in a subsequent policy decision the same afternoon, which again focused on "preserving evidence"; he added that no interviews would be undertaken at that stage.

14.33 On 19 April, WMP began to take over the investigation. The transition took a few days to complete. In a later letter to the South Yorkshire Joint Secretariat (the body that provided shared services, such as legal services, to various public authorities in South Yorkshire), Ch Supt Denton recalled that on 20 April, Detective Superintendent Roy Taylor of WMP (D Supt Taylor) instructed that all enquiries by SYP officers must be suspended. On 22 April, the SYP HOLMES account was closed and all data backed up to tape. The tapes were handed over to WMP and retained with other material. Then, on 24 April, all the documents and exhibits SYP had collated were also passed to WMP.

14.34 The IOPC has not found evidence to indicate there was anything inappropriate or unprofessional in this transfer of responsibility and evidence.

14.35 Alongside the activity in Sheffield, back in Birmingham, WMP had begun to plan its approach to gathering information. A team of senior officers worked together to identify lines of enquiry and consider staffing requirements. They produced a chart summarising these, which was included in ACC Jones's policy book and is shown as figure 14A.

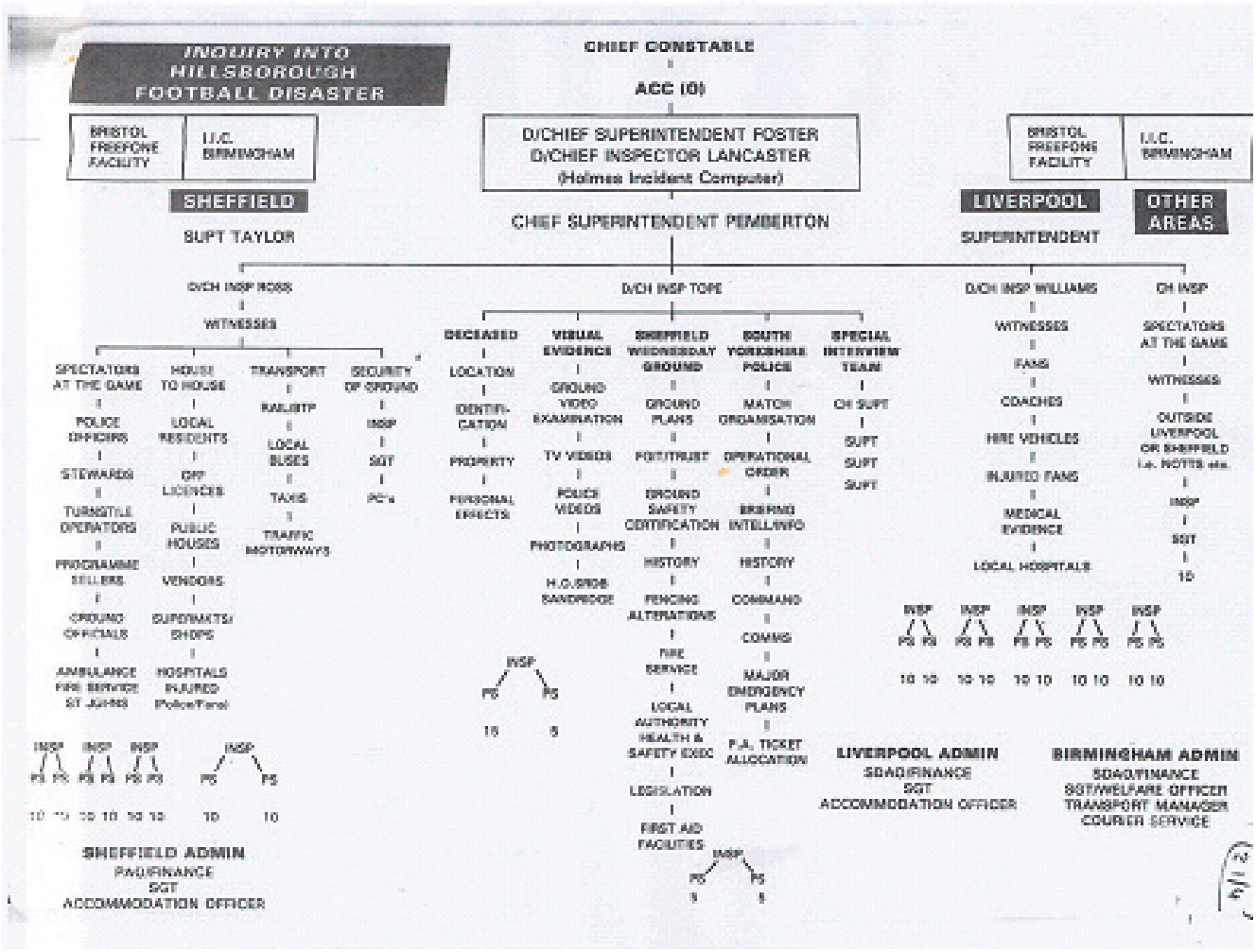


Figure 14A: WMP's initial investigation plan (Source: ACC Jones's policy books)

14.36 None of the topics included stands out as unusual or inappropriate in the context of investigating the disaster.

14.37 To gather information consistently from large numbers of witnesses, WMP chose to use questionnaires. These were a standard investigative tool, but the questionnaires in this case were mentioned in numerous complaints to the IOPC about WMP's work.

The use of questionnaires

14.38 WMP first used questionnaires in relation to the disaster in the incident information centre (IIC) that it opened on 18 April 1989. This was, in effect, an incident 'hotline', based at a WMP police station. On 22 April, ACC Jones recorded in his policy book that witnesses who called the IIC would be asked to answer a questionnaire. This consisted of just nine questions and was effectively a preliminary assessment of whether the caller should be interviewed in person.

14.39 By 25 April, WMP had decided that questionnaires would be used more widely in gathering evidence from supporters. A questionnaire was developed consisting of 54 questions, covering topics such as:

- whether supporters had been delayed on their journeys to the stadium
- the time at which supporters arrived in Sheffield and then at the ground

- police direction outside the ground
- recollections of entry to the ground and the opening of the gates
- police and steward control inside the ground
- the crush barrier breaking

14.40 One of the main recurring allegations related to WMP's evidence collection in Merseyside was that officers focused excessively on supporters' alcohol consumption. The questionnaires used for both Liverpool and Nottingham Forest supporters had three questions that mentioned alcohol or drunkenness.

- Did you witness prior to arrival at the ground any other supporters consuming alcohol?
- Did you witness any disorder, fighting or drunkenness between your arrival point and the ground?
- Did you witness any consumption of alcohol in the ground? If so, briefly explain.

14.41 Notably, there was no question directly asking supporters if they had drunk alcohol. Question 9—"Did you stop anywhere en route to the game, if so where and for what purpose?"—could be viewed as an attempt to secure that information.

14.42 This stood in stark contrast to the fact that almost 1 in 6 respondents to the IOPC witness appeal reported that WMP officers focused disproportionately on supporters' alcohol consumption.

14.43 Separate questionnaires were developed for use with other categories of witness, including SWFC stewards and turnstile operators, and local residents in the area around the stadium. Several hundred questionnaires were completed with these groups of witnesses. The IOPC did not receive any complaints about WMP's approach with regard to these.

14.44 As well as using questionnaires, WMP's intention from the start was to take formal statements under Criminal Justice Act rules (CJA statements) from witnesses in certain circumstances. It only submitted witness statements to the Taylor Inquiry; the questionnaires were effectively a screening tool to help determine whether a statement should be taken from the witness. The IOPC has not found any specific document that instructed officers when they should do this. Some WMP officers have indicated that the decision was left to them, when they were interviewing witnesses; others referred to being given specific instructions to take a statement, either as part of the first visit to a witness, or as a follow-up after the questionnaire had been examined. In practice, it seems likely all three applied.

14.45 However, it does appear that WMP officers did not always inform witnesses that they were using a questionnaire rather than taking a statement. This was raised by many respondents to the IOPC's witness appeal who had not been able to find their statement on the HIP's online document repository.

14.46 The IOPC was able to explain this and reassure many of the witnesses. For data protection reasons, the HIP had removed the names of most witnesses before publishing the documents. IOPC investigators had access to the original versions of all statements and questionnaires, which included the names of the witnesses. They could therefore find any statement or questionnaire registered by WMP in the respondent's name or identify where it had been published by the HIP and send it through. In many cases, this was sufficient, and the witnesses had no further concerns.

Evidence gathering in Liverpool

14.47 WMP's operation in Liverpool was based at Smithdown Lane Police Station. This was the headquarters of Merseyside Police Traffic Division. On 30 April 1989, in the early stages of evidence gathering, there were at least 120 WMP officers based in Liverpool. Broadly, this divided into six serials, each consisting of an inspector, two sergeants and up to 20 PCs. Superintendent David Thursfield (Supt Thursfield) was the head of the Liverpool operation.

14.48 During the initial phase of about three weeks, the WMP officers were, in general, working 12-hour shifts for six and sometimes seven days a week to take accounts from as many witnesses as possible. In total, WMP recorded 3,885 questionnaires from Liverpool supporters and 151 questionnaires from coach company owners or drivers who had taken supporters to the game. The majority of these were completed before 30 May.

14.49 Once the Taylor Inquiry hearings began, the operation in Liverpool was scaled back; by 4 June 1989, there were just 33 WMP officers still in Merseyside.

14.50 There is no single document setting out how WMP should, or did, gather information from Liverpool supporters. However, the accounts of the officers involved are reasonably consistent in describing the basic process, which is summarised below.

- **Supporters contacted WMP by phoning the dedicated freephone number for the IIC.** WMP call handlers used a short questionnaire to gather initial information, including the caller's name, contact details and where they were on the day of the game. These were reviewed in the WMP MIR, and actions were raised for officers based in the Liverpool office to go and interview the supporters.
- **Officers in the Liverpool office worked in pairs to conduct face-to-face interviews, using the standard questionnaire.** In most cases, the officers telephoned the supporters in advance and arranged a time to interview them. Some supporters who responded to the witness appeal indicated that WMP had turned up at their door without prior arrangement. WMP officers acknowledged in interviews with the IOPC that this had happened on occasion; however, they suggested that this was when they had not been able to contact the witness in advance.
- **The officers were not required to inform witnesses that they were completing a questionnaire and, in general, it appears that they did not.** Officers also did not necessarily ask each question in turn; sometimes supporters gave answers to one question which meant a later one was not necessary or appropriate.
- **If a witness indicated that they had gone to the match with someone who had died, or they had been involved in trying to rescue or resuscitate other supporters, the WMP officers took a CJA statement**. They also took statements in some other cases, where they deemed it relevant or were instructed to do so.
- **All questionnaires and statements were submitted to the MIR.** They were read first by more senior officers so that any immediate actions could be raised. The documents were subsequently typed up and recorded on the HOLMES database.
- **Further interviews were conducted if necessary** to confirm some details or request extra information, or to take a CJA statement. It appears that where this happened, it was not necessarily the same officers who returned; if the witness had made a complaint or was being visited again in relation to a complaint from another witness, more senior officers were often tasked to make these additional visits.

14.51 The evidence available to the IOPC suggests a similar process was used for questionnaires of Nottingham Forest supporters, though only 269 of these were completed.

14.52 Based on documentary evidence from the time and the statements of former WMP officers to the IOPC, it is apparent that WMP initially underestimated the scale and complexity of the task. Though some interviews were conducted by detectives and more experienced officers (including inspectors), the majority were conducted by comparatively junior officers. They were required to interview deeply traumatised individuals about their experiences very soon after the traumatic event. Many of these junior officers had no specialist training in interviewing vulnerable people and received only limited briefings.

14.53 In statements to the IOPC, former WMP officers noted that, unsurprisingly, some supporters did get upset or angry, particularly at certain questions. Officers told the IOPC of the approaches they had taken to minimise the distress. For example, some sought first to let the interviewee simply give their account, unprompted; the officers would note down details at relevant points on the questionnaire, then ask questions to fill in any gaps. Others chose to adhere to the questionnaire as closely as possible and then use the more open questions at the end to let supporters speak more freely and provide their own recollections.

14.54 One consequence of these difficulties was that interviews would typically last longer than had been assumed in WMP's initial calculations. Officers recalled spending several hours in some households, particularly where more than one member of the household had been at the game.

14.55 Numerous supporters also described the long process; some indicated that they had found the WMP officers to be sympathetic. This was reflected in the responses to the witness appeal, where more than 800 witnesses answered the question whether they believed the account they gave to WMP adequately reflected their experiences on the day of the disaster with a "yes".

14.56 However, 490 answered this question "no". Following further contact with these witnesses, the IOPC recorded complaints in relation to various issues.

- 36 witnesses stated the officers did not accurately or adequately record their responses.
- 18 witnesses complained about the overall attitude of officers.
- 15 witnesses complained that officers focused excessively on supporters' alcohol consumption.
- 10 witnesses stated that when they tried to make complaints about the actions of SYP officers, these complaints were not recorded or subsequently investigated.
- 7 complaints referred to WMP officers interviewing witnesses under the age of 18 without an adult being present.
- 2 complaints related to the fact that, after the complainant had called the IIC, WMP did not follow up their initial information in any way.

14.57 Several of the complaints related to more than one issue and some were subsequently discontinued at supporters' request.

14.58 As part of its investigation, the IOPC researched each pair of officers who took statements and questionnaires from witnesses to explore whether any were subject to higher numbers of complaints. There were no officers that were subject to particularly high numbers of complaints, which indicates there was no specific pattern of behaviour.

Inaccurate recording of witness responses

14.59 Complaints about inaccurate recording of responses included witnesses identifying that some information they gave to WMP, which they believed was important, had not been included in the written accounts. This missing information included, for example, comments about their experiences at the 1988 FA Cup Semi-Final at Hillsborough Stadium and criticisms of the police operation. In another case, the witness recalled saying to WMP officers that he had seen other supporters "drinking cans of Coke" but in the questionnaire they had written that he "saw a few Liverpool fans drinking from cans." As he noted to the IOPC, this completely changed the meaning. The IOPC agreed and upheld his complaint about the inaccurate recording of his comment.

14.60 Other complainants said that WMP officers had used words in writing up their accounts that the witnesses themselves would not have used. The IOPC fully accepts that this would have occurred. A witness account, whether a CJA statement or a questionnaire, does not have to be a continuous verbatim record of what the witness said, especially where the interview was not audio-recorded, which was the case with the interviews conducted by WMP. It was, and still is, common practice for police officers to use alternative forms of words, or to omit digressions and asides, to make the account easier to follow.

14.61 Given the length of interviews, and the fact that questionnaires were designed for information gathering rather than composition of a statement, it is perhaps inevitable that WMP officers sometimes edited what was said. As a result, most complaints about WMP phrasing accounts using different words to those the witnesses used have not been upheld.

14.62 Further, it is not clear that any amendments to the wording of witness accounts negatively affected the overall quality of evidence collected from Liverpool supporters. In particular, the evidence does not suggest that interviewing officers consistently and deliberately failed to record information about specific topics.

14.63 As an example of this, across all the questionnaires and statements WMP took from supporters, IOPC investigators identified more than 3,000 comments that were in some way critical of police actions on the day. While some pairs of officers recorded more critical comments than others, every pair recorded at least one.

14.64 This suggests that while it is highly possible that some criticisms of the police were not fully recorded, this was not the result of a systematic approach to avoid recording criticisms. In almost all of the cases where complainants raised this issue, the completed questionnaire did include some criticism or negative comment about the police operation.

Allegations of a disproportionate focus on alcohol

14.65 The IOPC investigated 15 complaints about WMP focusing disproportionately on alcohol, but more than 200 respondents to the witness appeal commented on it. This indicates a widespread perception among Liverpool supporters that questioning around this topic was excessive. One supporter told the IOPC, for instance, that WMP officers

"continually asked questions about alcohol things like 'did we drink on the coach' 'did we see anyone else drinking'." Another commented: "Very quickly I became concerned that the questions they started to ask me were focused on drinking before the game."

14.66 When shown the questionnaires completed in their name, several supporters noted the discrepancy between their recollection of the interview and the written record. For example, one said: "although the questionnaire only actually has a few questions about alcohol, it is my clear recollection that they asked me many, many more questions about drinking."

14.67 As set out at paragraphs 14.40–14.41, just four questions out of the 54 in the supporters' questionnaire could be deemed to refer to alcohol and none of these asked supporters if they had drunk alcohol. This raises various possibilities:

- WMP officers went 'off-script' and asked additional questions about alcohol, either as a result of instruction or their own perspectives
- WMP officers made additional efforts to ensure that they asked the questions about alcohol as these were deemed more important
- due to the sensitivity of the topic, supporters particularly remembered WMP asking questions about alcohol consumption more than any other topic of questioning

14.68 No WMP officer has said they asked extra questions about alcohol or in any way prioritised asking about this topic.

14.69 Beyond the questionnaires and statements, there is no written record of what WMP officers asked or what witnesses said. This lack of evidence meant that in most cases it was not possible for the IOPC to uphold complaints about WMP officers focusing disproportionately on alcohol when interviewing supporters. Nonetheless, there remains a clear gap in perceptions between supporters, many of whom (not just those who made a complaint about it) recalled repeated questioning about alcohol consumption, and WMP officers, who suggested it was just another topic they covered.

14.70 The IOPC asked WMP officers who had been based in the Liverpool office about the briefings they were given and, in particular, whether there were any 'informal' instructions to ask about alcohol consumption. With one uncorroborated exception, officers did not recall any such formal or informal instruction.

14.71 The IOPC's analysis of the evidence collected by each pair of officers did show that some officers recorded more information about alcohol consumption than others. Similarly, in analysing the responses to the witness appeal, there were some pairs of officers about whom there were more concerns or dissatisfaction, related to asking questions about alcohol. However, there were no pairs of officers who stood out as being subject to substantially more concerns, or as having recorded substantially more information about alcohol consumption.

14.72 Senior WMP officers have stated to the IOPC that they believe it was appropriate to ask questions about alcohol consumption in the questionnaire. It was identified early as a necessary line of enquiry, particularly given the media coverage which had suggested the level of alcohol consumption among supporters was a factor in the disaster. Furthermore, several of these senior officers have argued that the evidence WMP gathered about this issue helped Lord Justice Taylor to reach the conclusion that it was not a factor.

14.73 The IOPC fundamentally accepts that, in a set of circumstances where alcohol consumption had been publicly and widely identified within days of the disaster as a potential causative factor, it was necessary to ask supporters about this. However, this would not have extended to asking supporters aggressively or insistently about the subject.

14.74 Further, the questions included on the questionnaire appear of limited value in addressing the issue. They offered no insight into whether any alcohol consumption that was witnessed was different from normal.

14.75 In short, even though the IOPC has not been able to uphold the specific complaints on the subject, the evidence shows WMP investigated this important topic inappropriately and ineffectively.

Complaints about interviewing witnesses under 18

14.76 The evidence in relation to the seven complaints that WMP interviewed young witnesses (under the age of 18) in an inappropriate way was more clear-cut.

14.77 One complainant, who was 15 at the time, described being so upset that his mother intervened. Another person who was also 15 at the time recalled being stopped by police officers on his way home from school, and being asked to get in the police car, where he was interviewed; a family member spotted this and intervened. A third teenager recalled being interviewed by two WMP officers at home when his parents were out. He was asked a series of leading questions and said the officers were aggressive.

14.78 Guidance at the time stated that when the police interviewed anyone under the age of 18 as a witness, there should have been an appropriate adult present. However, this was only guidance and not a requirement; it appears this was not always followed by WMP officers working in Merseyside in the aftermath of the disaster.

14.79 By contrast, the IOPC established that the 'house to house' questionnaire used by WMP officers when interviewing local residents in Sheffield had advice printed on it to the effect that no questionnaire should be taken from a juvenile. No such advice was included on the questionnaire used for interviewing Liverpool supporters, or indeed on the other supporter questionnaires.

14.80 Regardless of the instructions, officers should have been sufficiently alert to recognise when witnesses were vulnerable or where a traumatised witness had become too distressed to continue the interview.

14.81 As a result, the IOPC upheld all but one of the complaints about WMP interviewing under 18s without an appropriate adult present.

14.82 It should be noted that WMP interviewed many under 18s in relation to the disaster; some in the company of a parent or other adult, some on their own. The majority of these did not lead to complaint. This may suggest that in other instances, the interviews were conducted more sympathetically.

Complaints about the attitude of WMP officers

14.83 Supporters complained that some WMP officers were rude or intimidating, or that they did not seem interested in what they had to say. For example, one witness told the IOPC: "One officer sat down and the other stood up in front of me, with his hands in his pockets for the whole time he was in my house."

14.84 In May 1989, WMP also received a complaint about the manner of its officers in Sheffield. A young man, who was a student in the city and had been at the match, responded to the witness appeal and agreed to go to a police station and provide a statement. However, when he was interviewed, he was upset by the manner of the questioning and what he felt were unfair allegations.

14.85 He detailed his experiences in a letter to his mother. These included one of the officers adopting an aggressive manner and appearing not to believe his account, to the extent of expressing doubt that he had even been at the game, because he had no injuries.

14.86 The man's mother showed the letter to his godfather, who was a former detective chief superintendent. The godfather then wrote to WMP to complain. This was not recorded as a formal complaint, but ACC Jones instructed D Ch Supt Foster to "Initiate a follow-up to smooth troubled waters." [Underlining in original.] The officers who had conducted the interview were contacted and responded that they thought the young man's evidence had been inconsistent and that he was 'anti-police'.

14.87 On 19 June 1989, D Ch Supt Foster wrote back to the man's godfather on behalf of WMP and told him that he had spoken with the two officers in question. He further explained that the WMP team as a whole had dealt with approximately 4,000 supporters as part of their enquiries, and that this was the only incident where someone had raised concerns. While there was in fact some evidence of other supporters expressing concerns about WMP's approach, very few raised such concerns to WMP at the time.

14.88 The man complained to the IOPC about the WMP officers who had interviewed him. Having reviewed the evidence, the IOPC upheld his complaint that WMP had recorded his comments inaccurately and incompletely, with several material errors in the accounts they drafted. The IOPC also upheld, in relation to one of the two officers, the man's complaint that during the interview process, he was accused of lying and was intimidated and threatened with charges of wasting police time.

14.89 Complaints about specific interactions between WMP officers and individual witnesses are inherently difficult to investigate. The interviews were not audio- or video-recorded, so the only documentary evidence from the time is the questionnaires or statements themselves. The IOPC has sought to contact the officers involved; not all have agreed to speak to investigators, as is their right, but those who have replied denied behaving inappropriately.

14.90 The IOPC has also looked at the evidence of the wider work undertaken by each pair of officers complained about. In all of the cases, there was no documentary evidence or witness evidence to suggest that these officers were repeatedly or consistently rude, intimidating or biased.

14.91 It is apparent that some interviews ended acrimoniously or abruptly, where witnesses were upset or angered by the questions, or simply by the emotional trauma of recalling the events. While clearly this is regrettable, it is also not surprising that this happened on occasion, given the number of interviews conducted by WMP and the nature of the matters under investigation.

14.92 This does not alter the fact that some supporters were sufficiently upset or shocked by WMP's behaviour that they wished to complain.

14.93 These issues were undoubtedly of deep significance to those affected. In some cases, the manner of evidence collection added to the trauma of being present on the day; for others, it damaged trust in the integrity of the investigation into the disaster.

14.94 However, the broader picture demonstrates that these issues were experienced on an individual level rather than a systemic one. Further, the overall body of evidence does not support the allegation that WMP **deliberately** lost, inaccurately recorded, amended or mishandled witness accounts.

How WMP gathered evidence from SYP officers

14.95 As examined in chapter 9, WMP did not take statements from SYP officers. Instead, it requested that SYP send officers' own accounts for the Taylor Inquiry team to review. This was a significant decision because there are important differences between a statement, made under CJA rules, and a written account.

14.96 Firstly, a statement includes a declaration of truth that the maker must sign, acknowledging that they are aware that it is a criminal offence to include anything they know to be untrue. Secondly, the process of producing a statement typically involves an interview, where the witness can be asked to explain gaps or inconsistencies in their statement; their evidence can be probed and challenged before the statement is signed.

14.97 The available evidence indicates that, at first, WMP did intend to take statements from SYP officers, and that SYP expected this. The initial instructions sent to SYP officers included that their accounts should be an aide-memoire for when WMP interviewed them. When DCC Hayes told ACC Jones, on 25 April 1989, that SYP wished to obtain accounts from its officers, ACC Jones confirmed that he had no objection but hoped that "these could be made available at a later time when my officer's interview yours."

14.98 Then, on 29 April 1989, WMP received an instruction from Lord Justice Taylor that six senior SYP officers who had been on duty should provide written recollections. ACC Jones wrote to CC Wright at SYP to ask for these accounts, adding that "Lord Justice Taylor has indicated some urgency on this particular action." He further confirmed that WMP would not interview the senior officers (at least at this stage). The first of the senior officers' accounts was received by WMP on 3 May 1989 with more following on 4 May.

14.99 At a meeting on 3 May involving WMP senior officers and representatives from the Taylor Inquiry team, there was further discussion of how accounts would be obtained. Chief Superintendent David Baker of WMP was reported as noting that "South Yorkshire Police are calling their key police officers in and taking statements from them." ACC Jones responded: "I don't want to get into interviewing I just want a written submission."

14.100 ACC Jones compiled a list of policy directives from the meeting. One of these was that "officers who were posted to the Leppings Lane area are to be identified, and actions raised to invite written recollections of their account of the day from 2.30 pm

onwards." This indicates that a decision had been made at, or as a direct result of, the meeting to extend the request for written accounts to a wider group of officers. There was no indication in the meeting notes that any member of the Taylor Inquiry team requested this.

14.101 Though the policy decision was made on 3 May, it was not communicated to SYP until 7 May (just over a week before the Taylor Inquiry hearings were due to start). In a letter to CC Wright, ACC Jones wrote: "I have now been asked by Counsel appointed by Lord Justice Taylor to request from a selected number of your officers their recollections in writing, of what happened at Hillsborough on 15th April 1989."

14.102 The wording of the letter appeared to suggest ACC Jones was simply following Counsel's instructions. However, the IOPC has not found any other documentary evidence of such an instruction. D Ch Supt Foster suggested it was agreed in a conversation between ACC Jones and Mr Collins, at which he was not present.

14.103 The letter then listed 122 officers from whom accounts were requested. Most of these had been on duty at the Leppings Lane end of the stadium.

14.104 Over the following weeks, WMP issued SYP further requests for accounts from other groups of officers.

14.105 The request on 7 May was the catalyst for SYP to start its review and amendment process, which resulted in it sending accounts to WMP only after they had been reviewed by either Hammond Suddards or (later) SYP's in-house team. As detailed in chapter 9, around 1 in 4 SYP accounts were amended before WMP received them.

14.106 The IOPC sought to understand why WMP had chosen to use the accounts written by SYP officers, rather than taking statements. ACC Jones stated to IOPC investigators that the possibility of WMP taking statements from SYP officers "never came on the agenda." The meeting notes detailed here, taken from his policy books, indicated differently.

14.107 In evidence to the Goldring Inquests, he explained that the decision was made on a purely practical basis: there would not have been the time for WMP to interview all the SYP officers concerned.

14.108 This was echoed by D Ch Supt Foster, who suggested to the IOPC that allowing SYP officers to write their accounts was the only way to get sufficient evidence from them in advance of the Taylor Inquiry hearings, which were scheduled to start on 15 May. He added it was not "practically possible" for WMP officers to interview all the SYP officers required in the time available.

14.109 There was a reasonable argument that by 7 May—the date of the letter to CC Wright—it would not have been possible to take statements from 122 officers before the Taylor Inquiry hearings were due to start on 15 May. However, 7 May was some two weeks after WMP had begun its investigation and four days after the policy had been agreed. By this time, the WMP team in Liverpool had interviewed hundreds of witnesses and the WMP team in Sheffield had conducted extensive house-to-house enquiries and interviewed SWFC stewards and turnstile operators. It seems reasonable to suggest that, if WMP had taken a different approach from the start, or prioritised activity differently, they would have been able to take statements from at least some of these officers.

14.110 D Ch Supt Foster also indicated he was not concerned about the accuracy of the accounts, as there was a basic expectation that police officers would tell the truth. Another WMP officer, DCI Ross, was of a similar view. He stated to the IOPC that it was "standard practice for police officers to write and provide their own statements."

14.111 Both D Ch Supt Foster and DCI Ross pointed out that using officer accounts at this stage did not remove the possibility of taking statements later, for example, in the event of a criminal investigation where statements made under CJA rules would be necessary for a prosecution. However, as is detailed in chapter 15, when WMP did begin a criminal investigation, they did not attempt to convert the accounts into CJA statements. To add further confusion, WMP recorded the officers' accounts as statements on the HOLMES system.

How WMP responded to being told accounts were being amended

14.112 It appears that almost as soon as SYP decided to have the accounts reviewed before submitting them to the Taylor Inquiry, WMP was made aware of this change in process. On 9 May, the same day that Ch Supt Denton sent the first batch of SYP accounts to Mr Metcalf at Hammond Suddards, ACC Jones recorded in his policy book a discussion with Mr Brummell from the Taylor Inquiry team expressing concern that they would not receive accounts until 11 May at the earliest.

14.113 Though ACC Jones did not record any explanation as to why submissions would not be provided before 11 May, the policy note included an agreement "that Mr Brummell would speak to South Yorkshire Police's solicitors and indicate the importance of a balanced account." This indicates that both WMP and the Taylor Inquiry team appeared to attribute the delay to the involvement of SYP's solicitors, and that they had concerns about potential imbalance in the accounts as a result. However, there is no evidence of any action from WMP to intervene in this process, which—as detailed in chapter 9—there was no bar to SYP following.

14.114 On 23 May, DCI Ross sent a memo to ACC Jones, describing a telephone call he had received from an SYP officer who was upset about his account being amended in a way the officer felt was significant. According to the memo, DCI Ross explained to the caller that this was an "accepted procedure" that the Taylor Inquiry team was aware of. He added that "statements were being examined by South Yorkshire Police Legal Department in an attempt to remove from the recollections any comments which were made with full emotion following the incident and which were or could be considered embarrassing or detrimental to the South Yorkshire Police in general and individual officers in particular." The memo to ACC Jones did not provide further details of what the significant changes were, and there is no evidence to show that DCI Ross asked for details.

14.115 This explanation—and in particular the reference to comments which "could be considered embarrassing or detrimental to the South Yorkshire Police"—suggested that WMP understood that the review process involved more than simply removing inadmissible evidence, as SYP had by this stage claimed was the purpose of the legal review.

14.116 DCI Ross concluded his note by saying he had advised the caller to take the matter up with his senior officers within SYP. The IOPC has found no evidence to suggest that WMP offered any further support to the caller.

14.117 In a statement to the IOPC, DCI Ross commented: "they may have been editing hearsay and opinion which would not cause me concern as I believed that we would need to obtain CJA statements in the event of any legal proceedings."

14.118 ACC Jones informed the Taylor Inquiry team of the telephone call and then separately wrote to CC Wright about it. The letter began: "I thought I would advise you discreetly that we have had two approaches from separate sources suggesting that certain omissions have been made from officers' recollections." The first approach was the call received by DCI Ross and the second approach was a call from a *Sheffield Star* journalist "who said a man purporting to be the brother of a South Yorkshire Police Officer had also had his recollection subjected to some editing."

14.119 ACC Jones did not ask CC Wright whether he was aware accounts were being amended to this extent, or to ensure that no more material changes were made.

14.120 This letter was sent to CC Wright the day after the Taylor Inquiry team had expressed concerns to ACC Jones about the speed at which SYP officer recollections were being provided to them. However, ACC Jones did not ask CC Wright about the delay, or whether the review process was part of the reason for it.

14.121 Neither WMP nor the Taylor Inquiry team asked for the review process to be changed or stopped, even when after this there were further delays in SYP providing accounts. That was despite the fact that the Taylor Inquiry team did not believe the review process was necessary.

14.122 As part of the Stuart-Smith Scrutiny, D Ch Supt Foster was sent six accounts that had been amended and asked for his comments. In a written response, he indicated that in his view, in all but one instance, the amendments made were unnecessary or inappropriate. He told the IOPC that, though he was aware at the time that accounts were being reviewed by SYP's legal team, the first time he was aware of any concerns with the process was when it was raised by the Stuart-Smith Scrutiny.

14.123 When interviewed under caution by the IOPC, ACC Jones was asked about his awareness of SYP's amendment process, in the context of the memo from DCI Ross. He stated: "What was going on in South Yorkshire Police was of no concern really... we didn't have time to start getting involved in that."

14.124 Even allowing for the time pressure around gathering material for the Taylor Inquiry, this appears an extraordinary response. It suggests that a senior officer in charge of gathering evidence for a public inquiry effectively dismissed an allegation that material changes were being made to other police officers' evidence as "of no concern".

Analysing documentation from SYP

14.125 The evidence indicates that WMP was similarly passive when SYP did not provide some of the documentation it had asked for.

14.126 On 25 April, at the very outset of WMP's evidence-gathering process, Detective Superintendent Roy Taylor (D Supt Taylor) requested that the Operational Orders for both the 1988 and 1989 Semi-Finals should be obtained from SYP. An action was promptly raised in the WMP MIR to obtain the original versions, rather than copies, of both. The instructions stated that the 1988 Order was "required urgently" and gave a deadline for obtaining both documents of 4 May, so they could be made available to Lord Justice Taylor and his team before the hearings started.

14.127 By comparing the two main Operational Orders, WMP would have been able to identify how SYP's plan changed between 1988 and 1989. In turn, this would allow WMP to consider whether any such changes may have had an impact on the events that unfolded in 1989.

14.128 The action result was recorded on 7 May, noting that SYP did not know where the original versions of either document were. The IOPC has found no evidence to suggest that WMP made any further effort to trace the originals, despite viewing this initially as an urgent requirement.

14.129 Using copies, WMP did conduct a comparison of the Operational Orders, which identified a series of changes between the two. This was significant, because SYP officers involved in match planning said in evidence to the Taylor Inquiry that the 1989 Operational Order largely followed the 1988 one. In a report on what the comparison had showed, WMP officers explained that the most notable change was a significant reduction in the number of officers on duty at the Leppings Lane end. WMP's analysis found that the reduction was higher than had been suggested by SYP officers. Despite this, WMP raised no further investigative actions into the difference.

Summarising evidence for the Taylor Inquiry

14.130 One of WMP's key tasks for the Taylor Inquiry was to provide some analysis and summary reports of the evidence that had been collected. In some cases, reports were produced in response to specific requests from the Taylor Inquiry team. In other instances, it appears WMP chose to produce summaries or reports on issues that senior officers viewed as relevant.

14.131 The largest of these reports was a document referred to by ACC Jones as "an interim report on the progress of our investigation." Submitted to the Taylor Inquiry on 26 June, it was 148 pages long and appears to be a compilation of reports written by multiple different authors, some of which had already been submitted separately, such as the comparison of the Operational Orders.

14.132 The report was not made available to the HIP. The IOPC found a copy of it in some boxes of papers retrieved from the archives of the Government Legal Department in June 2015.

14.133 Towards the end of the report, there was a summary section which began by noting that, to date, because WMP had been "a supply on demand team for Lord Justice Taylor", it had "made little progress in actual investigation work". The report suggested: "The time is now approaching when we can assess the vast amount of written and visual evidence with a view to identifying major issues." It then gave some examples of the issues that would be addressed, such as examining whether there was a link between supporters coming through Gate C, "the 'forcing' of the iron gates, the surges in Pens 3 and 4 clearly visible on video and related in numerous statements and the time the barrier broke."

14.134 Strikingly, it also suggested: "Alcohol has featured to a large extent but there is no direct evidence of drunkenness to the degree of this factor alone being a primary cause. Nevertheless one third of [the] deceased were over the legal driving limit and a further third had traces of alcohol. Consideration is being given to a statistical analysis of this to the total amount of supporters on the terraces. Expert evidence is being sought because it is felt that the behaviour of the crowd was a factor and alcohol was a feature."

14.135 The report did not state who felt that the behaviour of the crowd was a factor or that alcohol was a feature. Further, the observation about the number of those who died who were over the legal driving limit was neither accurate (the figure was far lower than a third) nor relevant in itself, or as the basis for extrapolating a figure for a crowd of over 10,000.

14.136 The IOPC has identified that, from even earlier in WMP's evidence gathering for the Taylor Inquiry, ACC Jones wanted to bring the alleged behaviour of Liverpool supporters to the fore. In notes of a WMP management team meeting on 23 May, there was an action for ACC Jones "to write to Andrew Collins re his opening speech, include in the letter items such as: i) Alcohol ii) Fans without tickets."

14.137 There is no record in the policy books of any letter to Mr Collins to that effect, but ACC Jones did send a letter dated 1 June to Mr Brummell, with information about ticket touts.

14.138 The WMP interim report picked up the issue of supporter behaviour, with the authors observing that "The video evidence for 1988 shows a totally different picture to 1989 in the crowd build up at, for example, 2.50pm. This needs to be explored and questions posed on the reasons why." It included some possible reasons for this: all of these were related to the alleged presence of large numbers of supporters without tickets. However, it did not make any reference to the possibility that this different picture could have been linked to other factors, such as changes in police tactics or traffic delays en route, even though there was evidence available to WMP to suggest that either could have been relevant.

Potential involvement of WMP in the King report

14.139 There is some evidence to indicate that WMP—and specifically ACC Jones—may also have contributed to a report submitted by SYP to the Taylor Inquiry. This report was produced on the instruction of Ch Supt Wain and compiled by Detective Inspector Alan King of SYP (DI King) and is informally known as the King report. Its aim was to examine and provide evidence of a so-called 'conspiracy theory', apparently circulating within SYP, that large numbers of Liverpool supporters without tickets would intentionally congregate outside a ground then collectively force their way in. The report primarily consisted of information from a number of police forces about the behaviour of Liverpool supporters at matches in their area in the preceding seasons. Despite considering several matches at different grounds, it provided little evidence to support the conspiracy theory.

14.140 Paragraph 4.2 of the King report included a comment that appeared to be based on input from WMP. This read: "Whilst the evidence does not have any bearing on the match played between Liverpool and Nottingham Forest at Hillsborough, or the fans who attended the match, the Everton supporters behaviour at Villa Park shows a remarkable coincidence with the Liverpool supporters at Hillsborough which may indicate some Liverpool characteristic."

14.141 This referred to the other 1989 FA Cup Semi-Final, involving Everton (a club based in the city of Liverpool) and Norwich City, which had taken place at Villa Park—a large stadium in Birmingham—on the same day as the disaster. WMP had been the force responsible for policing the match and ACC Jones had been on duty.

14.142 SYP submitted the King report to the Taylor Inquiry on 22 June, a few days before the end of the Inquiry hearings.

14.143 On 9 June, almost a fortnight before DI King's report was submitted to the Taylor Inquiry, ACC Jones had written to Peter Whitehurst at the Treasury Solicitor's Department about the "behaviour of Everton supporters at the semi-final on 15 April 1989". In the letter, ACC Jones referred Mr Whitehurst to a previous conversation between them in which he had mentioned he had been at this other semi-final. He continued: "I expressed my concern about aspects of that event which reflected similar behaviour to the Liverpool supporters at Hillsborough."

14.144 ACC Jones wrote that, following this conversation with Mr Whitehurst, he had asked senior officers who had been on duty at the Everton v Norwich City game to provide him with statements. He enclosed three statements with the letter, which ACC Jones concluded: "I would only add that, in my opinion, I had not previously experienced dealing with supporters in such great number who had consumed so much alcohol. Consequently the accounts that I have read on Liverpool supporters behaviour at Hillsborough show some remarkable coincidences which may indicate some Liverpool characteristic."

14.145 Aside from questions about the accuracy of such a comparison, this appears a highly inappropriate comment for the officer in charge of evidence gathering to make. It appears to suggest the actions of a small number of football supporters were representative of the alleged behaviour and character of a city of almost half a million people. It further could be taken to imply that ACC Jones had a fixed mindset or preconceptions about the behaviour of people from the city, while investigating a disaster involving those same people.

14.146 The similarity between the wording of ACC Jones's letter and DI King's report is striking—and indeed a copy of the letter was found in a bundle of papers related to the King report. This raised the possibility that ACC Jones had provided his input directly to DI King; that a colleague at WMP had done so; or, that Mr Whitehurst had done so.

14.147 There is no evidence to suggest that, as part of his research in compiling the report, DI King contacted the Treasury Solicitor's Department. However, he did contact all police forces. It therefore seems most likely that the letter was provided to DI King by WMP.

14.148 If ACC Jones himself had submitted a letter to an officer compiling a report in defence of the very force ACC Jones was investigating, this could be construed as a conflict of interest. When interviewing ACC Jones under caution, the IOPC showed him a copy of the letter he had sent to Mr Whitehurst and asked him to comment on it. ACC Jones responded: "I have no independent recollection of writing this letter twenty-five years ago however I accept writing it. I had not recalled using the term Liverpool characteristic before."

14.149 He was then asked about it at the Goldring Inquests and rejected the suggestion that this was an example of a lack of independence and impartiality from WMP.

Response to Mr Collins's final observations

14.150 On 13 July, Counsel to the Inquiry Mr Collins gave his final observations. These began with some highly complimentary remarks on WMP's "immense effort in interviewing witnesses and collecting the necessary evidence and in producing for us, often at very short notice, exceedingly helpful reports and summaries of their enquiries."

14.151 Mr Collins then provided a summary of the evidence heard, expressing views on issues such as failings around stadium safety and the fact that Ch Supt Duckenfield did not foresee the consequences of his order to open the gates.

14.152 Mr Collins also set out his view of the evidence that had been heard relating to the behaviour of supporters. While he stated that there was "a considerable amount of boorish and loutish behaviour", he said he believed "it was a minority of fans who were guilty of it." Crucially, he added that such behaviour "did not cause the trouble."

14.153 D Ch Supt Foster sent ACC Jones a memo in response to Mr Collins's closing observations. The IOPC found this on one of the floppy disks obtained from the Sheffield Archives. It has not previously been published and was not examined by the HIP.

14.154 In the memo, which according to its title was written at ACC Jones's request, D Ch Supt Foster listed a number of areas where he disagreed with Mr Collins's conclusions.

14.155 For example, D Ch Supt Foster challenged Mr Collins's assertion that the crush on the terraces was an "inevitable result" of not blocking the tunnel to the centre pens once the gates were opened. D Ch Supt Foster wrote: "I find it difficult therefore to have expected and planned for the majority to have gone down the tunnel to Pen 3 and Pen 4" and later added: "Mr Duckenfield could not have anticipated it." D Ch Supt Foster offered the view that "If anyone should [have anticipated it] then it is my contention the experience of Mr Marshall, Mr Murray places that responsibility firmly with them."

14.156 However, perhaps the most notable feature of the memo was the number of references D Ch Supt Foster made to alcohol consumption and supporter behaviour.

14.157 The first of these was on the first page of the memo, where D Ch Supt Foster wrote: "I would suggest many Liverpool supporters left it late, deliberately having no tickets or consuming alcohol to a greater degree then [than] emphasised at the Public Inquiry." The IOPC has not found compelling evidence in the wider body of questionnaires or statements taken by WMP to support any of these three suggestions.

14.158 D Ch Supt Foster then commented: "I question the use of the word minority in relation to Alcohol etc outside [sic] who forced open the Leppings Lane perimeter gates. I suggest (and the statements confirm) that the final crowd build up were in the majority those who had been drinking." [Underlining in original.] It is not clear which statements he was referring to here. Some officer accounts did refer to large numbers of supporters consuming alcohol or appearing drunk; however, there were also plenty of officers who did not suggest this was the case. The overwhelming majority of actual statements WMP had taken, from supporters and other witnesses, certainly did not support D Ch Supt Foster's assertion.

14.159 Next, in a section of the memo subtitled "Alcohol", D Ch Supt Foster wrote: "I really do believe this is more of a problem than identified. I have to say that the evidence suggests the majority of the latecomers were those who had been detained drinking.

There is no other explanation based upon the times of arrival of the coaches, private cars etc. Add to this the evidence of the local residents, licensees, supermarket outlets, Police on duty and the picture is clear."

14.160 The evidence WMP had gathered from local residents and licensed premises absolutely did not support this assertion.

14.161 D Ch Supt Foster stated at the end of the memo that his comments were made "straight off the hip with no real preparation time". It was an internal memo, not intended for external audiences. Nonetheless, the memo appears to set out a very different view of the available evidence to that articulated by Mr Collins.

14.162 IOPC investigators asked D Ch Supt Foster about this memo when interviewing him under caution. D Ch Supt Foster stated: "I've written that based on the evidence that was before me at that particular time."

14.163 In a response to the summary of proposed criticisms of D Ch Supt Foster sent by the IOPC in 2024, his solicitors wrote that he did not accept that this memo indicated he disagreed with Mr Collins's conclusions. They emphasised that the memo was an initial reaction to the closing observations and highlighted that the memo also included a number of points where he directly agreed with Mr Collins.

14.164 The content of this memo appears to illustrate that D Ch Supt Foster had formed a closed view of the available evidence. While this was arguably of limited impact on the Taylor Inquiry, the consequences of such a closed view became more apparent in the criminal investigation that followed.

14.165 Though the IOPC has identified some issues with WMP's work for the Taylor Inquiry—particularly in relation to its collection of evidence from police witnesses—it remains clear that WMP was working at this stage on behalf of the Taylor Inquiry team. Supporting a public inquiry was an unusual role for a police force; the need to gather so much evidence at speed meant that decisions had to be made about priorities. The IOPC's concerns should therefore be balanced against the consistent view of the Taylor Inquiry team that WMP performed a complex task very well.

15. WMP's criminal investigation into the Hillsborough disaster

What was investigated?

The IOPC's terms of reference included investigating:

The conduct of officers involved in WMP's investigations. This will include:

a) the involvement of WMP in the decisions taken about how to gather evidence/ obtain witness accounts

b) whether police officers involved in this investigation put inappropriate pressure on any witnesses to alter their accounts or influence the content of those accounts

c) whether the summaries of evidence WMP presented at the individual inquests were accurate

d) whether there is any evidence of bias in favour of SYP on the part of those involved in or leading the investigation

e) whether any accounts provided were deliberately lost, inaccurately recorded, amended, or mishandled (including not following up on key witnesses)

f) investigating other recorded complaints or conduct matters about the actions of WMP in the gathering or presenting of evidence

This chapter focuses on the criminal investigation WMP carried out in relation to the Hillsborough disaster.

What was found?

- **WMP completed just 76 actions related to lines of enquiry for the criminal investigation:** a very small number for a major manslaughter investigation.
- **Only ten actions were raised in relation to lines of enquiry into the opening of the exit gates at the Leppings Lane end**—which the Taylor Interim Report had described as "a blunder of the first magnitude." Just two of these actions related directly to Gate C and only one of these was completed.
- **The IOPC identified 37 potentially key witnesses that WMP did not approach or take statements from as part of its criminal investigation**, including SWFC directors, representatives from Eastwood & Partners or SCC employees. All three organisations were under investigation for manslaughter. In addition, it did not initially interview the senior SYP officers who had been on duty.
- Though senior detectives had raised the issue that the SYP officer accounts submitted to the Taylor Inquiry had been amended and were not admissible as evidence for a criminal prosecution, **WMP still did not take statements from officers** and continued to rely on the SYP accounts.

- **Further, in the file of evidence WMP submitted to the DPP for charging decisions, the lead author specifically highlighted that the accounts were not suitable for a criminal investigation**—without acknowledging that WMP alone could have addressed that.
- **The file of evidence did not accurately reflect the evidence that WMP had at its disposal.** This was particularly notable in relation to the impact of traffic delays on supporters' arrival times and the claim that there was a "consensus" among local residents that the behaviour of supporters at the 1989 Semi-Final was much worse than it had been at the 1988 game.
- In the section of the file where D Ch Supt Foster analysed the evidence submitted, he included **repeated references to the behaviour of supporters and how much alcohol had been consumed**, and indicated this was a mitigating factor in what had happened.
- When WMP did, belatedly, interview the suspects, **the interviews did not meet the expected professional standards of the day.**

Significant new evidence

ACC Jones's policy books were a major source of previously unavailable evidence about WMP's criminal investigation.

To assist with the review of WMP's suspect interviews, the IOPC commissioned an expert in police investigative interviewing to review the interview transcripts using a methodology called the Griffiths Question Map.

15.1 After the Taylor Interim Report was published on 4 August 1989, strongly criticising SYP, CC Wright asked WMP to undertake a criminal investigation into the disaster. WMP was formally appointed to the task on 16 August 1989, with manslaughter the main offence under consideration. As well as SYP, three other organisations and their staff were under investigation: SWFC, Eastwood & Partners and SCC.

15.2 On 30 March 1990, WMP submitted a file of evidence to the DPP. This included the analysis by D Ch Supt Foster of whether there was sufficient evidence to justify bringing charges of manslaughter in relation to the disaster.

15.3 On 30 August 1990, the DPP announced that no criminal charges would be laid against any person or organisation.

15.4 WMP's criminal investigation has not previously been re-examined in depth. However, the HIP Report included various observations on the file of evidence WMP had submitted to the DPP—in particular suggesting that it put "the issues of drunkenness and ticketless fans… back on the agenda."

15.5 As part of its wider investigation into the work of WMP, the IOPC sought to re-examine WMP's criminal investigation. It considered the overall quality and professionalism of the criminal investigation that WMP conducted, comparing it to the standards that would have been expected at the time and assessing whether there was any evidence of bias towards fellow police officers.

Appointment of WMP to conduct a criminal investigation

15.6 On the day the Taylor Interim Report was published, CC Wright wrote to the DPP to ask him to consider the question of criminal offences arising from the disaster. Over the following days, a series of conversations ensued, that led, on 8 August 1989, to CC Wright asking ACC Jones if WMP would undertake a criminal investigation. ACC Jones provisionally accepted this task, and the linked work for a police disciplinary investigation, on the basis that WMP saw these tasks as connected. On 16 August, WMP issued a press release confirming that it had been asked to "undertake a full criminal inquiry into all the circumstances that surrounded the events at Hillsborough on 15 April 1989."

15.7 However, WMP did not immediately start work, even though members of the DPP's team indicated they would like that to happen. This was due to questions around how the criminal investigation would be funded.

15.8 Following extensive correspondence involving the chief constables of both forces and the respective police authorities, on 27 September 1989 these financial issues were finally resolved. The South Yorkshire Police Authority (SYPA) agreed to reimburse WMP for its work, with no limit placed on the costs; the SYPA itself would subsequently be reimbursed by the Home Office. With this confirmed, WMP officially began the investigation.

Limited scope of WMP's criminal investigation

15.9 The fact that this was a criminal investigation meant that, unlike when it was supporting the public inquiry, WMP was now back on familiar territory. It had a team of officers with extensive experience in complex and high-profile criminal investigations. They therefore should have been well aware of what would be required from a criminal investigation. The Taylor Interim Report had provided a clear starting point in terms of lines of enquiry, and WMP had a large volume of evidence and information to draw on. This included thousands of statements and questionnaires, the accounts of SYP officers, reports from the HSE, and its own analysis and reports conducted for the Taylor Inquiry.

15.10 On 6 September 1989, D Supt Taylor sent ACC Jones a memo setting out anticipated resource requirements and key tasks for the criminal investigation. These included:

- converting officers' recollections into CJA statements
- questioning those with some degree of culpability
- interviews of new witnesses
- reinterviews of witnesses and police officers

15.11 He suggested the number of WMP officers that might be required for each task.

15.12 The task of converting officers' recollections into CJA statements had also been cited by ACC Jones during his negotiations concerning the costs of the investigation.

15.13 However, none of these tasks was undertaken. In fact, the scope of WMP's criminal investigation was extremely and inexplicably limited. It effectively ended on 31 March 1990, with the submission of the file of evidence to the DPP.

15.14 This submission date appears to have been decided by WMP alone. The IOPC has found no evidence that there was any request from any other party to complete the investigation by that date. In fact, it was slightly later than ACC Jones had initially envisaged; several policy book entries show that WMP's aim had been to complete the investigation by the end of February.

15.15 This was a very compressed timetable for a major manslaughter investigation, and no explanation has ever been given for why the timetable was fixed in this way. CC Dear specifically stated to the IOPC that he was not aware of any time pressure.

15.16 During the six months from the end of September 1989 up until 31 March 1990, just 168 actions were raised in relation to lines of enquiry that were specifically undertaken as part of the criminal investigation. Of these 168, 92 resulted in no further action being taken—meaning that during this time period, WMP completed just 76 actions related to lines of enquiry for the criminal investigation.

15.17 By way of contrast, across the same period, WMP undertook around 1,000 actions in support of the Popper Inquests and 194 related to investigating complaints against the police.

15.18 It is also worth noting that 45 of the actions considered as part of the criminal investigation were related to supporter behaviour. Although 40 of these resulted in no further action being taken, the figure stands in marked contrast to the number of actions centred on the opening of the gates at the Leppings Lane end: 10.

15.19 While there is evidence that supporters were considered a subject for investigation, the main offence being investigated was manslaughter, and the opening of the gates had been identified in the Taylor Interim Report as a critical moment. Further, the Taylor Interim Report had noted that failing to close the tunnel to the centre pens, when the gates were opened, had been a critical error.

15.20 The fact that the tunnel had been closed on previous occasions but was not closed on the day of the disaster was accepted by all parties, including SYP. However, as discussed in chapter 11, several of the most senior SYP officers on duty had given evidence to the effect that they were either unaware that the tunnel had been closed previously or had only become aware of it following the disaster. They suggested that the tunnel had been closed by junior officers, acting on their own initiative.

15.21 A large amount of oral evidence given to the Taylor Inquiry had indicated that tunnel closure may have been a more common occurrence or even a formal police tactic. Furthermore, a number of officer recollections submitted to WMP indicated that the action had previously been carried out on the instruction of more senior officers.

15.22 In the context of an investigation into the possible offence of manslaughter by gross negligence, this issue was of considerable significance. If evidence was found to demonstrate that:

- closing the tunnel was an accepted SYP tactic to prevent overcrowding in the pens, **and**
- that officers in the PCB were aware of this tactic

then the failure to implement that tactic could have been deemed an indicator of negligence.

15.23 It would have been a logical and appropriate investigative step to interview each of the officers who had given evidence about this, to seek to verify their accounts and ascertain what their understanding of the police tactic was. However, the IOPC has found no evidence to suggest WMP made any effort to contact them again. Instead, actions were raised to ask some officers that had been on duty at the 1988 Semi-Final about their knowledge of any action to close the tunnel on that occasion. These did not result in further information.

15.24 Of the 168 actions for the criminal investigation, three were recorded as high priority. Two of these involved taking statements from a married couple who had not been at the match. They had travelled from Manchester Airport on the M62 towards Sheffield, on the way home to Wakefield in West Yorkshire, on the day of the disaster. This meant they had taken a similar route to some Liverpool supporters on the way to the match.

15.25 An instruction from D Ch Supt Foster shows that WMP took statements from these two individuals at the request of SYP.

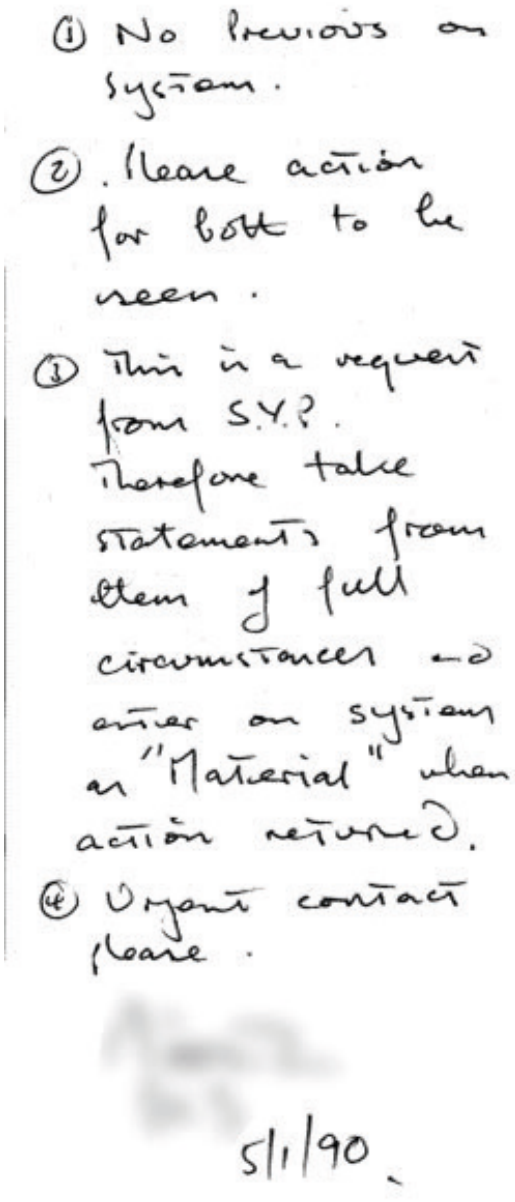


Figure 15A: Note from D Ch Supt Foster, 5 January 1990 (Source: SYP Archive)

15.26 The statements were obtained within a week and were very similar in their wording. In particular, both stated: "I was disgusted by the conduct of the football fans, the fact that they had been drinking and were urinating at the side of the road, in full view of other road users." Both were included in the file WMP submitted to the DPP in March 1990.

15.27 In 2016, the wife gave a statement to Operation Resolve. With regard to the allegations made about supporters, she stated she could "no longer recall much of their behaviour. I no longer recall seeing fans urinating in public places."

15.28 It is notable that WMP acted so promptly to obtain these statements—especially given the very small number of actions raised during its criminal investigation. It is also striking that D Ch Supt Foster determined that the information these witnesses could give was "material" before it had been gathered.

15.29 Conversely, the IOPC has identified 37 potentially key witnesses that WMP did not approach or take statements from as part of its criminal investigation. As well as some police officers who may have been able to provide vital additional information, such as those in the PCB, WMP did not take statements from SWFC officials, or Eastwood & Partners or SCC employees. All three of these organisations were under investigation for possible manslaughter.

15.30 SWFC officials could also potentially have been investigated for health and safety offences; Operation Resolve secured the conviction of Mr Mackrell (SWFC Club Secretary) for offences involving health and safety legislation, almost entirely on the same evidence available to WMP. The HSE had advised the Taylor Inquiry that there had been a repeated failure to adhere to the Green Guide and potential failure to meet obligations under the SSGA 1975. However, at the start of the criminal investigation, the HSE informed ACC Jones that it viewed the issues around the disaster as not falling under its prosecutorial remit. Despite this. the evidence indicates WMP gave little or no consideration to such offences.

15.31 Even though some senior SYP officers were identified early on as suspects in the manslaughter investigation, WMP chose not to interview them under caution before submitting its file of evidence. This was a highly unusual decision.

15.32 Altogether, this meant that during its criminal investigation, WMP did not substantially add to the evidence that had been presented to the Taylor Inquiry. In a letter to the Taylor Inquiry team in October 1989, ACC Jones acknowledged this, commenting: "You will see, apart from the provision of more detail and improved identifications of the deceased, nothing new has emerged." He reiterated this in conversation with the Secretary of the Taylor Inquiry team in December 1989. However, in the file it submitted to the DPP, WMP appeared to reach a very different view of that evidence.

The file of evidence WMP submitted to the DPP

15.33 The file of evidence WMP submitted to the DPP was more than 7,200 pages long. It included hundreds of statements, over 800 photographs and was supported by 60+ hours of video material.

15.34 It was produced in seven parts, ostensibly to divide the evidence into logical sections.

- Part 1 included an overall introduction, followed by evidence from SWFC staff.
- Part 2 covered the history of SWFC and the development of Hillsborough Stadium.

- Part 3 was visual evidence, including photographs and written summaries of the video footage.
- Part 4 provided evidence about Liverpool supporters, as well as evidence from Liverpool supporters.
- Part 5 consisted of material from SYP, including officers' accounts and the Operational Orders.
- Part 6 focused on the emergency response and included evidence from SYMAS and SYCFS staff and SJA volunteers.
- Part 7 was titled "The report". It sought to summarise the evidence presented and draw conclusions about each individual under scrutiny, to assist the DPP in making decisions about whether or not to charge anyone.

15.35 After it had submitted the main file of evidence, WMP submitted some additional evidence. This included transcripts of interviews under caution, which were conducted in June and July 1990, and some correspondence from SWFC. The additional evidence was clearly marked as such and linked to the relevant parts of the initial file. No further analysis or report was submitted.

15.36 Parts 1 to 6 started with a commentary from WMP, explaining the nature of the material provided in that part of the file and identifying key pieces of evidence.

15.37 The IOPC has analysed each part of the file in depth and identified a wide range of concerns regarding the content. These can be summarised as follows.

- **Inaccurate presentation of information**: while every statement cited was included in full, there were a number of instances where WMP's commentary provided an inaccurate summary of the original statement. For example, in the commentary for part 1, there was a reference to a steward's statement, in which he had described "500 or 600 Liverpool fans" turning up to the ground to protest about the FA's decision to allocate fewer tickets to Liverpool than Nottingham Forest. In WMP's commentary, an extra zero was added, meaning it referred to "5-6000 Liverpool fans". This may well have been a mistake, but it changed the impression created considerably, implying a very large number of Liverpool supporters in an organised protest outside the ground—which would have caused considerable additional challenges for the police. In fact, the only other evidence WMP had of any protest came from the questionnaire of a different steward, who did not provide an estimated number of protesters.
- **Selective presentation of information**: it was the responsibility of WMP to select what it believed was the most relevant evidence to present to support its case. However, compared to the underlying body of evidence available, WMP consistently omitted information that portrayed SYP in a negative light. For example, though the commentary to part 5 acknowledged that there was evidence from police officers that the tunnel to the centre pens was closed at the 1988 Semi-Final and said that "relevant statements are included", no such statements or officer accounts were in part 5. It did include the written account of Ch Insp Creaser, who had given evidence about tunnel closure in 1988 during the Taylor Inquiry hearings. However, he did not mention it in his written account. The account of PS Higgins, which specifically mentioned past actions to close the tunnel, was added to part 2 in June 1990—almost three months after WMP had originally submitted its file, even though WMP had obtained the statement in June 1989.

- **Confusing decisions about where information was placed**. The structure of the report might be deemed to indicate that all evidence from SWFC was in part 1, all evidence from supporters in part 4 and all evidence from SYP officers in part 5. However, this was not the case. The accounts of senior SYP officers Ch Supt Mole, Ch Supt Nesbit and ACC Jackson were included in part 2. Part 4 began with an account from a police officer, and it was over 300 pages into part 4 before WMP presented a statement from a Liverpool supporter. In total, around half of the statements included in this part were not from supporters: instead, they were from local residents, shop and licensed premises staff, coach drivers and even members of the public travelling between Liverpool and Sheffield on the day of the game.
- **Recurring references to supporter behaviour and, in particular, alcohol consumption, which appears disproportionate when compared to the underlying evidence**. For example, the commentary stated that there was a "consensus" among local residents that "the Liverpool supporters were generally badly behaved and that alcohol influenced this behaviour". It further suggested that the behaviour was far worse in 1989 than it had been in 1988. While the file contained some statements that supported this claim, the IOPC has established that out of the 880 questionnaires WMP conducted with local residents for the Taylor Inquiry, 120 said they witnessed "drunkenness": by no means an insignificant proportion, but emphatically not a "consensus" on the subject.
- **Assertions which appear to be based on a selective reading of the evidence.** This was particularly significant in part 7, which drew conclusions about the evidence in the rest of the file. However, there were other examples: in part 3, there were 23 photographs with captions that referred in some way to misbehaviour by supporters. However, the actual evidence of criminal or antisocial activity in these images is minimal. Some photographs showed supporters gesticulating or with what appear to be angry expressions; in the context of the events of the day, it would be no surprise that some were angry or upset.
- **Nine photographs were included which focused purely on litter**, either on the streets or in waste bins in the Leppings Lane area. These were simply listed in the file and there was no reason given as to why they were included. There was a close-up photograph of a single beer can on the ground, the evidential value of which is hard to discern. The only photographs of supporters drinking alcohol showed Nottingham Forest supporters, which was not acknowledged.



Figure 15B: Photograph of litter, submitted by WMP to the DPP (Source: SYP Archive)

15.38 Potentially key issues were overlooked. For example, WMP asserted in its commentary that traffic delays did not affect the arrival of Liverpool supporters in Sheffield, even though more than 2,000 supporters had reported experiencing delays on their journey. In a section comparing the Operational Orders for the 1988 and 1989 Semi-Finals, the file's lead author D Ch Supt Foster commented that the 1989 plan was essentially the same as the 1988 one, with just a small reduction in officer numbers. However, WMP's own analysis had found several differences between the two.

15.39 Part 6 included statements from several SYMAS and fire service staff involved in the rescue effort who said that they had asked the police for information about what had happened and where they could best assist but had not been given helpful answers by SYP. This was not acknowledged in the commentary. Instead, D Ch Supt Foster wrote that "The police plan indicates they have the key role in control and coordination at the scene of a disaster" and commented: "To some extent this reflects what took place at Hillsborough" and further, that liaison "at a lower level" between services "appears to have worked well."

15.40 Part 5 of the file was focused on evidence from police officers. At the start of it, D Ch Supt Foster commented on the fact that the accounts of SYP officers were not CJA statements and that some of them had been amended by SYP's legal team. While it was important to make the DPP aware of this fact, there was no explanation in the file that this was a result of WMP's decision not to interview SYP officers and take statements from them.

15.41 However, the most significant part of the file was part 7, "the report", which was D Ch Supt Foster's summary of the evidence gathered. It was 178 pages long (including two appendices) and, unlike the previous parts, did not include any supporting statements or accounts. Instead, it referred to statements, accounts and documents included in the six previous parts, as well as to the Taylor Interim Report.

15.42 It began with several pages of background, covering the Taylor Inquiry, the ongoing Popper Inquests and the decision to launch a criminal investigation. It also summarised the organisations and individuals under investigation and why, as well as the volume of evidence considered.

15.43 In these initial pages, D Ch Supt Foster again drew attention to the fact that the file included written recollections, rather than CJA statements, and noted: "from a criminal investigation perspective this is clearly unsatisfactory." He offered an explanation for why recollections had been gathered—to meet the Taylor Inquiry timetable—but not why WMP had not taken action to convert the recollections into CJA statements.

15.44 D Ch Supt Foster also stated early on: "The evidence on which Lord Justice Taylor drew his conclusions has not been added to significantly nor contradicted by our investigation findings since the publication of his Interim Report. Notwithstanding there are aspects of this disaster which in the opinion of the Investigating Officer may not have been given sufficient prominence; for example, the role of supporters."

15.45 When the IOPC asked D Ch Supt Foster, during an interview under caution, why he felt this was the case, he said his position was based on the evidence. He did not specify what evidence.

15.46 A couple of pages later, he wrote: "The extent to which the effects of alcohol played a part, the late arrival of many thousands of Liverpool supporters and even perhaps their own failure to recognise the distress of fellow supporters in pens 3 and 4 are important issues in this disaster investigation."

15.47 This comment from D Ch Supt Foster clearly contradicted the body of evidence from Liverpool supporters on the terraces—corroborated by video footage and media coverage—that they had repeatedly sought to draw police attention to the crush and had begun rescue attempts before the emergency services arrived. It also offered a very different perspective from the Taylor Interim Report, which had stated unequivocally that "the great majority were not drunk nor even the worse for drink".

15.48 WMP had repeatedly adhered to the assertion that it had not substantially added to the evidence that was available to Lord Justice Taylor. This comment from D Ch Supt Foster about the importance of examining supporter behaviour appears to suggest that, though WMP had viewed the same evidence as Lord Justice Taylor, they had reached very different conclusions.

15.49 This comment also appeared to echo the views D Ch Supt Foster had expressed in his memo to ACC Jones in response to Mr Collins's closing observations at the Taylor Inquiry.

15.50 After the introduction, there was a section covering "Key issues". Under the subheading "The Build up at the turnstiles", D Ch Supt Foster wrote: "the behaviour of the fans undoubtedly contributed to the problems". He acknowledged this was his opinion but did not mention some of the other factors that could have contributed to this build-up, such as travel delays or the changes to turnstile arrangements. This again reflected the views he had set out in his memo to ACC Jones regarding Mr Collins's closing remarks, where he had similarly linked late arrivals at the ground to supporter behaviour.

15.51 D Ch Supt Foster then considered SYP's failure to take appropriate steps to prepare for the opening of the exit gates. He described this issue as "perhaps the most important of all in respect of possible criminal culpability." He accepted as fact that Ch Supt

Duckenfield and Supt Murray had not considered the consequences of opening the gates before they issued the order to do so, but asked, "can that be construed as a criminal or disciplinary offence? Or is it incompetence?"

15.52 To answer this, D Ch Supt Foster examined past evidence of crushing at the Leppings Lane end and what SYP knew of it. He identified that the crush at the 1981 FA Cup Semi-Final was very similar to the events in 1989. However, he then stated that the 1987 Semi-Final passed without incident. That was despite the fact that the Taylor Inquiry had heard evidence from a supporter who had been caught up in a crowd crush at the Leppings Lane end before and during the 1987 game. Later in his report, D Ch Supt Foster cited this very individual's evidence, in reference to SWFC's knowledge of previous crushing incidents.

15.53 Regarding the 1988 Semi-Final, D Ch Supt Foster stated that there was evidence of a crowd crush leading to injuries. He also wrote that there was evidence that SYP officers had closed the tunnel to the centre pens of the Leppings Lane terraces. However, he accepted that the match commander at the 1988 Semi-Final, Ch Supt Mole, did not know about the injuries or the tunnel closure, so could not have informed Ch Supt Duckenfield about them. Furthermore, because Ch Supt Mole believed the 1988 Semi-Final had been a successful police operation, D Ch Supt Foster suggested that there would have been no need to give Ch Supt Duckenfield any information about any previous incidents. D Ch Supt Foster wrote that as a result: "the link with the 1981 problem was broken."

15.54 Yet D Ch Supt Foster had asked neither Ch Supt Mole nor Ch Supt Duckenfield about this. He also did not appear to consider whether anyone else could have informed Ch Supt Duckenfield about the 1988 incident.

15.55 Later in the report, D Ch Supt Foster referred to allegations made about other SYP officers and, for the most part, dismissed them.

15.56 For instance, the complaints against PC Smith and PC Illingworth related in part to the fact that, despite being stationed on the perimeter track and thus having the closest view of the terraces, they failed to recognise the severity of the crush, as examined in chapter 5 of this report. D Ch Supt Foster wrote that "no one either police or Club employee, recognised the fact that pens 3 and 4 were overcrowding. Nor for that matter did any other observer recognise the fact including professionals who regularly attend matches, such as the media personnel."

15.57 Yet some of the evidence cited in WMP's file to the DPP directly contradicted this. Some supporters, members of SWFC ground staff and media representatives, including well-known and experienced football journalists Jeff Powell and Colin Gibson, had all stated to WMP that they saw a situation of overcrowding and distress, where there was serious potential for a crush incident. Some SYP officers, cited in part 5, had indicated that they had identified overcrowding. There was even an account in part 5 from the Chief Constable of Nottinghamshire Police to the same effect.

15.58 Further, it contradicted previous WMP analysis of the evidence. In a report written in August 1989, in response to a request from D Supt Taylor, DCI Ross had found that "the Constables, without exception, noticed a large build up of fans in the Pens 3 and 4, some becoming concerned about the matter, but no action was taken by any of them". This evidence was either overlooked by D Ch Supt Foster in preparing this summary or deliberately ignored.

15.59 The IOPC also identified that some potentially valuable analysis conducted by WMP during its investigation was not included in the file it submitted. IOPC investigators reviewing WMP's HOLMES account found a detailed sequence of events around the opening of Gate C, built on some 452 references to statements and questionnaires. This was not submitted to the DPP.

15.60 The file also contained little or no analysis of what caused the build-up of supporters on Leppings Lane, which ultimately led to the gates being opened. It offered minimal examination of whether deficiencies in the police planning arrangements and/or ground layout contributed to this build-up. Above all, it did not consider in detail the police planning for the 1988 FA Cup Semi-Final, the crowd crush that occurred during it or the circumstances leading to the closure of the tunnel—all of which could have served as vital points of comparison to the events of 1989.

15.61 The 1989 Semi-Final took place at the same ground and involved the same teams as in 1988. The sets of supporters were allocated the same ends of the ground. As ACC Jones had identified at the very start of the WMP investigation, the pivotal question therefore was "what was the difference?" This was never adequately explored by WMP, neither in its investigation, nor in the file it submitted to the DPP.

15.62 This point was raised by the barristers appointed by the DPP to review the file. Notes of a meeting on 20 April 1990—three weeks after the file was submitted—involving one of the barristers (Peter Birts QC), D Ch Supt Foster and Mr Kennedy of the CPS recorded that "Mr Berts [sic] was particularly concerned about learning more concerning the procedures for the passing on of information to other officers following the earlier incidents which had happened at the semi finals at Hillsborough in 1987 and 1988." The notes included Mr Birts's observation that these previous incidents of overcrowding at the Leppings Lane end were "of crucial significance to any decision to prosecute the police for corporate manslaughter in this case."

15.63 In response to the request from Mr Birts, D Ch Supt Foster personally conducted follow-up enquiries and secured CJA statements from Ch Supt Mole and Ch Supt Denton, which he submitted to the CPS on 8 May 1990 with a brief covering letter. In these statements, both officers referred to an SYP file for football matches, which contained among other things the minutes of the debrief following the 1981 Semi-Final. They both stated they showed this to D Ch Supt Foster.

15.64 However, there is no evidence that D Ch Supt Foster asked to retain this potentially invaluable file to examine it, make copies of the documentation to support WMP's investigation, or pass it to the CPS.

15.65 D Ch Supt Foster was interviewed under caution on four separate days and the file of evidence submitted to the DPP was discussed on each occasion. As noted earlier, he made clear from the outset that he was the lead author of the file and accepted responsibility for its content. He also acknowledged that there may have been mistakes in the WMP investigation and suggested that if he himself were to review it in depth, he was certain he would find aspects he was not happy with. However, he stated categorically that any such mistakes were not the result of bias.

15.66 He accepted that the decision not to take any statements from SYP officers was a mistake. He said his logic at the time was that it would be easy to convert recollections into CJA-compliant witness statements if the DPP chose to prosecute. While this may have been his intention, this was not how it was presented in the file. There, the fact

that recollections would not be admissible was cited as an obstacle to a successful prosecution; D Ch Supt Foster did not explain in the file that if a prosecution was launched, it would be easy to resolve the issue.

15.67 IOPC investigators asked D Ch Supt Foster specifically about some of the information included in or omitted from the file.

15.68 On the subject of the tunnel closure, D Ch Supt Foster recalled that he had written a "considerable section on the tunnel", adding: "I think I made it clear that the failure to close the tunnel by South Yorkshire Police officers was a major cause of the deaths of many of the supporters." While D Ch Supt Foster did indeed write that not closing the tunnel was a major cause of death, he did not clearly attribute that failure to SYP officers. Instead, the file content concluded that Ch Supt Duckenfield would not have known there was any need to close the tunnel—a very different point.

15.69 On the subject of the emphasis he had placed on supporters' alleged behaviour, unsupported by evidence, D Ch Supt Foster had acknowledged, when interviewed as a witness by the IOPC at the outset of its investigation, that WMP put this issue "back onto the table" for the criminal investigation, adding: "we felt it was a factor."

15.70 During his interview under caution, D Ch Supt Foster pointed investigators to the end of part 4, stating: "I think it's at the very conclusion what I write and say is although alcohol played a part it was a sunny day erm it was no different in alcohol terms to most other football matches in that era." If that was the case, it is not clear why he then suggested that alcohol had not been considered adequately.

15.71 IOPC investigators referred him to his comments in part 7 that the behaviour of supporters had not been "given sufficient prominence" and that "the extent to which the effects of alcohol played a part" was an important issue, asking if these were intended to show that supporters had been at fault. D Ch Supt Foster replied: "I don't think that's a conclusion I just … I just think I say there these are important issues in this disaster investigation I don't say that they are reasons for the disaster."

15.72 D Ch Supt Foster further stated: "It's important that they [the DPP and his QCs] didn't come back and say I think this report is wrong or that I think there's things in there that … the evidence doesn't justify." Instead, he stated that the discussions after the file was submitted focused on who would be interviewed under caution.

15.73 These interviews were then arranged in June and July but also proved flawed.

Flaws in the suspect interviews conducted by WMP

15.74 Seven SYP officers were interviewed under caution, as was Mr Mackrell. D Supt Taylor led the interview with Mr Mackrell, D Ch Supt Foster led five, and Chief Constable Leslie Sharp of Cumbria Constabulary (CC Sharp) led the interviews of ACC Jackson and Ch Supt Duckenfield. CC Sharp had been appointed to oversee the disciplinary investigation of CC Wright (see paragraphs 7.114–7.119), after CC Dear's retirement. At the time, it was a requirement of police disciplinary processes that officers should be interviewed by an officer of equal or higher rank. The incoming Chief Constable of WMP was Ron Hadfield who, in his previous role as Chief Constable of Nottinghamshire Police, had attended the match as a spectator. It was therefore agreed that he should not be involved in the investigations.

15.75 The IOPC examined the transcripts of these interviews and asked an expert witness—Michael Confrey, a former specialist investigative interview adviser at Greater Manchester Police (GMP)—to do the same. Mr Confrey used a technique called the Griffiths Question Map (GQM) to analyse the interviews. This classifies the questions asked as appropriate/productive, or inappropriate/unproductive.

15.76 Questions are deemed inappropriate/unproductive when they are:

- closed—these are questions that invite a yes/no answer (clearly, closed questions can be appropriate, but inappropriate ones are poorly timed in the interview, or could elicit more information if they had been asked in an open-ended way)
- leading—these are questions that appear to lead the interviewee to a particular answer
- based on a forced choice—these are questions where the interviewee is given a limited choice of possible answers
- multiple—this is where several questions are asked as one, meaning the interviewee can 'choose' which one to answer
- opinion statements—this is where no specific question is posed; instead, the interviewer makes a statement and invites the interviewee to agree

15.77 No GQM was produced for the interviews with Ch Supt Duckenfield and Supt Greenwood, as both provided a prepared statement to WMP and indicated that they would not answer questions, as was their right. When the interviewers received confirmation of this from Ch Supt Duckenfield and Supt Greenwood, the interviews were promptly terminated and no questions asked.

15.78 Mr Confrey found that in each interview, more than two-fifths of the questions asked were inappropriate or unproductive.

15.79 The most commonly used category was "leading questions"; Supt Marshall, Supt Murray and ACC Jackson were all asked more than 120 of these in their interviews. For example, in interviewing Supt Marshall, D Ch Supt Foster asked about the build-up of the crowd at the Leppings Lane end. While this was an appropriate topic, the line of questioning restricted the answer. Instead of asking Supt Marshall simply to describe the build-up, D Ch Supt Foster stated: "We have got a situation where there was a considerable build up of supporters that I think you described as as build up quite significantly late on around 2.35pm time". This had the effect of closing down any potential response Supt Marshall may have given about what happened.

15.80 A further recurring issue was the failure of interviewers to follow up on potentially significant information disclosed in the interviews. For example, in his interview Supt Marshall criticised the quality of the pre-match intelligence supplied by Merseyside Police, stating that it left "a lot to be desired". D Ch Supt Foster did not ask him why he felt that way, what Supt Marshall felt was absent from this intelligence or how improved intelligence could have altered the events that occurred.

15.81 In the interview with PC Smith, there was an even more striking example of this failure to follow up potentially significant information. This was during questioning about the allegation that PC Smith pushed supporters back into the pens, without recognising there was a crush. D Ch Supt Foster asked him: "Do you recall pushing people back in at any stage? PC Smith replied: "Yes."

15.82 At this point, D Ch Supt Foster paused the interview, commenting: "Can I just say at the minute I I don't think the officer's too well. Do you want to have a break for a few minutes? The time is 1109. Police Constable Smith isn't well in my opinion at the moment and I would prefer to stop the interview."

15.83 The interview was suspended for around 40 minutes. When it restarted, D Ch Supt Foster changed the subject and asked PC Smith no further questions about this admission.

15.84 Overall, the interviews under caution, repeatedly identified in the file of evidence WMP submitted as the critical next step in the criminal investigation, did not add to the evidence already gathered. On 1 August 1990, WMP sent the transcripts to the DPP. Four weeks later, the DPP announced that no one would be charged with a criminal offence in relation to the disaster.

Responsibility for the gaps and shortcomings in WMP's criminal investigation

15.85 Taken as a whole, the IOPC's review of WMP's criminal investigation found that there was a series of gaps. There were also some decisions made that meant the investigation did not adhere to the standards of the day: notably, the decision to rely on amended officer accounts rather than taking statements.

15.86 Unlike when it was gathering evidence for the Taylor Inquiry under the direction of Lord Justice Taylor and his team, WMP had full control over the criminal investigation, including what it investigated and how it did so. WMP also set its own timescales: it was WMP's decision to set the date of 31 March 1990 for submitting the file of evidence to the DPP. There was no external pressure to complete work by then.

15.87 WMP of course had substantial experience in conducting criminal investigations. On this basis, it can be assumed that any gaps in the investigation were entirely WMP's responsibility. More specifically, the responsibility sat with the officers leading the investigation, ACC Jones and D Ch Supt Foster.

15.88 The IOPC interviewed both officers under caution and asked them about the gaps identified and the decisions made. D Ch Supt Foster accepted that there may have been mistakes in the WMP investigation; in particular, he acknowledged that the decision not to take statements from SYP officers was a mistake. He suggested that if he himself were to review WMP's investigation in depth, he was certain he would find further aspects he was not happy with. However, he stated categorically that any mistakes were not the result of bias. ACC Jones similarly rejected the allegation of bias.

15.89 However, the available evidence does indicate that, throughout its criminal investigation and in particular in the file submitted to the DPP, WMP repeatedly focused on issues around supporter behaviour. Alternative lines of enquiry were not adequately pursued, or evidence revisited as part of the criminal investigation. While the file of evidence fell short of suggesting that supporters had caused the disaster, the consistent theme was that the Taylor Inquiry had underestimated the impact of supporter behaviour—effectively making it a mitigating factor for the failings of SYP.

15.90 This echoed the comments made by D Ch Supt Foster in his memo to ACC Jones at the end of the Taylor Inquiry and raises the possibility that WMP—and in particular, these two officers leading WMP's work—approached the criminal investigation with a fixed pre-existing view of the evidence.

15.91 The IOPC also found evidence of a couple of instances where it appears WMP may have in some way given SYP preferential treatment, compared to other parties, or shared information with SYP in a way that undermined the independence of its work.

Referral to the CPS

15.92 The series of failings the IOPC identified in WMP's criminal investigation were sufficient to indicate a criminal offence may have been committed, which is the basis on which the IOPC is required to refer material to the CPS for its consideration. In January 2017, the IOPC therefore referred ACC Jones and D Ch Supt Foster to the CPS for a decision on whether both should be charged with the criminal offences of misconduct in public office and perverting the course of justice, in relation to the WMP criminal investigation.

15.93 In March 2018, the CPS announced that no charges would be brought as the evidential threshold for prosecution had not been met. The CPS stated that "whilst there was found to be some cause for concern in the actions of both suspects, there is insufficient [evidence] to reach the high threshold required to prove a criminal offence." In particular, the CPS noted that while there was evidence that some aspects of the investigation were not carried out to a high standard, "there is a lack of evidence showing any deliberate plan or action by the suspects to hinder it."

15.94 The CPS decision not to charge either former officer was challenged under the Victims' Right to Review Scheme. The evidence was reviewed by a different prosecutor, who upheld the original decision.

15.95 The IOPC nonetheless reached the view that both ACC Jones and D Ch Supt Foster would have had a case to answer for gross misconduct, for failing to investigate SYP effectively. In addition, both would have had a case to answer for not intervening in SYP's account amendment process.

15.96 Further, D Ch Supt Foster would have had a case to answer for not submitting all relevant evidence to the DPP and for failing to investigate the competence of SYP's match commander.

15.97 In each case, the disciplinary offence would have been neglect of duty.

15.98 Further, the IOPC was of the view that the fixed mindset with which both ACC Jones and D Ch Supt Foster approached the criminal investigation meant that consciously or unconsciously, they failed to conduct a rigorous investigation because they were biased towards the force and against the supporters. On this basis, the IOPC view was that both officers would have had a case to answer for gross misconduct, for the disciplinary offence of discreditable conduct.

16. WMP's investigation of complaints made against SYP officers

What was investigated?

The IOPC's terms of reference included investigating:

The conduct of officers involved in WMP's investigations. This will include:

a) the involvement of WMP in the decisions taken about how to gather evidence/ obtain witness accounts

b) whether police officers involved in this investigation put inappropriate pressure on any witnesses to alter their accounts or influence the content of those accounts

c) whether the summaries of evidence WMP presented at the individual inquests were accurate

d) whether there is any evidence of bias in favour of SYP on the part of those involved in or leading the investigation

e) whether any accounts provided were deliberately lost, inaccurately recorded, amended, or mishandled (including not following up on key witnesses)

f) investigating other recorded complaints or conduct matters about the actions of WMP in the gathering or presenting of evidence

This chapter focuses on the police disciplinary investigation WMP carried out in relation to the Hillsborough disaster.

What was found?

- **Overall, WMP's investigation of complaints against SYP officers was broadly in keeping with the professional standards of the time.** WMP took relevant investigative actions—more overall than were undertaken for the criminal investigation—and the majority of members of the public contacted by WMP in relation to complaints had no issues with what WMP did.
- **Though WMP recorded more than 3,000 adverse comments about SYP, only 18 complaints were investigated.** However, the IOPC has not found evidence to suggest that WMP deliberately sought to minimise the number of complaints it was investigating.
- **The allegation that Detective Superintendent Stanley Beechey (D Supt Beechey) was involved in the miscarriages of justice perpetuated by the notorious WMP Serious Crime Squad (SCS) is not correct.** His involvement with the SCS was brief and not in an operational role.
- **Some witnesses complained to the IOPC that WMP did not allow them to complain about SYP at the time or incorrectly recorded that they did not want to complain.** The available evidence around this was inconclusive, but did not suggest it was a recurring or deliberate issue.

- **WMP's reports into complaints about Ch Supt Duckenfield and Supt Murray offered contradictory assessments of their respective responsibilities,** despite suggesting that they should be considered together.
- **Though the IOPC has identified some shortcomings in WMP's complaints investigations, the evidence does not suggest these were the result of bias.** Further, it should be emphasised that WMP's investigation did lead to the PCA recommending that Ch Supt Duckenfield and Supt Murray should face disciplinary proceedings. No such proceedings took place, because Ch Supt Duckenfield retired on medical grounds.

Significant new evidence

For this strand of the investigation, the IOPC was able to draw on the information contained in ACC Jones's policy books, which had not previously been considered, and the evidence of CC Sharp of Cumbria Constabulary, who was involved in WMP's disciplinary investigation. In addition, the IOPC gathered information about the policing career of D Supt Beechey of WMP.

16.1 In August 1989, at the same time that it took on the criminal investigation, WMP was also asked to undertake a police disciplinary investigation into complaints that had been made against SYP officers, related to the Hillsborough disaster. As part of this task, WMP was also required to investigate any further complaints that were received relating to the disaster.

16.2 Over a period of around 12 months, WMP investigated 18 complaints about SYP officers. As well as complaints that had already been made to SYP, WMP investigated some complaints it identified after reviewing supporters' questionnaires and statements. WMP was also involved in investigating three complaints about comments made by CC Wright to a newspaper in February 1990.

16.3 The fact that no SYP officer was ever disciplined in relation to the disaster has led some to the view that the complaints and conduct investigations were biased, or part of a police cover-up.

16.4 Furthermore, some respondents to the IOPC's 2013 witness appeal told the IOPC that in 1989 they had sought to complain to WMP about SYP. However, they felt either that their complaints had not been investigated properly, or that they had in some way been prevented or deterred from complaining. The IOPC received eight complaints to this effect.

16.5 This chapter addresses these two issues. It examines whether WMP conducted its complaints investigation in line with the standards in place at the time and whether there was any evidence of bias in the handling of complaints.

The first complaints arising from the disaster

16.6 In the months following the disaster, SYP received a small number of complaints about the actions of its officers on the day. These included complaints about the actions of some PCs who had been on duty at the Leppings Lane end of the stadium (inside and outside the ground) and a complaint that an officer had taken money to allow supporters into the ground. It had also received a complaint about Ch Supt Duckenfield's comments to the FA and SWFC officials, shortly after the match had been stopped, that gave the impression that the disaster had been caused by supporters forcing a gate open. As detailed in chapter 7, Ch Supt Duckenfield has since acknowledged this was a lie.

16.7 Due to the seriousness of the allegations, SYP had initially invited two different police forces to investigate. Northamptonshire Police was asked to investigate the complaint about Ch Supt Duckenfield and GMP was asked to investigate the complaint about an officer taking money. SYP asked the PCA to supervise both investigations, which was standard practice at the time for more serious complaints. Unlike the IOPC, the PCA could not carry out investigations itself; it could only supervise them.

16.8 In these first months, WMP had no authority to investigate complaints, even though its officers were working for the Taylor Inquiry and the Popper Inquests. Instead, its responsibility was to alert SYP to any complaints it received.

16.9 On 20 April 1989—within the first few days of WMP's involvement—ACC Jones recorded a policy decision that: "Where allegations of discipline offences appear these will be referred to the Senior Investigating Officer and a decision will be made on the merits of each as to the further action that needs to be taken. Once again the necessity to conserve evidence must be followed."

16.10 A few days later, it was noted that any complaints or allegations against SYP should be "actioned and referred to office manager or Detective Chief Superintendent Foster." D Ch Supt Foster was the most senior detective involved in the WMP investigation. He had also previously worked as a detective superintendent in WMP's Complaints and Discipline department, giving him experience of managing complaints about police officers.

16.11 When interviewed under caution by the IOPC, D Ch Supt Foster pointed out that, at the point ACC Jones set this policy (26 April 1989), WMP did not have jurisdiction to investigate complaints. He suggested that any complaints received by WMP should have been simply forwarded to SYP to consider. This would have been the correct protocol under the police complaints framework in place at the time.

16.12 The IOPC has identified one occasion on which this protocol appears to have been followed. On 5 June 1989, Supt Thursfield—the WMP officer in charge of the force's temporary operation in Merseyside—forwarded written statements from two Liverpool supporters for the attention of Ch Supt Denton of SYP. The statements contained allegations that officers on duty at the game had offered to let spectators without tickets into the ground, for money. This was the complaint that SYP asked GMP to investigate. The IOPC has found no reason to explain why GMP was invited to do this, but there is nothing to indicate it was an inappropriate decision. After taking statements from the complainant and other witnesses, GMP was unable to identify who the officer(s) may have been and recommended no further action.

16.13 In addition, on one occasion, a prospective complainant was advised to make their complaint to SYP rather than to WMP.

16.14 The IOPC has also identified two occasions where WMP did not follow this basic principle of passing matters back to SYP. One of these related to a letter sent by a Liverpool supporter, which was shared with WMP by Liverpool Football Club. In the letter, the supporter said he saw a police officer punch three supporters. WMP registered the letter on its HOLMES database, but no actions were raised. The apparent complaint—which, as it amounted to possible assault by a police officer, was a serious matter—was not referred back to SYP to be recorded.

16.15 The letter writer later complained to the IOPC that WMP had failed to recognise his letter as a complaint. The IOPC upheld this complaint.

16.16 In this initial period of evidence gathering, WMP developed a means of identifying potential complaints about the police as it processed questionnaires and statements gathered for the Taylor Inquiry. When the team in WMP's MIR read a statement or questionnaire, they were required to tick relevant boxes on a standard 'category template' form to indicate the categories that the statement or questionnaire should be linked to. One of the categories set up was "Recognition"; this covered positive and negative comment about the police. It included sub-categories for "Adverse comments" and "Complaints".

16.17 The IOPC has reviewed completed category templates against the contents of the questionnaires and statements. It appears the "complaints" box was only used where the witness was specifically recorded as stating that they wanted to complain. However, in total, around 3,000 witness accounts (questionnaires and/or statements) on WMP's HOLMES database were marked as being in the category of adverse comments.

WMP took over the complaint investigations

16.18 WMP's responsibilities changed from 9 August 1989, when it was invited to undertake both the criminal and complaint investigations, which both SYP and WMP recognised were related. However, this necessitated WMP taking over the ongoing investigation of complaints about Ch Supt Duckenfield, which had been started by Northamptonshire Police.

16.19 As with the criminal investigation, WMP's involvement was then delayed by discussions around the financing of its work. These were eventually resolved by late September 1989, but the investigation by Northamptonshire Police had essentially been on hold up to that point.

16.20 WMP formally began its complaints investigation on 27 September 1989. At this stage, SYP had informed WMP of complaints against six of its officers. On 28 September, ACC Jones contacted Northamptonshire Police to arrange the collection of all documentation it had gathered in relation to the complaints.

16.21 One of the first steps WMP took was to review the evidence it already had from supporters to identify whether there were any other complaints. The officer tasked with leading this review was D Supt Beechey.

16.22 D Supt Beechey's involvement in WMP's Hillsborough investigation has been subject to online criticism and speculation. Much of this relates to the fact he was associated with WMP's SCS, which was disbanded in 1989 after numerous allegations were made of serious misconduct by officers working for it. Several convictions secured by the SCS were subsequently overturned.

16.23 In light of the online comments about him, and some complaints the IOPC received about his work, the IOPC examined D Supt Beechey's role and professional experience. It established that D Supt Beechey's association with the SCS lasted just two months and was in an oversight role rather than an operational one. His work in relation to the SCS was not under investigation and the allegations about misconduct within the SCS pre-dated D Supt Beechey joining.

16.24 The process D Supt Beechey devised for reviewing existing evidence involved re-examining any questionnaires and statements WMP had taken from supporters which had been identified on initial review as including an "adverse comment" about the police. Under the review process, the 3,000+ questionnaires and statements in this category were reassessed.

16.25 Many were immediately marked "NFA", meaning that WMP would take no further action. These included cases where the adverse comment was a general observation about police failings that could not be attributed to particular officers, so could not readily be investigated as complaints.

16.26 Where the adverse comment was about a potentially identifiable officer, witnesses were recontacted by WMP to ask for further details. This process led to complaints being recorded against three further SYP officers, including PC Scott (the mounted officer who claimed his horse was burned by supporters' cigarettes, as examined at paragraphs 10.54–10.64 of this report), about whom four complaints were recorded.

16.27 Though the process did lead to further complaints being recorded at the time, out of more than 3,000 adverse comments, there were in total only 18 recorded complaints. Some of these were based on multiple adverse comments about the same officer for the same incident. Nonetheless, the total number of recorded complaints was a small proportion of the total number of adverse comments.

How WMP investigated complaints

16.28 Once the complaints were recorded, the available evidence indicates that WMP largely investigated them in line with the legislation and guidance of the time. The IOPC identified that, in total, WMP raised 220 actions related to the complaint investigations—more than it raised in its criminal investigation. Complainants and some witnesses (including some of those who had made an adverse comment) were contacted and asked to provide a further statement. Where WMP had identified relevant video footage, this was shown to witnesses. In some cases, officers who had been close to the alleged incident were contacted and also provided statements.

16.29 These tasks were the sort of things that would normally be expected when investigating complaints and, for the most part, the evidence indicates that the tasks were completed in accordance with legislation and guidance. The work completed was mostly documented, through statements taken and written updates to the actions.

16.30 The majority of the members of the public contacted by WMP in relation to investigating the complaints had no issues with what WMP did.

Examining whether WMP followed up potential complaints adequately

16.31 However, the disparity between the number of adverse comments made about the police and the number of complaints recorded led to the concern that WMP may have deliberately sought to minimise how many complaints it had to investigate.

16.32 One key allegation was that WMP did not follow up on some adverse comments, or recontact some witnesses, even though their records suggested they had done. Over the course of its investigation, the IOPC received three complaints from individuals who—according to WMP records —had been contacted by phone in relation to an adverse comment they had made. All three told the IOPC that they had no recollection of being contacted.

16.33 In three of the four cases, records on the WMP HOLMES database showed that the individual was recontacted by WMP by telephone in relation to an adverse comment they had made. According to these records, the individual advised WMP that they did not wish to make a complaint. There was no statement taken to this effect, so the records were simply in the form of brief messages to the MIR from the officer involved. In each case, the officer was D Supt Beechey.

16.34 Each of these three complainants told the IOPC that they had no recollection of this further contact from D Supt Beechey. All three also stated to the IOPC that they would not have said they did not wish to make a complaint.

16.35 The IOPC examined all available evidence about what WMP did in these three instances. Though documents do not prove that WMP did recontact all witnesses, the specific detail of notes made by D Supt Beechey indicate that he did at least make efforts to contact each of them. This does not therefore support the view that WMP was deliberately seeking to minimise the number of complaints under investigation.

16.36 The IOPC also identified some instances where initial evidence indicated that WMP may not have managed a complaint—or potential complaint—in the correct way. During the course of WMP's investigation, various actions were raised for D Ch Supt Foster to review witness accounts that included adverse comments, to determine how they should be handled. In a small number of these instances, D Ch Supt Foster instructed that the individual should be recontacted as a potential witness for an existing complaint about a PC on duty, rather than as a complainant in their own right. On a couple of further occasions, he specifically advised that individuals should be recontacted to see whether they wished to complain. If they did not, he advised they should be treated as witnesses for existing complaints.

16.37 However, when IOPC investigators reviewed the questionnaires and statements that include these adverse comments, they found details in some of the accounts that made it unlikely that the witness was describing the actions of the officers already under investigation.

16.38 For example, in one of the cases where D Ch Supt Foster advised that the individual should be treated as a witness for the allegations against PC Scott, the witness referred to a mounted officer allegedly using his stick (a police officer's baton) against supporters. However, the recorded complaints against PC Scott were in relation to him striking a supporter with his hand—an act that had been shown on TV footage in the

days after the disaster—rather than a baton. This was more than a simple inaccuracy on D Ch Supt Foster's part; the use of a baton against supporters was a serious allegation that merited investigating in its own right.

16.39 Two allegations about the actions of officers on the perimeter track in front of the West Terrace included references to officers punching or kicking supporters who were trying to escape the pens. These were stronger allegations than those that had already been recorded against PC Smith or PC Illingworth, who were under investigation for pushing supporters back.

16.40 The IOPC reviewed how WMP followed up on the instructions to treat these individuals as additional witnesses.

16.41 In most cases, there is documentary evidence to suggest that the individuals were recontacted. Some were recorded as stating they did not wish to complain. Others who were reinterviewed several months after the disaster were unable to recall further details to help identify the officers who may have been involved.

16.42 Some of those who had made adverse comments about a mounted officer were subsequently shown the footage of PC Scott appearing to strike a supporter. They were asked if this was the same incident they had witnessed or indeed involved the same officer. None of those shown the footage recognised PC Scott as the officer involved in the incident they had witnessed.

16.43 Failing to revisit some individual cases could be seen as omissions, particularly the serious allegation that a mounted officer used a baton against supporters. However, this occurred in a very small proportion of the potential complaints. This does not suggest that WMP systematically sought to prevent further complaints being made.

The complaint investigations conducted by WMP

16.44 All of the officers under criminal investigation were also under police disciplinary investigation. In addition, WMP investigated complaints about three officers who were not subject to criminal investigation. In each of these three cases—including the investigation of complaints about comments made to a journalist by CC Wright in February 1990, summarised in chapter 7—the evidence indicates the investigations were largely conducted in line with the guidance and legislation of the time.

16.45 Complaints about Police Constable Roger Cuckson (PC Cuckson) related to his alleged actions on the perimeter track. Two supporters complained that they witnessed a police officer pulling a fellow supporter from the railings at the front of the terraces, and then not checking on the supporter's wellbeing after he had fallen heavily.

16.46 At the start of its complaint report, WMP pointed out that PC Cuckson had acknowledged the incident in his initial account before any complaint was received—so had not sought to conceal what happened—and that that there was no evidence that the supporter had been seriously injured.

16.47 Overall, it appears that the complaint was investigated in line with the standards of the day. As part of its investigation, WMP approached the complainant, obtained statements from other witnesses and examined video footage.

16.48 The PCA subsequently determined that the complaint was unsubstantiated.

16.49 WMP investigated the complaints about PC Scott together and took some relevant steps in doing so. For example, WMP:

- used video footage to confirm the identity of the officer complained about
- attempted to identify the victim of the assault
- sought relevant witnesses
- asked the head of WMP's Mounted Section for his assessment of the incident

16.50 Further, the investigation outcome was that PC Scott should receive advice about his future actions. This could be deemed appropriate for the type of incident, insofar as he slapped or swiped at supporters, rather than punching, to prevent injury to the horse and minimise the risk of injury to bystanders.

16.51 However, the evidence also suggests that aspects of the investigation did not have a sufficiently broad scope. In particular, WMP did not take sufficient steps to investigate PC Scott's explanation for why he struck out at supporters. Witness accounts disputed the suggestion that anyone was threatening his horse with a cigarette, and other mounted officers did not recall a horse being burned. It seems reasonable to suggest that in investigating the complaint, WMP could have taken further steps to verify whether there were any official reports of injuries to a police horse, such as veterinary records. The evidence appears to suggest that WMP does not seem to have considered this possibility, focusing instead on confirming PC Scott's identity, which was not in dispute.

The complaint reports completed by WMP into the officers under criminal investigation

16.52 In the other complaint reports WMP submitted to the PCA and SYP, a common theme was that the matters under investigation as complaints were the same as those under criminal investigation. WMP therefore argued that if the DPP did not find sufficient evidence to charge the officer(s) with a criminal offence, they could not be deemed to have committed the police disciplinary offence either.

16.53 When the DPP announced there would be no criminal charges, SYP (who had the responsibility to decide on how to proceed in relation to the complaints) concluded that no disciplinary offences had been committed. This reflected the fact that, at the time, an officer could only be found guilty of a disciplinary offence if it was proven to the same standard as required for a criminal offence (that is, beyond reasonable doubt). This changed in 1999. Today, the standard of proof for police disciplinary investigations is the civil standard, on the balance of probabilities.

16.54 While this justified WMP's argument, it meant that the same flaws in the criminal investigation—such as the poor quality of the suspect interviews—also affected the complaints investigations.

16.55 There were also some instances where the actions under investigation did not directly correspond to a criminal offence. For example, PC Illingworth was being investigated for the criminal offences of manslaughter and culpable malfeasance (also known as misconduct in public office). According to one of the disciplinary notices issued against him, PC Illingworth was also investigated for the disciplinary offence of abuse of

authority. This was in relation to the allegation that he had mouthed abusive comments to supporters inside the pens. There was no parallel criminal offence to this, but the disciplinary investigation was discontinued.

The end of the WMP's complaint investigations

16.56 Having completed its investigation and reached provisional conclusions, WMP submitted reports to SYP, for SYP to determine what (if any) disciplinary action to take, once other legal processes had been completed. This was in line with normal practice for finishing complaint investigations.

16.57 At the end of the Popper Inquests in March 1991, ACC Anderson, who was responsible for complaints and discipline at SYP, wrote to the PCA stating that the force did not feel disciplinary action was appropriate in respect of any of the complaints. He included a rationale for each of the complaints, which largely followed the views WMP had set out in its reports. ACC Anderson added that, following the verdicts of the Popper Inquests, there was no additional evidence that would make it necessary to refer the matters back to WMP for further investigation.

16.58 The PCA accepted this in most cases. However, in the cases of Ch Supt Duckenfield and Supt Murray, it recommended that SYP start proceedings on the basis of the disciplinary offence of neglect of duty. The PCA argued that this was not the same as any criminal offence that had been considered by the DPP.

16.59 SYP did not do so. After a prolonged period of correspondence, the PCA sought to use its powers to direct (that is, force) SYP to begin disciplinary proceedings. However, various administrative and evidential issues meant that there was a further delay before a tribunal could begin. By this time, Ch Supt Duckenfield had been on sick leave for a sufficient period that he was permitted, under the Police Pension Regulations 1987, to apply for early retirement on medical grounds. He retired in October 1991.

16.60 Because at the time police disciplinary proceedings could only be taken against serving officers, this meant that no proceedings could be taken against him. Regarding Supt Murray, the PCA then determined that: "it would be unjust and inappropriate to pursue the charge against the Superintendent alone, in the absence of his superior officer."

16.61 In a statement to the IOPC, Captain Noel Taylor, who had been the PCA representative overseeing WMP's work in relation to the Hillsborough disaster, recalled this sequence of events. He said that when Ch Supt Duckenfield's retirement was announced, both he and the Chair of the PCA at the time were angry "because the timing of the decision seemed very convenient for both Duckenfield and SYP".

The question of bias

16.62 Perhaps the most important question in relation to WMP's complaints investigations is whether the fact that no proceedings ensued was due to any failure on WMP's part. The evidence does not suggest there were fundamental failures, either intentional or accidental, to follow the required procedures. Instead, it appears that WMP largely fulfilled its basic legal responsibility to identify complaints and investigate them.

16.63 The evidence also does not support the suggestion that WMP attempted to minimise the number of complaints under investigation. It was within the scope of WMP's role to review adverse comments and to reach a decision on whether to take them forward as complaint investigations. The IOPC's examination found that in the majority of cases,

appropriate reasons were recorded for not taking complaints forward. In some cases, there was no specific incident described that could form the basis of a complaint; in others, there was insufficient detail to identify which officer(s) may have been involved.

16.64 While there appear to have been some instances where potential complaints were not adequately addressed, and some witnesses who felt that WMP did not give them the opportunity to complain, this was not systematic. However, inadequacies in the criminal investigation also affected the quality of complaint investigations in relevant cases.

17. WMP's work for the Popper Inquests

What was investigated?

The IOPC's terms of reference included investigating:

The conduct of officers involved in WMP's investigations. This will include:

a) the involvement of WMP in the decisions taken about how to gather evidence/ obtain witness accounts

b) whether police officers involved in this investigation put inappropriate pressure on any witnesses to alter their accounts or influence the content of those accounts

c) whether the summaries of evidence WMP presented at the individual inquests were accurate

d) whether there is any evidence of bias in favour of SYP on the part of those involved in or leading the investigation

e) whether any accounts provided were deliberately lost, inaccurately recorded, amended, or mishandled (including not following up on key witnesses)

f) investigating other recorded complaints or conduct matters about the actions of WMP in the gathering or presenting of evidence

This chapter focuses on the work WMP did in support of the Popper Inquests.

What was found?

- **The evidence does not suggest WMP had any improper involvement in key decisions about the scope and structure of the Popper Inquests, such as the 3.15pm cut-off.** While there is evidence that officers—particularly ACC Jones—were consulted by Dr Popper, this was within the expected parameters of discussion between a coroner and the police team.
- **There is also no evidence to suggest WMP had any role in deciding how information about the blood alcohol levels of those who died was presented.** Solicitors representing the families were consulted on this matter and did not object to the approach.
- **Though WMP did make some errors in compiling the summaries of evidence about each of those who died for the individual inquests, these were not intentional or systematic.** They were corrected as soon as they were discovered and none of the errors resulted in misidentification or anything that could be perceived as detrimental to those who died.
- **The IOPC's investigation did not find evidence to support the allegations that WMP officers had acted inappropriately in the way they took the additional statements from two witnesses—Police Constable Derek Bruder (PC Bruder) and Special Constable Debra Martin (SC Martin)—for the inquest into the death of Kevin Williams.**

- **WMP did assist Dr Popper in preparation for the generic hearing and offered advice when requested on a range of matters.** This is normal when coroners prepare for an inquest of any size. The evidence available to the IOPC does not indicate that WMP overstepped the mark in the work it undertook, or in providing views where they were asked for.
- **ACC Jones gave SYP information about the witnesses Dr Popper intended to call.** He did not give this information to any other party.

Significant new evidence

The main new sources of evidence available regarding the Popper Inquests were ACC Jones's policy books and a detailed statement from Dr Popper.

17.1 This chapter examines WMP's role in supporting the Popper Inquests and whether WMP performed the expected duties of a police force in such a role in a professional manner. In particular, it considers the allegations that WMP may have inappropriately influenced Dr Popper in some of his decisions about the format and scope of the inquests. It also looks at:

- the allegations that some WMP officers pressured witnesses into changing their evidence
- issues relating to the accuracy of the summaries of evidence about each of those who died, that were presented to the individual inquests

17.2 As is detailed in chapter 1 of this report, the Popper Inquests followed an unusual structure. Almost a year after the disaster, individual inquests were held for each of the (then) 95 who had died. These focused on confirming the time and place of death, plus the medical cause of death, for each person. WMP officers read out a summary of evidence relating to the movements of each of those who died.

17.3 Then, in November 1990, there was a generic hearing that focused on examining the wider causes of death. This ran for almost six months and heard evidence from 230 witnesses. On 28 March 1991, the jury returned majority verdicts of accidental death in all 95 cases.

17.4 The decision to split the Popper Inquests into these two phases is one of several sources of controversy around them. Others include:

- Dr Popper's ruling that he would not consider evidence relating to events after 3.15pm. This ruling was made on the view that all those who died would have suffered such severe injuries before 3.15pm that any treatment provided (or not provided) after this point would not have affected the outcome.
- Some allegations, first aired at the Stuart-Smith Scrutiny in 1997, that WMP officers pressured two other police officers into changing their evidence in relation to one young man who died in the disaster. This latter issue was one of the matters WMP referred to the IOPC to investigate.

WMP's initial work for the Popper Inquests

17.5 WMP was first appointed to support Dr Popper on 21 April 1989, after the inquests had been formally opened then adjourned to allow the Taylor Inquiry to take place. Over the following months, WMP provided a range of support for the coronial process, including taking statements from SYP officers who had been in contact with any of those who died, as an essential part of the body continuity process.

17.6 ACC Jones also kept Dr Popper informed about the evidence WMP had gathered, sending him copies of reports WMP had produced for the Taylor Inquiry and, from August 1989 onwards, for its criminal investigation. Evidence shows that ACC Jones and Dr Popper were in regular contact and discussed various matters, including the likelihood and potential scope of a criminal investigation. This was of direct relevance to the Popper Inquests' timetable, as it was understood that—in line with normal practice—they could recommence once the criminal investigation was finished, so that inquest witnesses could give evidence without the prospect of it affecting any potential prosecutions.

17.7 In January 1990, WMP informed the DPP and Dr Popper of its intention to submit the file of evidence relating to its criminal investigation into the disaster by the end of March. This enabled Dr Popper to start considering when the inquest hearings could take place.

The decision to split the inquests

17.8 Documents show that around this time, there was an initial discussion between Dr Popper and WMP about the possibility of splitting the inquests into two phases: an initial phase where the evidence heard would be strictly limited to avoid any conflict with possible prosecutions, followed by a broader examination once all criminal matters were dealt with. The rationale for doing so was simply that it had already been a long time since the disaster and that families had not yet received any "official explanation" of how their loved ones died. However, at this point, both Dr Popper and the WMP officers involved, including ACC Jones, agreed that it would be too difficult to control what evidence would be heard in the initial phase.

17.9 A few weeks later, the position changed. Dr Popper had received a letter from the secretary of the Hillsborough Steering Committee (HSC), a group of solicitors who represented most of the bereaved families and those injured in the Hillsborough disaster. The letter asked Dr Popper to progress as soon as possible, because the solicitors needed information about the movements of those who died, to assist in settling civil litigation claims.

17.10 With the full agreement of ACC Jones, Dr Popper wrote to the DPP to propose the resumption of the inquests in early spring on a limited basis. The DPP accepted the request and planning promptly began for what would become the individual inquests.

Errors in the summaries of evidence prepared by WMP

17.11 It was agreed that, for the individual inquests, WMP would compile and present summaries of evidence about each of those who died. The HSC was made aware of this and agreed to share the draft summaries with the solicitors representing each of the families in advance of the hearings. The intention was that these could then also be passed to the families, if they wished to read them.

17.12 The summaries consisted of "factual and non-adversarial" evidence about each of those who died. Using eyewitness accounts, including those of close friends and family members, plus video material, the summaries traced their known movements on the day.

17.13 The draft summaries were sent to Dr Popper, who corrected various factual or typographic errors before they were sent on to the families' solicitors. His corrections addressed various issues created by mistakes in documentation around the post-mortems, none of which were deliberate or resulted in anyone being misidentified.

17.14 The changes to the summaries were fully documented in memos that were retained in the individual coroner's files for each of those who died. The IOPC has reviewed the files and examined the evolution of the individual summaries.

17.15 IOPC investigators did not find evidence of any errors which could be construed as an attempt to portray those who died, or Liverpool supporters in general, in a negative light. Similarly, the mistakes did not in any way result in SYP or individual officers being portrayed in a more positive light.

17.16 Despite this process, further errors in the summaries were identified while they were being presented. Though these were promptly corrected and do not indicate a deliberate attempt to mislead the jury, they were understandably deeply upsetting to the families of those who died. They may also have created, or reinforced, perceptions that the authorities were uncaring or insensitive.

Focus on blood alcohol levels

17.17 The summaries also included the blood alcohol level of each of those who died. This meant that at the start of each individual inquest, the person's blood alcohol level was read out for the second time. The first time had been when the toxicologist who had conducted most of the blood alcohol testing, Dr Forrest, gave evidence. He was the third witness called and after describing the tests he had carried out, he read out a list of names of all of those who died, followed by their blood alcohol levels. It has been suggested this repetition of information about blood alcohol placed an inappropriate emphasis on the issue.

17.18 The IOPC has identified evidence that shows that the presentation of information about blood alcohol levels was discussed with a solicitor from the HSC at a pre-inquest review meeting. According to Dr Popper's meeting note, the solicitor confirmed he was happy with the creation of summaries of evidence that included a reference to blood alcohol levels, but "wondered whether it would be possible to add something to the summary to indicate how many pints of beer equivalents that particular level was." This information was subsequently included.

17.19 The IOPC has not found any documentary evidence to explain why Dr Popper decided to repeat this piece of information in each individual inquest. However, there is no indication that WMP had any involvement in the decisions about how or when information about blood alcohol levels were presented, or the decision to repeat the information.

The 3.15pm cut-off

17.20 After the pre-inquest review meeting, WMP sought guidance from Dr Popper about the cut-off time for the evidence that would be considered. This was a wholly understandable question, as WMP needed to know so that officers could determine what evidence should be included in the summaries.

17.21 Documents suggest that Dr Popper indicated an appropriate point would be once the first of those who died had been brought to the temporary mortuary at the stadium. WMP did not challenge this or disagree, but there was no specific reason for them to do so; it was a decision Dr Popper was not only entitled to make but actually had a responsibility to make.

17.22 The cut-off point for evidence was subsequently determined as 3.15pm, which was when the first ambulance arrived on the pitch. By this time, some of those who had died were already in the temporary mortuary. Others were still in the pens. The arrival of the ambulance was identified as a convenient marker, but more broadly the time was chosen as a point at which, based on medical evidence, Dr Popper believed all those who died were either already dead or had received the injuries that caused their death. Again, there was no evidence that WMP had any involvement in that decision.

17.23 The 3.15pm cut-off was then retained for the generic hearing.

Allegations that WMP pressured witnesses

17.24 As a result of the decision to set a 3.15pm cut-off time, WMP was tasked to revisit two witnesses who, in their initial accounts, had given evidence that indicated the young man they had assisted (Kevin Williams) was still alive after that time. This contradicted the pathology findings from the post-mortem.

17.25 The two witnesses were PC Bruder, a Merseyside Police constable who had been at the Semi-Final as a spectator and then helped with the rescue effort, and SC Martin of SYP, who had been on duty at the match.

17.26 Both have subsequently alleged that WMP actively sought to get them to change their evidence, because it was inconvenient to the Popper Inquests. Their interactions with WMP were also depicted in the 2022 ITV docudrama *'Anne'* which focused on the campaigning efforts of Kevin's mother, Anne Williams, in relation to the disaster.

17.27 PC Bruder complained to the IOPC that Inspector Matthew Sawers of WMP (Insp Sawers) had sought to get him to change his statement and to put words into his mouth. SC Martin has stated publicly that she was bullied by Detective Sergeant Julie Appleton of WMP (DS Appleton) to change her statement and retract the comments about Kevin. SC Martin did not complain to the IOPC.

17.28 The IOPC investigated both allegations in detail.

17.29 In his initial statement, PC Bruder had described how he had attempted mouth-to-mouth resuscitation on the young man later identified as Kevin while an SJA volunteer attempted heart massage. This was corroborated by photographic evidence and a statement from the SJA volunteer.

17.30 PC Bruder stated that he had felt "a slight pulse" in Kevin's neck before he started resuscitation attempts.

17.31 The individual inquest for Kevin was held on 2 May 1990 and evidence from PC Bruder's original statement was included in the summary. After the summary was read, the pathologist who had conducted the post-mortem on Kevin, Dr David Slater, gave evidence. He said that Kevin would have become unconscious within seconds of receiving his injuries and died before he was rescued from the pens. This therefore contradicted PC Bruder's account that Kevin was still alive when he reached him on the pitch.

17.32 On 3 May 1990, PC Bruder was visited at home by Insp Sawers. Insp Sawers was not accompanied by any other officer. By the end of that day, PC Bruder had signed a new statement, which included a number of differences from his original statement. Overall, these made his evidence considerably less definite about what he had witnessed than his original statement had been.

17.33 For example, in the statement from 3 May 1990, PC Bruder said that while he was certain that he checked for a pulse in Kevin's neck, he could not be certain that he found one. His new statement included the comment: "I may have also touched the area of the 'Adams Apple' or felt something in the neck region which I originally thought was a pulse but may have been mistaken."

17.34 On 4 May 1990, Dr Popper explained, in open court, that Insp Sawers had visited PC Bruder the previous day "because we wanted to be sure we had the facts." Insp Sawers was called to give evidence. He summarised the new account from PC Bruder and what had changed. It was made wholly clear to the jury that Insp Sawers had been to see PC Bruder at Dr Popper's request and that Insp Sawers had led the discussion with PC Bruder.

17.35 The changes in PC Bruder's evidence were examined by the Stuart-Smith Scrutiny in 1997. PC Bruder stated to Lord Justice Stuart-Smith that he had not been put under pressure to change his account.

17.36 In 2012, following the publication of the HIP Report, PC Bruder wrote to SYP to make a formal complaint about the WMP officer who had interviewed him. In his letter, PC Bruder alleged that:

- the officer had made a deliberate attempt to persuade him to change his account, using information the officer knew to be false
- the officer then repeated this false information under oath at the inquest into the death of Kevin Williams
- in doing so, the officer conspired with others to pervert the course of justice

17.37 PC Bruder did not complain that he was pressured to change his statement.

17.38 In 2015, PC Bruder gave a statement to the IOPC as part of the investigation into his complaint. In it, he said that after being at his house for around three hours, he could sense that Insp Sawers was becoming impatient. He recalled that it was "absolutely clear" that Insp Sawers had been sent to obtain a further statement addressing the anomalies between his original statement and the other evidence that had been presented to the inquest. He said: "What he wanted to include in this further statement was clearly at odds with what I was willing to concede. Whilst I did not feel threatened by his presence, I would describe the atmosphere as extremely awkward, and certainly tense."

17.39 PC Bruder also referred to the fact that while Insp Sawers was at his house, he made a phone call to Dr Slater. After the call commenced, Insp Sawers handed the phone to PC Bruder to speak to Dr Slater. PC Bruder stated that Dr Slater informed him that "it was highly likely that Kevin Williams was brain dead when he was placed on the pitch, and that it was also highly likely that I would not have been able to feel a pulse."

17.40 Following the phone call, PC Bruder agreed to give a further statement, that reflected Dr Slater's assessment. He said that he and Insp Sawers had detailed discussions about the wording of the further statement and that he refused to concede one point, about the presence of an ambulance on the pitch; it was later confirmed that PC Bruder's recollection of this was correct.

17.41 PC Bruder told the IOPC that after Insp Sawers left, he reflected on the conversation and felt sure that something was not quite right. Later in the statement to the IOPC, he said: "I felt strongly that DI Sawers and Dr. Slater had made a conscious and determined effort to put words into my mouth in relation to medical aspects of my evidence relating to Kevin Williams."

17.42 The IOPC asked Insp Sawers about his recollection of visiting PC Bruder. He said: "Dr Popper simply asked me to visit the witness and clarify points, as there were some points in the statement that sat at odds or uncomfortably with the summary as a whole."

17.43 He remembered organising the phone call to Dr Slater but said: "I believe Dr Popper asked me to do that." Insp Sawers recalled that Dr Popper wanted to be updated as to the progress of his meeting with PC Bruder; he therefore telephoned Dr Popper from PC Bruder's house. According to Insp Sawers, Dr Popper suggested that Insp Sawers should telephone Dr Slater and update him too.

17.44 Insp Sawers was adamant that he in no way pressured PC Bruder.

17.45 Both PC Bruder and Insp Sawers gave evidence at the Goldring Inquests. Their evidence was largely consistent with their statements to the IOPC and, in PC Bruder's case, with previous accounts he had given.

17.46 The alterations to PC Bruder's evidence were made wholly transparently. While there remain some important differences in the various accounts of what happened—notably about the involvement of Dr Slater—PC Bruder's revised statement served to clarify the original one, not replace it. The consequence of some of the clarifications is that PC Bruder's evidence was less definite in some areas than it originally had been. However, it was still made clear, both in the revised statement and in the oral evidence Insp Sawers gave during Kevin's inquest, that PC Bruder saw some movement in Kevin's body.

17.47 At the Goldring Inquests on 8 December 2015, expert medical witness Dr Jasmeet Soar was asked for his view on the evidence that had been heard about Kevin. In relation to PC Bruder's evidence that he saw Kevin twitch and felt a faint pulse, Dr Soar said that one possibility was that PC Bruder could have been mistaken. However, he stated that PC Bruder's account was plausible, and these were possibly signs of life. Dr Soar said that the twitches of Kevin's head implied there was some blood flow to the brain. However, combined with the fact that there was only a weak pulse, Dr Soar suggested that they could have meant that Kevin's heart was still beating, or that it had recently stopped beating and Kevin was in cardiac arrest.

17.48 Dr Soar commented that PC Bruder's decision to continue CPR was correct and that the video material indicated PC Bruder had carried out CPR in a textbook fashion.

17.49 Having considered the expert evidence of the pathologists, the jury at the Goldring Inquests determined that Kevin died between 3.05pm—when photographic evidence suggested he may have still been alive—and 3.45pm, when PC Bruder and the SJA volunteer stopped CPR.

17.50 In her initial recollection, SC Martin wrote that she had helped carry a young boy into the gymnasium. He had stopped breathing so she "gave him the kiss of life, and heart massage". She wrote that once in the gymnasium the boy started breathing, opened his eyes and said the word "mum". He then died. This again was later identified as Kevin.

17.51 Her evidence was not accepted by the jury at the Goldring Inquests, who determined Kevin had died before he was taken to the gymnasium. Dr Soar stated that he and his fellow pathologist did not think it was plausible that Kevin regained consciousness in the way SC Martin had described. He offered a possibility that SC Martin had heard an "agonal breath" but emphasised this was very unlikely.

17.52 SC Martin has described, on multiple occasions, being pressured by a WMP officer, DS Appleton into changing her original account. She has said she was visited repeatedly, and that on each occasion the pressure escalated. She described DS Appleton reportedly suggesting she had made her original account up and, on the final visit, saying that SC Martin had not even been at the disaster.

17.53 During this final visit on 17 March 1990, a couple of weeks before Kevin's inquest, SC Martin said she burst into tears and agreed to sign a statement to stop the visits. She told the IOPC that DS Appleton had brought a pre-written statement with her for SC Martin to sign. However, the IOPC has examined the signed statement, which is handwritten, and includes several crossings-out and corrections, that appear to have been made while the statement was being drafted. The corrections are initialled by SC Martin. These factors indicate that the statement was not pre-written but rather written up by DS Appleton in discussion with SC Martin.

17.54 SC Martin gave a slightly different account to the Goldring Inquests but still emphasised that she had been pressured.

17.55 DS Appleton gave evidence to the Goldring Inquests the same day. She confirmed that she had visited SC Martin at her home on 17 March 1990. She said that this was at the request of Dr Popper, because SC Martin had stated "that Kevin had said 'Mum' and the coroner thought it was highly unlikely, with the injuries Kevin had sustained, that he would be in a position to speak."

17.56 DS Appleton told the Goldring Inquests that she had visited SC Martin alone and on only on one occasion—though she accepted that the visit had lasted several hours. She said she asked SC Martin if she would like to make a new statement but emphasised that she did not have to. DS Appleton stated that she could not recall in precise detail the conversation but said that she had written the statement based on SC Martin's words and given her the opportunity to read the statement before signing it.

17.57 DS Appleton was asked whether she was sent to persuade SC Martin to change the "inconvenient" part of her evidence. She rejected this. She also strongly rejected the suggestion that she had bullied SC Martin.

17.58 In a subsequent statement to the IOPC, DS Appleton provided a very similar account.

17.59 The accounts of DS Appleton and SC Martin are wholly at odds with each other.

17.60 The only witness to the visits was SC Martin's mother, who was in the house at the time of DS Appleton's visit(s). Mrs Martin gave evidence at the Stuart-Smith Scrutiny. She said that DS Appleton had come to their house about four times and that she recalled her daughter saying that DS Appleton was bullying her.

17.61 In his report, Lord Justice Stuart-Smith commented that he "preferred" the account of DS Appleton over those of SC Martin and Mrs Martin. He offered no further explanation as to why.

17.62 Taken as a whole, the IOPC has found no evidence to corroborate SC Martin's allegations that DS Appleton bullied or pressured her to change her statement, beyond her mother's evidence to Lord Justice Stuart-Smith. The IOPC has found no corroborative evidence of repeated visits to SC Martin, again beyond her mother's evidence to Lord Justice Stuart-Smith.

17.63 While SC Martin has publicly alleged that she was pressured, she has not complained to the IOPC about this or about the actions of DS Appleton.

17.64 In both cases, the original statements were made available to the jury and Dr Popper clearly explained why additional enquiries had been made. The process was therefore transparent. The WMP officers involved have both stated they were instructed to contact the witnesses by Dr Popper, which is supported by what Dr Popper said in court. The underlying decision to check the evidence of both witnesses appears a valid one, in keeping with the purpose of an inquest.

17.65 However, there is no independent record of the conversation between the witness and WMP officer in either case. The IOPC did not uphold PC Bruder's complaint, as PC Bruder has consistently stated, including at the Goldring Inquests, that Insp Sawers did not pressure him to change his account or to include information which Insp Sawers knew or believed to be false.

Preparation for the generic hearing

17.66 The final aspect of WMP's work in relation to the Popper Inquests that the IOPC investigated was the preparation for the generic hearing. This began in earnest after the DPP's decision in August 1990 that no charges would be brought against anyone in relation to the disaster. The generic hearing then began in November 1990.

17.67 Throughout this period, Dr Popper continued to ask WMP for advice and assistance on a range of matters, as is typically the case with coroners preparing for an inquest of any size. The evidence available to the IOPC does not indicate that WMP overstepped the mark in the work it undertook, or in providing their views where they were asked for.

17.68 Nonetheless, it was notable that in a report produced after a meeting of WMP's Hillsborough investigation management team on 31 August 1990, there was a suggestion that Dr Popper may want to examine "the amount of drunkenness and unruliness during the build up to the crush outside the ground at about 1420 hours onwards." This was in the context of a discussion around the evidence that should be heard at the generic hearing. In relation to this, the officers advised Dr Popper: "we would suggest that you concentrate on the period between say 1420 hours when the crowd had noticeably built up, through to Superintendent Greenwood running on to the pitch at 1505 hours plus to stop the match."

17.69 These points appeared to suggest that, in WMP's view, events after 3.05pm had no impact on how people died, but alcohol consumption before 2.20pm may have done.

17.70 At a meeting with WMP a few days later, Dr Popper stated his intention to hear evidence up to about 3.20pm but also that "he would hear evidence for example, on the routes, the pubs, local residents etc."

17.71 It is not clear that this was a result of WMP's recommendation in its report of the earlier meeting. Some documents indicate that Dr Popper was already considering hearing evidence about these topics.

17.72 One of the central questions the IOPC sought to investigate in relation to WMP was whether it displayed any bias towards fellow police officers in its work. The IOPC identified one occasion in the preparation for the generic hearing where it appears ACC Jones shared information with SYP that he did not share with other parties. This was when he gave ACC Anderson a list of SYP officers who it was proposed to call as witnesses. No evidence has been found to suggest that a similar list of staff likely to be called was shown to SWFC or any other organisation.

17.73 This was one of the handful of instances identified by the IOPC across the whole of WMP's work where ACC Jones appeared to favour SYP in some way.

17.74 Taken as a whole, the work conducted by WMP in support of the Popper Inquests was largely in line with expected standards. WMP officers went to great lengths to track the movements of those who died on the day. When Operation Resolve conducted the same exercise 25 years later for the Goldring Inquests, using more advanced technology and additional evidence, it found that a substantial share of WMP's work on tracking movements had been accurate.

17.75 Though WMP officers advised Dr Popper, the evidence does not suggest this was inappropriate. Further, the main allegations around the Popper Inquests have not been proven. Though there were errors in some of the summaries produced for the individual inquests, these do not appear to have been deliberate. The evidence also does not support that WMP overstepped the mark in seeking to secure further statements from two key witnesses.

17.76 At the generic hearing, the jury returned a verdict of accidental death for all of the 95 who had died by this point. The evidence does not suggest that WMP had any inappropriate influence on the process, or the outcome.

18. The disappearance of video tapes from the stadium

What was investigated?

The IOPC's terms of reference included investigating:

The allegation that SYP may have been involved in the removal of video tapes from the Sheffield Wednesday Football Club (SWFC) CCTV room between 15 April 1989 and 16 April 1989, and the following specific conduct matter regarding the investigation conducted by WMP Detective Chief Inspector Kevin Tope (DCI Tope):

a) that DCI Tope failed to conduct an effective, thorough, and complete investigation into the alleged theft of two video tapes from the SWFC CCTV control room and, in doing so

b) that DCI Tope failed to secure and preserve evidence, pursue relevant and obvious lines of enquiry and interview key witnesses

What was found?

- **The IOPC found no evidence to support the suggestion that SYP was involved in the removal of the video tapes.** In fact, the evidence indicates that SYP acted promptly and professionally when looking into the matter.
- **SWFC did not alert SYP to the tapes' disappearance immediately.** When a detective first asked for them, he was told they were in a safe at the stadium.
- **There was no sign of forced entry into the video room or the lockable cupboard in the room where the video recorders were.** There remains some uncertainty over who had keys to the room.
- **There appear to have been multiple shortcomings in WMP's investigation into the disappearance of the tapes, or at least the records it made of the investigation.** These included the fact that there was no evidence to suggest that WMP made efforts to question SWFC officials who had access to the room.
- There is some evidence that **SYP officers were critical of WMP's approach to the matter.**

Significant new evidence

Beyond some witness statements, the IOPC did not obtain new evidence in this strand of its investigation. However, WMP's investigation into the disappearance of the tapes had not previously been re-examined. IOPC investigators were able to assess in detail the actions WMP took.

18.1 Shortly after 9am on 16 April 1989, a technical consultant working in the SWFC control room at Hillsborough Stadium reported to club officials that two video tapes, which would have held CCTV footage recorded during the afternoon of the disaster, were missing. The tapes were among 16 believed to have been recorded by SWFC on the day of the disaster, in line with its standard approach of recording the footage of all matches held at the ground in case it needed to be reviewed. The consultant said he had left them in a locked room at the stadium overnight.

18.2 Despite investigative work being undertaken by both SYP and WMP, the tapes have never been found. It has been widely alleged that they were stolen, at some point between late afternoon on 15 April 1989 and 9am on 16 April. Further, because one of the tapes should have held footage showing he area around Gate B and turnstiles 9-12 at the Leppings Lane entrance, which would have been directly relevant to investigating the disaster, it has been suggested that they could have been removed by SYP.

18.3 The disappearance of the tapes became public knowledge when it was referred to in the 1996 ITV docudrama *'Hillsborough'*. The incident was then further examined as part of the Stuart-Smith Scrutiny the following year, which concluded that, while there was no dispute that the tapes had been stolen, they would not have provided any new significant evidence.

18.4 For many of those who had raised concerns about the disappearance of the tapes, there was a view that questions remained unanswered. This was demonstrated when the IOPC received a complaint about the issue after it had started its investigation. The IOPC therefore added the disappearance of the tapes to its terms of reference, specifically focusing on the allegation that SYP could have been involved in the removal of the tapes.

The IOPC's reinvestigation of the disappearance of the tapes

18.5 Investigators re-examined the documents and evidence gathered as part of the original investigation, establishing what steps SYP had taken before it passed responsibility for the investigation to WMP. They then looked at the WMP investigation, as well as reviewing statements made to different inquiries by key witnesses such as the technical consultant. It was not possible to conduct any forensic examination at this stage. However, the IOPC did take new witness statements from some of those who had been involved in the original investigation into the disappearance of the tapes.

18.6 The available evidence did not enable the IOPC to find the tapes, or to shed any further light on who removed them.

18.7 The review of all previous materials showed a lot of agreement about the core facts among four main witnesses—the technical consultant, his recently appointed successor who was in the control room as an observer, a police officer who typically worked in the SWFC control room on match days and SWFC's head of security.

18.8 The technical consultant had revamped SWFC's CCTV system a couple of years previously. It involved a network of cameras positioned around the ground. Each camera was connected to a dedicated monitor in the control room, which was located in the South Stand, in an area of the stadium to which the public did not normally have access.

18.9 There was a video recorder (sometimes referred to as a video cassette recorder, or VCR), linked to each of the monitors, which recorded the camera's output on match days. These were standard video recorders, placed on shelves in a cupboard in the control room. Both the cupboard and the room itself were lockable, using separate keys. There were further keys to operate the alarm system for the room and to turn the computer and CCTV system on.



Figure 18A: Screens and lockable cupboard in the SWFC control room (Source: WMP)



Figure 18B: Video recorders inside the lockable cupboard (Source: WMP)

18.10 The technical consultant and police officer both recalled that the tapes had started recording as normal on 15 April, sometime between 12.30 and 1pm.

18.11 There was agreement that someone was in the room from the time the tapes started recording until 6pm.

18.12 By the time the tapes stopped recording late in the afternoon, the stadium was empty. In what he highlighted as a change from normal practice, the technical consultant ejected the tapes from the video recorders but left them resting in the carriages of the video recorders (that is, half in, half out). He has given two different explanations for this. In a statement he gave to SWFC's solicitors, he stated he did this "so that I could later know exactly which tape related to which monitor/area." At the Goldring Inquests, he suggested that ejecting them made sure they could not be inadvertently recorded over.

18.13 While no one in the room has stated categorically that all the tapes were there at this point, no one has indicated that any were missing.

18.14 There are some differences in accounts of what happened after 6pm, when the police officer and successor to the technical consultant both left. The technical consultant has stated he turned the alarm on and locked up but then had to return to the room to

produce some printouts from a computer. The head of security has also said that he went into the room to retrieve his coat—though in a different account, suggested he picked up his coat from elsewhere. This all happened before 7.30pm.

18.15 Both had their own set of keys to the room. Neither specifically stated that they locked everything up again.

18.16 The technical consultant has consistently stated that he discovered the tapes were missing when he returned to the ground at around 9am the following morning. He has stated that the control room door was locked when he arrived, but the door to the video recorder cupboard was ajar and two of the recorders did not have tapes in them. At some points, he has stated the alarm was working when he arrived but in his most recent account, a statement to Operation Resolve, he said the alarm was not set.

18.17 After discovering the tapes were missing, the technical consultant has consistently stated that he first searched the room for the two missing tapes, then reported the loss to Mr Mackrell. In some accounts, he has said he also informed the SWFC Chairman, Herbert McGee, at the same time.

18.18 Though the technical consultant discovered the tapes were missing on the morning of Sunday 16 April 1989, SWFC did not immediately report their disappearance to SYP.

Evidence that SYP acted professionally

18.19 On Monday 17 April, DS Oughton of SYP was instructed to obtain all video footage taken by SWFC on the day of the disaster, as part of SYP's work to preserve evidence. By this stage, SYP had already secured its own video tapes from the PCB for review. These were passed to WMP once it took over the investigation. This was all fully documented.

18.20 DS Oughton phoned SWFC and was told by a solicitor working for the club that all the tapes were in a locked safe at the ground, but that SWFC was not yet willing to release them. Later that same day, the solicitor phoned DS Oughton back and told him two of the tapes were missing.

18.21 On 18 April, DS Oughton visited the ground where he met the technical consultant, who showed him the recording system and described what had happened. DS Oughton made a report of this visit. He noted that the technical consultant said he had ejected the tapes, locked the room and set the alarm, then returned the following morning at 9am and found the tapes missing.

18.22 In his report, DS Oughton commented that there were no signs of forced entry to the room or to the cupboard where the video recorders were kept.

18.23 SYP did not conduct any further enquiries. Shortly after this, SYP handed over responsibility for all investigative actions related to the disaster to WMP and did not investigate the disappearance of the tapes further.

18.24 However, the evidence of this initial period indicates that SYP had acted promptly and professionally in relation to the issue. Further, the fact that SYP had already prepared its own videos for investigation—which were potentially far more damaging for SYP than SWFC's footage—indicates it is unlikely that SYP would then seek to prevent SWFC's tapes being made available.

Concerns about the rigour of WMP's investigation

18.25 While SYP's actions appear to have been in line with what might be expected, the IOPC has identified a series of concerns about the thoroughness of the WMP investigation and the records WMP made relating to it.

18.26 This investigation was led by Detective Chief Inspector Kevin Tope (DCI Tope), who began by taking signed statements from the four key witnesses, followed by further statements from the technical consultant and police officer who worked in the SWFC control room.

18.27 On 13 May 1989, DCI Tope submitted a report in which he wrote that, despite making "full enquiries" at the ground including a "thorough search", the tapes had not been found. However, there is no documentary evidence of what searches took place.

18.28 Given there were no signs of forced entry, this would tend to suggest that the room had either been left unlocked by the technical consultant or the head of security, or that it had been unlocked by someone else. WMP did not establish who had access to keys. There are indications in the existing accounts that there was at least one more set of keys, kept in Mr Mackrell's office, but the IOPC has not been able to confirm this, nor who would have had access to them. There is nothing to suggest that WMP attempted to interview Mr Mackrell about this or any other aspect of the tapes' disappearance.

18.29 No WMP officer contacted DS Oughton to ask him for further details of his initial steps.

18.30 Finally, the notes from DCI Tope on the action mentioned that "Supporters, relatives, press etc had virtually unrestricted access to stadium on 15.4.89 due to disaster." This comment appears to imply that any of those—or indeed, any other member of the public—could have removed the tapes. However, it overlooks some key points:

- according to several witnesses the room was locked
- there is no obvious reason for any of these individuals to have known that the facility even existed
- SYP officers and SWFC staff also had unrestricted access to the stadium

18.31 DCI Tope died in 1992. The IOPC has not found evidence of any occasion where he was asked about the investigation he conducted into the missing tapes.

18.32 While there are reasons to question the rigour of the investigation he conducted, there was insufficient evidence available 30 years on to ascertain exactly what steps he did take. This meant that the IOPC could not answer whether his investigation reached the standards that a competent detective could reasonably be expected to have achieved.

18.33 There is also some indication of disquiet or frustration among SYP officers about the way WMP investigated the disappearance of the tapes.

18.34 On 10 May 1989, D Ch Supt Addis sent ACC Anderson a report around the disappearance of the tapes. In it, he noted that the SYP officer who worked in the SWFC control room had been interviewed three times by WMP, "who, it appears, seems somewhat dissatisfied with our officers explanations." In a statement to Operation Resolve, he reiterated his concerns about this and commented that it appeared the SYP officer "was their only suspect."

18.35 In relation to the bigger picture, the IOPC also found no evidence to suggest SYP was involved in any cover-up, or indeed in the disappearance of the tapes in any way.

19. Alleged surveillance of family members of those who died

What was investigated?

The IOPC's terms of reference included investigating:

Complaints and recordable conduct matters about police surveillance and covert activity linked to the Hillsborough disaster involving family members of those who died, survivors and other complainants linked to the disaster.

What was found?

- **By 2014, no police force had any records of surveillance of the families of those who died in the disaster.** However, one explanation for this could be that records had been (correctly) destroyed after they had been held for the maximum permitted period.
- **In line with longstanding policy, the then Home Secretary would not confirm or deny whether anyone had been subject to telephone interception ('phone tapping') by the police.** However, families were directed to the public body that could answer this question.
- **In the view of various expert witnesses, the descriptions of intrusive noises during telephone conversations did not indicate that families were subject to lawful surveillance by the police.** They all indicated that the subjects of police telephone interception would not hear noises on the line as a result.
- **The IOPC was able to provide some families with detailed explanations of incidents involving police intrusion on their everyday lives.** Though this explained why the police were involved, it did not justify the manner of police interaction, particularly in one case where officers from WMP were intimidating.
- **In one case, an individual appears to have been under overt surveillance by the police for over a week,** without good reason. It has not been possible to investigate all instances where people complained they were followed by the police.
- **Some of the incidents cited as indicating police surveillance were not properly recorded or handled by Merseyside Police at the time.** This appears to have been the result of errors or poor practice, rather than an attempt to conceal police involvement in the incidents.

Significant new evidence

Almost of all the evidence around alleged surveillance was new, as these issues had not previously been looked at. The IOPC took statements from a large number of witnesses describing their experiences and why they suspected these to have been a result of police surveillance. In addition, the IOPC contacted expert witnesses in telephone interception, from both the policing perspective and the telecommunications industry. Further, the IOPC used its powers to obtain documents from Merseyside Police, after its initial response to requests for information had been insufficient.

19.1 Over the years since the Hillsborough disaster, there have been repeated allegations that family members of those who died, and members of campaign and support groups related to the disaster, were placed under surveillance by the police. The alleged surveillance ranged from telephone interception (that is, that their phone lines were 'tapped' so that others could hear their conversations), to individuals reporting being followed. There were also suggestions that:

- there may have been some form of police involvement in break-ins at homes or Hillsborough-related locations, whether to intimidate campaigners or obtain material related to the disaster and subsequent campaigns
- the police intruded in different ways on the everyday life of bereaved families

19.2 After the IOPC investigation into the aftermath of the disaster was first announced, the issue of alleged surveillance was raised in Parliament, with MPs representing constituencies where many families lived asking for an investigation into the matter. The then Home Secretary, Theresa May, agreed that it should be considered by the IOPC, and it was added to the terms of reference.

19.3 The IOPC received 27 complaints relating to alleged police surveillance and/or covert activity, from 25 complainants with connections to the Hillsborough disaster. All 25 alleged that some of their or their families' telephone conversations had been intercepted by, or at the instruction of, the police.

19.4 In 16 of the complaints, there was also a further allegation of surveillance or covert activity, such as an individual being followed by police officers, or of police intrusion in their family life.

19.5 The complaints covered a long timeframe. The earliest referred to incidents around the time of the Taylor Inquiry (1989–90) and the most recent involved noises heard on telephone lines during 2015. They also referred to the alleged actions of officers from a number of forces, including Merseyside Police, SYP, WMP and the Metropolitan Police. In several cases, the complainant was not able to identify any particular officer or force involved.

Regulations around police surveillance

19.6 Police surveillance powers in the UK are subject to a range of regulations. These regulations evolved over the period covered by the allegations, reflecting changes in lifestyle and technology. They have changed further since the start of the IOPC investigation.

19.7 However, there are some key principles that have remained at the core of the regulatory environment throughout. These include that all police surveillance has to be authorised, typically by senior officers, and that intercepting telephone calls is a particularly intrusive form of surveillance, which can only be authorised in strict circumstances by the Home Secretary.

How the IOPC investigated the allegations

19.8 To investigate the allegations, the IOPC began by taking statements from family members and others about what they had experienced and why they thought this could be a result of police surveillance. The issues most commonly cited related to problems with telephone lines.

- Twenty-one of the complainants who wrote to the IOPC reported hearing noises, such as clicks on the line, when they made or received telephone calls at home. Some also said they often experienced a delay at the start of a call. All suspected these noises and interruptions were the result of telephone interception carried out by, or at the instruction of, the police.
- In some cases, the noises continued even after the individuals had moved home or changed telephone provider.
- One complainant said that, in one property he lived in, he only heard these noises when speaking to another individual who wrote to the IOPC.
- One woman only heard noises when she called her mother, who was a prominent member of one of the campaign and support groups related to the disaster. Her concern was not about her own telephone line being intercepted, but rather her mother's.
- Four people referred to a specific crossed-line incident, which meant two individuals overheard, during a call between them, the separate telephone conversation of a third complainant. All already knew each other as a consequence of the disaster.
- Eight further individuals referred to hearing other voices on the line. Three of these (including two who referred to calls made from a public phone box near SYP HQ) specifically mentioned hearing sounds that were like police radio or other police conversations.

19.9 In some cases, family members had some form of contact with the police, which they believed occurred as a result of the police hearing something they had said in a phone conversation.

19.10 Understandably, those reporting the issues were often not able to state which police force, or forces, could have been involved. There was also no information on surveillance in the archives, or in the material disclosed to the HIP.

19.11 Five complaints referred to burglaries in Merseyside, as well as the interception of communications. Two of these incidents were at the Hillsborough Centre—set up to provide support to families and supporters who had been at the match—and two at the Hillsborough Justice Campaign (HJC) shop. A further two incidents, covered by the same complaint, took place at the home of a member of the HJC. Because in each case material that was stolen or damaged involved information relating to the disaster and the work of campaign and/or support groups, the complainants raised the possibility that the police were involved in the burglaries. This was on the basis that they felt only the police would have found the information of value.

19.12 The IOPC secured the support of the Home Secretary to ask all police forces to search for any records of surveillance related to family members of those who died, or to members of campaign and support groups related to the disaster, and to provide those records to the IOPC. No records were found. Again with the support of the Home Secretary, the IOPC then asked forces for all information they held related to the disaster, as a means of checking that nothing had been overlooked. Still no relevant information was provided.

19.13 While this could indicate that there had been no authorised police surveillance of the individuals, it could also mean that the records had been (correctly) destroyed after they had been held for the permitted period.

19.14 In relation to telephone surveillance, the legal framework meant that, at the time the IOPC made this request, records should have existed of every lawful police interception of telephone communications since 2000, and of every time a police force applied to the Home Secretary to intercept telephone communications. However, the longstanding government policy is that the Home Secretary will neither confirm nor deny whether any individual is the subject of telephone interception.

19.15 Instead, families were directed to contact the Investigatory Powers Tribunal (IPT), an independent public body which oversees complaints about the use of intrusive powers such as phone-tapping by intelligence services, law enforcement agencies and public authorities. It has the authority to view the details held by the Home Office of all authorisations granted to intercept telephone communications and to award damages to complainants.

Potential explanations for noises on telephone lines

19.16 The IOPC sought to examine potential explanations for the noises that people heard on their telephone lines, other than that they were a result of police surveillance. Investigators contacted three telephone engineers who had experience of supporting official surveillance during the 1990s and 2000s. They all indicated that if there had been authorised surveillance of telephone lines, the users would not have heard anything. This was because of the way such surveillance was conducted. They also suggested that in this period, crossed lines—that is, hearing a different conversation—sometimes occurred as a result of either a fault or water ingress on the line.

19.17 The IOPC also appointed an expert witness on surveillance, who had been part of the surveillance team at the Metropolitan Police Flying Squad. He was asked to comment on various matters, including the noises that complainants had heard on their telephone lines. He said that, as far as he was aware, authorised interception of communications took place in a sterile environment where "it would be impossible to hear intruding voices." He also observed that if voices could be overheard during an interception operation, it "would completely jeopardise and compromise the process." He could not offer an explanation for the clicking noises heard.

19.18 Together, these responses indicated that the noises were unlikely to be a result of official police surveillance.

Further investigation into specific allegations of police contact or surveillance

19.19 The IOPC also investigated each of the incidents where families suggested that police contact occurred as a result of the police listening to their telephone conversations. Investigators were able to provide family members with a plausible alternative explanation for what had occurred. These explanations were welcomed by the families, even where it could not be confirmed that this was what had happened. The IOPC identified that in some cases the manner of the police when they then contacted the families was not appropriate. In particular, in one incident where WMP officers were sent to retrieve a document that should not have been in the public domain, the evidence indicates the officers behaved in an unnecessarily intimidating way towards the family. This complaint was upheld.

19.20 The allegations of individuals being followed were in many cases too vague in terms of dates and locations to enable further investigation. However, the IOPC did look in detail into one specific allegation, where a family member was conspicuously followed by police officers for almost a week—and on at least one occasion, spoke to the officers directly. This complaint was upheld.

19.21 To investigate the burglaries, the IOPC instructed Merseyside Police to retrieve all material relating to them, from initial incident logs through to subsequent investigations, and to provide names and ranks of all officers who attended. The initial response was disappointingly slow, and the IOPC had to escalate the issue to senior officers, including the Head of Professional Standards at Merseyside Police, before receiving the material. Having looked into the matter, the Head of Professional Standards apologised to the IOPC for the poor initial response from the force and ensured more comprehensive information was provided.

19.22 This information indicated poor practice in the crime recording process, with key information relating to the crimes being recorded either inadequately or inaccurately.

- Two separate burglaries—the first burglary at the Hillsborough Centre and the first burglary at the HJC shop—were recorded as one incident.
- No information at all—not even a crime reference number—was found in relation to either of the break-ins at the home of the individual involved in the campaign and support group.

19.23 Despite this, the information that was available did not support the allegation that the police were in any way involved in the burglaries. Some of the recollections that only material related to the disaster was stolen proved incorrect and in one case, witness accounts described those involved in the incident as youths, indicating they could not have been police officers. This does not, however, prove the campaigner or the campaign and support groups were not under police surveillance.

Presenting the findings to families

19.24 Given the sensitivity of the subject and the sense of intrusion on individual lives, the IOPC provided the affected families with a comprehensive presentation of the evidence found in relation to alleged surveillance early in its investigation.

19.25 While the IOPC was unable to reach a finding on the complaints related purely to telephone surveillance, five of the complaints around surveillance were upheld.

20. Norman Bettison's appointment as Chief Constable of Merseyside Police

What was investigated?

The IOPC's terms of reference included investigating:

The following specific complaints/conduct matters relating solely to Sir Norman Bettison and not already covered elsewhere in the terms of reference:

a) whether Sir Norman Bettison was deliberately dishonest in relation to his involvement in the Hillsborough investigation during the application and appointment process for the post of Chief Constable of Merseyside Police in 1998

b) the nature and extent of various statements made by Sir Norman Bettison to the press and any other actions after publication of the Hillsborough Independent Panel Report, based on allegations that this was part of a continued effort to deflect blame away from SYP towards others, particularly Liverpool supporters

What was found?

- **During the initial application process, there was no point at which Norman Bettison was asked about his involvement in SYP's response to the disaster.** This meant there was no point during this phase when he should have declared this involvement.
- **Most of the Appointments Committee who decided to appoint Norman Bettison as Chief Constable of Merseyside Police have confirmed they were aware he had been involved in SYP's response to the disaster.** Two stated that when they appointed him, they were not aware of his involvement.
- **After protests against the appointment, Norman Bettison issued a statement in which he confirmed he had been involved in SYP's response to the disaster.** However, the description he gave of his role was not accurate and omitted some significant activities he performed.
- **There were also inaccuracies in the description he gave to the Merseyside Police Authority (MPA) of his involvement in the disaster.** Together, these give the impression that he deliberately downplayed the extent of his involvement in SYP's response.
- **Similar criticisms can be made of the public statements he gave after the HIP Report was published.**
- **The evidence is inconclusive about whether Norman Bettison told his MBA classmates that SYP intended to blame supporters for the disaster.** Only two of the 14 interviewed by the IOPC recall him saying this.

Significant new evidence

The major new evidence in relation to this part of the investigation came in the form of statements from MPA members and various witnesses, plus the prepared statements of Norman Bettison. The IOPC also reviewed other applications he made for senior roles around this time.

20.1 At the time of the disaster, Norman Bettison was a chief inspector at SYP. He was at the stadium as a spectator on the day of the disaster and responded to the emerging situation by helping organise an information point for those trying to find a missing friend or family member. As has been detailed throughout this report, he was then involved in various aspects of SYP's response to the disaster, including the production of the proof of evidence, and compiling a video, which he presented to MPs.

20.2 By October 1989, he had been promoted to superintendent. In 1992, he successfully applied to become an assistant chief constable at West Yorkshire Police (WYP). In 1998, he then applied to become Chief Constable of Merseyside Police: the force which serves the Liverpool area.

20.3 Following an application process which was based on best practice guidelines at the time, he was appointed Chief Constable of Merseyside Police in October 1998. However, his appointment was met with protests by family members of those who had died, due to his association with the disaster. It was suggested that he had deliberately avoided telling the Appointments Committee of the MPA (which was responsible for appointing the Chief Constable) about his involvement in SYP's response to the disaster. Having discovered the extent of Norman Bettison's role in SYP's response, two members of the Appointments Committee stepped down in protest at his appointment.

20.4 The IOPC investigated the appointment of Norman Bettison as Chief Constable of Merseyside and in particular the allegation that he in some way lied to or misled the Appointments Committee during the application process. It also looked at a separate allegation against him related to the contents of two public statements he made in 2012, following the publication of the HIP Report. The core of this second allegation was that in those statements, he did not fully or accurately describe his role in SYP's response to the disaster.

Reviewing the appointment process

20.5 To examine the appointment process, IOPC investigators reviewed all available documentation about it—including a comprehensive 1999 report from the Clerk of the MPA, who was at the heart of the appointment process. They then took statements from surviving members of the Appointments Committee, including one of the two who had stepped down, as well as others involved in the selection process or the fallout from it. These included two members of Her Majesty's Inspectorate of Constabulary (HMIC), which routinely provided an assessment of each candidate for chief officer roles to the selection panels. Investigators also received several prepared statements from Norman Bettison.

20.6 The evidence indicates that, during the initial application process, there was no point at which he was asked about his involvement in SYP's response to the disaster, and so there was no point during this phase at which he should have declared his involvement.

20.7 On the application form, candidates were asked to demonstrate their suitability for the role of Chief Constable with reference to actions in senior roles. These were understood to be roles of superintendent or above. Norman Bettison was a chief inspector at the time of the disaster and did not refer to any of the work he did in relation to the disaster in his responses on the form. The first role he mentioned was as superintendent in the SYP Traffic Division—a role he began in October 1989. There was no specific question asking for details of experience in more junior roles.

20.8 When the Appointments Committee met to review the applications, they were provided with a brief written assessment from HMIC of each candidate. The assessment of Norman Bettison mentioned that when he was at SYP, he had been a "member of a small enquiry team reporting to the Chief Constable on the Hillsborough incident". The HMIC assessor who wrote this, Dan Crompton, told the IOPC that he had included it because he "was conscious that anything relating to Hillsborough was an extremely sensitive issue in Merseyside." Some members of the Appointments Committee chose not to read the HMIC assessment, and two others stated they did not recall seeing it.

20.9 Seven candidates, including Norman Bettison, were invited for a two-day interview process. This included an evening gathering, where members of the Appointments Committee could meet the candidates in an informal setting. Though the interviews were structured to ask similar questions to each candidate, this gathering would have provided an opportunity for members of the Appointments Committee to ask about his association with the disaster. No such questions were asked.

20.10 At the end of the interview process, Norman Bettison was announced as the unanimous choice of the Appointments Committee.

Accuracy of comments made by Norman Bettison after his appointment was announced

20.11 This announcement was almost immediately met with protests from some members of the families of those who died, which were covered extensively in Liverpool's regional newspapers. These resulted in a series of press releases and statements from the MPA Appointments Committee and other parties, including HMIC, explaining the decision and the process that had been followed.



DAILY POST

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HILLSBOROUGH AND THE NEW CHIEF CONSTABLE

Our new man is still fit to head force, says Police Authority

MERSEYSIDE Police Authority last night stood by its choice of Norman Bettison as the new chief constable and said they had been aware of his Hillsborough connections.

The appointment of the former South Yorkshire police officer has outraged

By Jane Haase
Chief Reporter

relatives of victims of the disaster, who say he was part of a "sanitisation unit" set up to shift the blame from the police to the fans.

But in a statement, the authority said they had been aware of his association with Hillsborough, when as a chief inspector he was part of a team of officers set up following the 1989 tragedy.

It stated: "Mr Bettison was not involved in any of the pre-planning or policing of the match.

"Merseyside Police Authority has always recognised the sensitivity of this issue and the feelings of the families concerned."

Outstanding

It does stress, however, that Mr Bettison is an outstanding officer and that the Authority has every confidence in him. Hillsborough Family Support Group chairman Trevor Hicks last night described the appointment as "unacceptable" and urged the authority to reconsider.

He said: "We are absolutely staggered. We can't believe that the Police Authority has been so insensitive. If they were aware of the full facts it makes their decision even more appalling and we will be calling for the chairwoman of the police authority to resign."

In a debate in the House of Commons in May this year, Liverpool MP Maria Eagle accused the team, of which Mr Bettison was a part, of orchestrating "a black propaganda campaign which aimed to deflect the blame for what happened on to anyone other than themselves."

I saw Hillsborough unfold—Page 15

Figure 20A: Copy of front page of the *Daily Post* on 15 October 1998 (Source: The Trinity Mirror Group)

20.12 Norman Bettison also issued a statement via the WYP press office in relation to his involvement in the disaster. In this, he briefly covered his actions on the day itself and then described his involvement in the aftermath. He said he was assigned to a unit "tasked with looking at what had happened on the day of the disaster, making recommendations about the policing of the remaining football matches at Hillsborough before the end of the season and reviewing policing arrangements for football at Hillsborough and other grounds in South Yorkshire the following season". He also said that later on he "was given a specific role to monitor the public inquiry and the inquest and brief the Chief Constable on progress."

20.13 On 19 October, the Appointments Committee met to discuss the appointment and the response to it. Part of this meeting was open to the media and members of the public. Meeting notes show that two members of the Appointments Committee—the two who stated they had not seen the HMIC assessment—questioned whether Norman Bettison had deliberately concealed information about his role in the disaster during the appointment process. Mr Crompton was at the meeting and responded that Norman

Bettison had also recently applied for the post of Chief Constable with a different force, and that his application had been very similar and similarly focused on his senior command experience.

20.14 A further meeting was arranged for the whole of the MPA (not just the Appointments Committee) on 2 November. Norman Bettison attended; he read out an account he had prepared of his involvement in the disaster and then answered questions from MPA members. One of the Appointments Committee asked him why he had not raised the issue of his involvement in the disaster at any point. He replied that he had simply been responding to the questions asked and had not sought to set the agenda. He stated: "I did not go away from the interview thinking 'Phew! Hillsborough wasn't raised'."

20.15 Having compared the statement he made and responses he gave in the meeting with the evidence set out throughout this report, the IOPC has identified that Norman Bettison did not at any point provide a full account of his involvement in SYP's response.

20.16 While it could be reasonably claimed that covering every aspect of his involvement was not necessary for the purpose, and that it was possible that, ten years after the events, he had simply not recalled some of the tasks he did, the accounts he gave did not include some aspects of his role that could be deemed significant. For instance, he did not mention going to Parliament on behalf of the SYP Chief Constable to show MPs a video relating to the disaster (see paragraphs 8.45–8.52) or his role in SYP's preparation for the Popper Inquests (see paragraphs 11.29–11.60). He also did not mention his attendance at almost every day of the Taylor Inquiry hearings, or the tasks he carried out as a result of this, such as taking statements from Supt Chapman and a retired SYP officer to refute evidence given by Mr Lock (see paragraphs 10.106–10.109).

20.17 Following the meeting, the MPA confirmed there were no grounds on which to overturn the appointment. Some members of the MPA have stated to the IOPC that Norman Bettison's manner and responses during the meeting actually reassured them that he was a suitable person for the job. He served as Chief Constable of Merseyside Police until January 2005.

20.18 The two members of the Appointments Committee that felt he should have disclosed his link to the disaster during the application process both resigned immediately.

20.19 In statements to the IOPC and in evidence to the Goldring Inquests, Norman Bettison has consistently stated that he did not intentionally conceal his involvement in the aftermath of the Hillsborough disaster from the Appointments Committee. He explained that he did not feel that the work he had done in the aftermath of the disaster was relevant to his application and that he was not asked about it at any time before he was offered the post of Chief Constable.

20.20 Broadly, the evidence supports both of these points. However, after he was offered the post, the description he gave of his involvement in the aftermath of the disaster was neither accurate nor comprehensive. Having reviewed the evidence around this, the IOPC identified three occasions in October and November 1998 when what Norman Bettison said about his association with the disaster could be interpreted as misleading. These included the statement issued through WYP's press office on 14 October, which underplayed the extent of his role, and the written account he gave to the MPA on 2 November.

20.21 The IOPC felt that a reasonable misconduct panel could conclude that he deliberately downplayed his role in the aftermath of the Hillsborough disaster, so would have had a case to answer for gross misconduct, if he had still been serving with the police.

The charges against Norman Bettison

20.22 The third instance the IOPC referred to was during a telephone conversation between Norman Bettison and the head of HMIC, David O'Dowd. This took place after the appointment was challenged; Mr O'Dowd was asked by the MPA to provide a press release about it, to reassure people that the process had been robust, and the appointment had been made properly. In it, Mr O'Dowd wrote: "Comments have been made about Mr Bettison 'playing a key role in the post Hillsborough events'. This is factually incorrect and his role was peripheral."

20.23 In a statement to the IOPC in October 2016, Mr O'Dowd said that before he wrote the press release, he spoke to Norman Bettison who "assured me that his role in the enquiry had been peripheral."

20.24 On 28 June 2017, Norman Bettison was charged with four offences of misconduct in public office. One of these offences was related to "untruthfully describing his role in the response of the South Yorkshire Police Force to the Hillsborough Stadium Disaster to Sir David O'Dowd as 'peripheral'."

20.25 Following this announcement, Mr O'Dowd contacted the CPS to express his concern about the charge as he was not certain that Norman Bettison had used the word peripheral. He then gave a further statement to the IOPC, in which he explained: "My use of the word 'peripheral' has caused me concern, as I am not sure where it actually came from. It is not a word I would normally use. I can only assume that the word was used by either Dan Crompton when he briefed me about Mr Bettison, or Mr Bettison himself when I spoke to him on 23/10/98 on the telephone."

20.26 There are no records of exactly what was said in the call on 23 October 1998, but in his statement to the MPA on 2 November, Norman Bettison described his association with the Hillsborough disaster as "a peripheral link more than a decade ago".

20.27 In his first prepared statement to the IOPC, Norman Bettison commented that his link to the disaster was peripheral. However, he added: "I do not say, in any contemporaneous account, and have no recollection of ever saying, that my role in the aftermath was a peripheral one."

20.28 The distinction between his peripheral role in the disaster itself, and his non-peripheral role in the aftermath, may not have been clear to all members of the MPA.

20.29 Nonetheless, Mr O'Dowd was clear that whether the exact word "peripheral" was used or not, he did not feel he had been misled.

20.30 On 21 August 2018, the CPS announced that, following a review of evidence, the prosecution would be discontinued. This decision was challenged under the Victims' Right to Review Scheme. The evidence was reviewed by a different prosecutor, who upheld the decision to discontinue.

Accuracy of comments made by Norman Bettison after the HIP Report was published

20.31 In 2007, Norman Bettison was appointed Chief Constable of WYP and was still in this role when the HIP Report was published on 12 September 2012. His name appeared repeatedly in the HIP Report and there were some implied criticisms of what he did in the aftermath of the disaster.

20.32 On the day after the HIP Report was published, he issued a press statement through WYP's press office. He acknowledged the HIP Report had named him but said he had "absolutely nothing to hide." He then summarised his "personal actions in respect of the Hillsborough tragedy". Also within the statement was a comment that "Fans' behaviour, to the extent that it was relevant at all, made the job of the police, in the crush outside Leppings Lane turnstiles, harder than it needed to be."

20.33 His statement was widely criticised, in particular for the comment on the behaviour of supporters. On 14 September 2012, he then issued a second statement, in which he apologised for the upset caused by the first statement and sought to clarify his comments.

20.34 On 24 October 2012, he resigned as Chief Constable of WYP with immediate effect. He stated he was resigning "not because of any allegations about the past, but because I share the view that this has become a distraction to policing in West Yorkshire now and in the future."

20.35 The IOPC examined the accuracy of the two statements he made against the evidence it had gathered about his role in the aftermath of the disaster. It found several inaccuracies in these two statements, notably related to a comment he made that his involvement ended after the Taylor Inquiry and that he had no involvement with the Popper Inquests and later proceedings.

20.36 The statements were the subject of a conduct investigation, commenced by the IOPC. Having reviewed the evidence in the conduct report, the IOPC was of the view that a misconduct panel could conclude that Norman Bettison's actions in issuing these statements were a deliberate attempt to mislead the public. On this basis, he would have had a case to answer for gross misconduct, if he had still been serving.

Allegation that Norman Bettison told people SYP was trying blame fans

20.37 The IOPC also investigated some wider allegations that Norman Bettison told fellow students on an MBA course that SYP was trying to concoct a story and blame Liverpool supporters for the disaster. This was further explored at the Goldring Inquests, with two former students giving evidence about what he had said (separately) to them.

20.38 While there are strong consistencies between the accounts of these two individuals, there were also some differences, including around the date it occurred. The IOPC also spoke to several other students from the same group. Though all remembered Norman Bettison taking time off from the course to assist with SYP's response to the disaster, they did not recall him suggesting anything improper.

20.39 In short, the balance of evidence did not support the allegation.

21. The allegation that SYP and WMP sought to deflect blame for the disaster away from the police

What was investigated?

The IOPC investigated:

Whether there is evidence to suggest that there may have been a general attempt by officers within SYP and/or WMP to deflect or minimise blame for the disaster from the police service, including by focusing on the behaviour or alleged behaviour of supporters.

What was found

- **SYP did attempt to deflect blame for the disaster away from the police.** Senior officers, working with the legal team, sought to advance a case that the disaster was caused by unprecedented and unforeseeable events, including the failings and actions of others, rather than as a result of any failings on the part of SYP corporately or of individual officers.
- **The IOPC has reached this view based on the consistent patterns in SYP's actions following the disaster and in response to the various investigations into it**—such as presenting a case that SYP had never been responsible for monitoring safety in the pens and then removing any references to that from officers' accounts.
- **SYP consistently tried to find and/or promote evidence of drunken behaviour by supporters.** Even though this was largely dismissed by the Taylor Inquiry, SYP continued to promote such evidence in meetings with MPs and during the Popper Inquests.
- **This was an ongoing process, starting with the evidence presented to the Taylor Inquiry and continuing through the civil litigation and Popper Inquests.** At different times, different senior officers were aware that at least some of these actions were taking place.
- **SYP was legally entitled to present the force's best case to the Taylor Inquiry.** Because they did not give evidence under oath, and police officers did not have a duty of candour at the time, as long as they did not put forward evidence that was false, misleading or inaccurate, they were not breaching professional standards.
- However, **as detailed throughout this report, SYP consistently and intentionally presented unsubstantiated evidence. It also altered the evidence of officers before it was submitted, by amending their accounts.** Even if such actions were legally permissible in relation to the Taylor Inquiry, they were not in keeping with the Inquiry's aim to gain a full understanding of the disaster and to prevent such an incident from happening again.

- **There is no evidence that the attempt to deflect blame was related to Freemasonry, or that officers' actions were undertaken to protect a fellow Freemason.**
- **The IOPC has not found evidence that WMP was instructed, or deliberately attempted, to deflect blame for the disaster away from the police in general and SYP in particular.** However, WMP's approach to its work for the Taylor Inquiry made it easier for SYP to present the case it wanted. Further, there is evidence to suggest that the officers leading WMP's flawed and narrow criminal investigation had a fixed view of the evidence before they started.

Significant new evidence

The majority of the evidence the IOPC considered in addressing this term of reference was reviewed or gathered and analysed in relation to the other terms of reference for the investigation. This is shown by the number of cross-references in this chapter to evidence set out earlier.

However, the IOPC did gather new evidence about membership of the Freemasons among SYP officers, including from official records held by the United Grand Lodge of England (UGLE). This enabled investigators to assess the influence of Freemasonry within SYP at the time.

21.1 The IOPC investigation focused on a range of allegations about the police response to the disaster, as examined over preceding chapters. However, looking at each of these allegations in isolation only tells part of the story. It has long been claimed that these individual aspects were part of something bigger: an orchestrated attempt by the police to shift the blame for the disaster from them on to supporters.

21.2 The first suggestion that there was some form of police 'cover-up' was reported in the media in the days after the disaster. Over the years, similar comments have been made by a wide range of people: not only by the families of those who died and Liverpool supporters, but also by some journalists, public figures and campaigners as well as other football supporters. In short, many believe that there was a cover-up, and the IOPC received several complaints to that effect.

21.3 These complaints related to the actions of different officers over a long period of time. A range of police actions has been identified as allegedly forming part of this cover-up, and there have also been suggestions of involvement from the wider 'establishment'.

21.4 This issue was therefore included in the IOPC's terms of reference. In response, the IOPC sought to assess whether there was evidence, from across the whole of its investigation, of an organised or consistent attempt to minimise potential blame against police officers, and of organised or consistent attempts to draw attention to the behaviour of supporters.

21.5 The evidence, already set out across the chapters of this report, strongly indicates that SYP did deliberately and consistently try to deflect the blame for the disaster away from the police.

Consistent evidence of an attempt to deflect blame

21.6 The IOPC investigation has not identified any single act, or found a document, that unequivocally demonstrates a clear intention to this effect. However, it has found evidence of patterns of behaviour by senior officers within SYP, over a substantial period of time, which together indicate a deliberate and sustained attempt to deflect or minimise blame.

21.7 Broadly, this evidence relates to the way that a group of senior officers within SYP, with the assistance of the legal team appointed by the force's insurers (rather than the force's in-house solicitors), sought to show that the disaster was not caused by failings on the part of SYP corporately, or on the part of individual officers. Instead, they advanced a case that the disaster was a result of unprecedented and unforeseeable events—meaning that SYP could not be blamed for failing to foresee, or prepare for, what happened.

21.8 The following examples of this can be identified from the initial period up to the publication of the Taylor Interim Report.

- The core team of officers and legal representatives took steps to control the content of the accounts that were submitted to WMP and the Taylor Inquiry, in many cases leading to substantive amendments being made to officers' accounts, as detailed in paragraphs 9.129–9.147. Notable amendments included removal of many comments that criticised the inaction of senior officers and of all comments related to previous actions to close the tunnel to the centre pens. When WMP alerted CC Wright to concerns raised by junior SYP officers about this review and amendment process, CC Wright did not seek to stop it (see paragraphs 9.125–9.128).
- SYP actively sought evidence that purported to demonstrate supporters' alcohol consumption, including through videos and photos that showed litter which potentially could have been left by supporters (see paragraphs 9.11–9.27), and by asking officers to include in their accounts comment on the mood of supporters (see paragraphs 9.85–9.88).
- Senior officers, including the match commanders, were invited to meet and agree suitable answers to potential criticisms of them, and of the police operation in general, before they gave evidence to the Taylor Inquiry (see paragraphs 10.94–10.104). In some cases, the answers they then gave could not have been based on their personal experience.
- In SYP's written submissions and the oral evidence of officers, it was repeatedly asserted that there was very little difference between the police operation at the 1989 FA Cup Semi-Final and the police operation at the 1988 Semi-Final (see paragraphs 3.9–3.10), and evidence to the contrary was minimised (see paragraph 10.39).
- SYP maintained that previous police actions to close the tunnel to the centre pens were solely the result of junior officers acting on their own initiative and that SYP was not responsible for monitoring capacity on the Leppings Lane terraces. In line with the way that all references to past actions to close the tunnel were removed from SYP officers' initial accounts (see paragraphs 9.145–9.146), several senior officers who had been on duty argued in their evidence to the Taylor Inquiry that SWFC stewards were responsible for monitoring capacity and safety in the pens. However, their accounts contradicted the evidence other SYP officers had given in the 1985 court case of

Harris v Sheffield Utd (see paragraphs 9.151–9.153), as well as comments some of the same officers had made in meetings following the disaster (see paragraphs 9.148–9.150).

21.9 The IOPC has identified a range of evidence that appears to undermine the denials made by Ch Supt Duckenfield, Ch Supt Mole, Supt Greenwood, Supt Marshall and Supt Murray at the Taylor Inquiry and Popper Inquests of their prior knowledge of police tactics such as tunnel closure (see paragraphs 10.70–10.82).

21.10 These denials mirrored the approach taken in SYP's written submissions to the Taylor Inquiry, where evidence that may have indicated police responsibility for monitoring the capacity of the pens and controlling access to them, via closing the tunnel, was removed from the final versions, despite having been in earlier drafts.

21.11 Further, SYP actively sought to gather and submit additional written evidence to the Taylor Inquiry to refute oral evidence, given by non-police witnesses, that SYP was responsible for monitoring the pens (see paragraphs 10.106–10.109).

21.12 As a whole, these actions meant that SYP's evidence to the Taylor Inquiry painted a largely consistent picture of its officers being overcome by unforeseeable circumstances, including unprecedented levels of drunkenness among the supporters. Lord Justice Taylor summarised this evidence in his interim report as follows: "the police case was to blame the fans for being late and drunk, and to blame the Club for failing to monitor the pens."

21.13 Given the considerable differences between this narrative and the evidence of other parties—notably the evidence provided by supporters—Lord Justice Taylor described the SYP case as an "unrealistic approach" and concluded that the main cause of the disaster was a failure of police control.

Evidence that SYP continued to try to deflect blame after the Taylor Interim Report was published

21.14 Despite these findings, SYP continued to advance a similar case in the period from the publication of the Taylor Interim Report up to the end of the Popper Inquests.

- SYP arranged two events where MPs were shown a video about the disaster, compiled by Ch Insp Bettison and colleagues. At the first of these, attended by a single MP, individual officers were encouraged to share their experiences and recollections, so that the MP present could later "speak up" for the police (see paragraphs 8.21–8.32). Most of the officers at this first meeting then gave graphic accounts of supporters being under the influence of alcohol; in several cases, these included details that had not been in their original written accounts. The second meeting involved Ch Insp Bettison presenting the same video to an audience of MPs at Parliament; the MPs who recall it have all agreed it was an unpersuasive attempt to position SYP's side of the story.
- On the advice of legal representatives, the SYP action team invited some officers to "review" aspects of the evidence that they had given to the Taylor Inquiry, which contradicted or undermined SYP's preferred account of events. In particular, this request focused on evidence given about police responsibility for monitoring the pens and past actions to close the tunnel (see paragraphs 11.37–11.42).

- In preparation for the Popper Inquests, SYP sought to identify witnesses whose accounts discussed supporters' alcohol consumption, so that it could ask, via its legal team, for them to be called to give evidence (see paragraphs 11.55–11.62).
- On legal advice from Mr Metcalf, SYP adopted a "strategy" for the Popper Inquests which sought "to bring out the issue of drink-related hooliganism" (see paragraph 11.63).

21.15 Senior officers also repeatedly made clear to their legal team that at the contribution hearings they wished to challenge the Taylor Inquiry finding that SYP had accepted "de facto" responsibility for monitoring the safety of supporters in the pens. While this was consistent with the case they had sought to put to the Taylor Inquiry, doing so was against the advice of SYP's appointed barrister (see paragraphs 11.17–11.23 and 11.45–11.46). This therefore undermines the argument, made by several of these senior officers at different times, that they were simply following legal advice.

21.16 Further, in interactions with the media right up to his retirement, CC Wright continued to indicate that he believed alcohol was a factor in the disaster and that more evidence would still emerge.

The extent of the attempt to deflect the blame

21.17 While the examples listed here appear to demonstrate a wide-ranging and consistent attempt to deflect the blame away from the police, not all of SYP's actions in the aftermath of the disaster—or those of its officers—form part of this pattern.

21.18 For example, chapters 12 and 13 of this report summarise the IOPC's investigation into the allegations that blood alcohol testing and PNC checks were carried out on those who died to besmirch their reputations: the IOPC has not found evidence that this was the intent. Nor is there evidence that SYP was behind, or even involved in, the disappearance of two video tapes from the SWFC control room.

21.19 There is no doubt that Ch Supt Duckenfield's lie that the disaster was caused when supporters broke through a gate has had a lasting impact. Similarly, the media coverage after the disaster that focused on the behaviour of supporters led to an enduring public perception that they had somehow been to blame, even though the Taylor Interim Report wholly rejected that view. The HIP Report again called this perception into question and the Goldring Inquests reaffirmed that the actions of supporters in no way caused or contributed to the disaster.

21.20 Yet despite the immense damage and hurt that the lie and the media coverage caused, it is not clear that either was the result of a coordinated corporate attempt to deflect blame from the police. The lie was told so quickly, there was no chance for SYP to organise it, and CC Wright corrected it on the night of the disaster. Aside from CC Wright, the central figures quoted in the media reporting did not act or speak on behalf of SYP. The IOPC has not found evidence to indicate that the ensuing coverage was a result of any organised effort by SYP or its legal team.

21.21 Though large numbers of SYP officers have provided accounts or statements, and given oral evidence, in which they have highlighted the behaviour of supporters, it is not clear that these accounts were made purely or primarily in an attempt to deflect or minimise blame. Many were responding to a request to provide recollections of what they did and saw, "including crowd behaviour" and to comment on issues such as the mood of the supporters and their own "fears, feelings and observations."

21.22 While the result is that officers described personal experiences that, when viewed collectively, may have supported an attempt to deflect the blame, the IOPC has not found evidence that they wrote their accounts to fit an 'agreed' storyline, on the instruction or under direction from senior officers.

21.23 Officers made these accounts in an unusual format (see paragraph 9.80). This offered SYP an opportunity to control and amend the evidence its officers gave. However, it cannot be determined that this was SYP's intention from the outset. Some senior officers have provided plausible alternative explanations for the approach. Further, the evidence indicates there was no forcewide instruction to officers that they should not write pocket notebook entries as normal. Therefore, the IOPC does not view the fact that accounts were made in an unusual format, or the fact that some officers have stated they were not to use their pocket notebooks, as part of the coordinated attempt to deflect blame.

Speculation about links to Orgreave

21.24 There has been speculation that one reason SYP adopted this unusual approach to collecting evidence was because of its experiences in the aftermath of events at Orgreave coking plant, during the 1984/85 miners' strike.

21.25 On 18 June 1984, Orgreave was the scene of violent confrontations between police officers and striking miners. The plant was in the SYP area, near Sheffield, so a substantial proportion of these officers were from SYP; however, officers were also drawn from other forces around the country. Following the events, 55 protesters were charged with riot. All charges were eventually withdrawn, amid questions over the validity of some of the arresting officers' statements. It transpired that, among other issues with the statements, when officers from other forces were making statements, SYP officers gave them a standard introduction to use, which set out key locations that the visiting officers would not have known.

21.26 Between 2012 and 2015, the IPCC received two voluntary referrals from SYP in relation to allegations of police misconduct relating to Orgreave. In 2015, having reviewed the available information, the IPCC announced its decision not to investigate these allegations nor to reopen complaints about police conduct relating to Orgreave.

21.27 After this decision was announced, the IOPC Hillsborough investigation team requested access to the material that had been considered in making it. This was because of the possibility that there could be parallels between SYP's approach to evidence gathering in both cases.

21.28 The Hillsborough investigation team appointed independent counsel to conduct a comprehensive review of the Orgreave material, to assess its relevance to the Hillsborough investigation. The review found there was no material related to Orgreave that was relevant to the Hillsborough criminal investigations or the complaint and conduct investigations being undertaken by the IOPC and Operation Resolve.

SYP's right to deflect the blame away from the force and its officers

21.29 While the evidence points to SYP undertaking such a coordinated effort, there is an essential point to recognise: it was legally entitled to do so and to present its 'best case' to the Taylor Inquiry. There was no legal duty for the force, or individual officers, to obtain or put forward to the Taylor Inquiry any information which might present a different version of events to their preferred narrative. As long as officers did not put forward evidence that was false, misleading or inaccurate, they were not breaching the professional standards of the time.

21.30 In the aftermath of the disaster, SYP was, rightly, under intense scrutiny. Its reputation was under threat, damaging public confidence in the force. It faced the prospect of officers being prosecuted and the force having to pay large sums in compensation to those affected. As a publicly funded body, the force had a right to defend itself and to seek to fairly apportion blame, if it believed other individuals and organisations were to some degree responsible.

21.31 This appears particularly applicable to SYP's persistent argument that officers were not responsible for safety on the terraces, and that this was the role of SWFC stewards, as the Green Guide would indicate.

21.32 In such circumstances, a police force is—like any other party—allowed to defend itself against allegations and put forward its best case. However, this did not give SYP total freedom to consistently and intentionally:

- present unbalanced and unsubstantiated evidence, placing a disproportionate emphasis on supporter behaviour even where it could not prove certain allegations (for example, that large numbers of supporters attended without tickets and/or arrived late, deliberately)
- alter the underlying evidence of officers before it was submitted, by amending accounts to fit the narrative it wished to present
- minimise the evidence that was given in relation to previous police actions to close the tunnel and monitor capacity in the pens, and in relation to the extent to which the police had previously managed the arrival of supporters at the Leppings Lane end

21.33 While such actions may have been legally permissible in relation to the Taylor Inquiry, where there was no duty of candour, they were very clearly not in keeping with the Inquiry's aim to gain a full understanding of the disaster and prevent such an incident from happening again.

The response of SYP officers to allegations of a cover-up

21.34 The allegation that there was a deliberate attempt to blame supporters for the disaster was repeatedly raised during the Goldring Inquests. Several former senior SYP officers were asked by barristers representing some of the families whether their actions in the aftermath of the disaster had been part of a cover-up. While some accepted that, in hindsight, certain actions were hard to justify, and in some cases even acknowledged that SYP had been on the defensive, all denied that they were involved in a deliberate cover-up of any form.

21.35 Ch Supt Duckenfield was asked if his lie was the start of a cover-up; he said no. Ch Insp Beal was directly accused of being a key figure in a police cover-up—an accusation he strongly rejected.

21.36 DCC Hayes was asked: "It is right, isn't it, that in preparing for the inquests in particular, officers under your command were trying to raise the profile of evidence which blamed the fans?" He replied: "Yes, I think that's true." He later reframed this as SYP trying to draw attention to evidence that **involved** supporters, rather than blamed them. He also rejected the suggestion this amounted to a cover-up.

21.37 Ch Supt Wain was asked about a memo he had written, in which he instructed DI Cleverly to "interrogate the system" to identify the officers who could give the best evidence about "Unruly behaviour by Liverpool fans" and alcohol consumption. He responded that he was "shocked" to see it and, when the barrister described it as "clear evidence of an attempt to denigrate the fans", Ch Supt Wain replied: "I must agree with you."

No evidence found of masonic influence

21.38 It has been suggested that one reason some senior officers persisted in these attempts to deflect blame was because they were Freemasons, and wished to protect a fellow Freemason, Ch Supt Duckenfield.

21.39 At some point after the disaster, it became public knowledge that Ch Supt Duckenfield was not only a Freemason but actually had been the head of a masonic lodge in Sheffield. This led to allegations that he was promoted above his capability and experience because he was a mason, and that fellow masons 'closed ranks' around him in the aftermath of the disaster.

21.40 To investigate these allegations, the IOPC sought to establish which other SYP officers were Freemasons; whether there was evidence to support the inference that membership of the masons improved career prospects within SYP; and, specifically, whether any of the officers who were masons were in a position to influence Ch Supt Duckenfield's promotion or to protect him following the disaster.

21.41 When interviewing SYP and WMP officers, IOPC investigators routinely asked them whether they were or had ever been a member of the Freemasons. Very few stated they were, or had ever been, masons. However, some alleged that masons were in a position of influence in SYP at the time and that being a mason increased an officer's likelihood of promotion. Others wholly dismissed this.

21.42 The IOPC approached UGLE, the governing body of Freemasonry in England, Wales and the Channel Islands to ask for its assistance. UGLE agreed and in May 2016, the IOPC provided UGLE with a list of 98 names that had featured in its investigation, to ask if they had been masons. These included senior officers from both SYP and WMP who featured repeatedly in the IOPC investigation.

21.43 Of the 98 names submitted, UGLE found 12 matches on its membership records. Nine of these were confirmed matches; there were also one possible and two probable matches. This indicated that membership among senior officers was not as widespread as had been rumoured.

21.44 ACC Anderson was one of the confirmed matches and some in the force believed he remained a high-ranking mason in 1989. This has led to the suggestion that he recommended the promotion of Ch Supt Duckenfield because both were masons. At the Goldring Inquests, ACC Anderson asserted he did not know Ch Supt Duckenfield was a mason; the IOPC has not found any evidence to support or challenge this.

21.45 Having reviewed details of his career, the IOPC has not found evidence to indicate that Ch Supt Duckenfield was promoted because he was a mason.

21.46 Nor has the IOPC found evidence that SYP's actions in the aftermath of the disaster were motivated by a desire to protect fellow masons; there were multiple other potential motivations. Further, the IOPC has not found evidence to support claims of a broader masonic conspiracy or cover-up.

Considering whether WMP also sought to deflect the blame away from the police

21.47 The IOPC was also tasked to investigate whether there was evidence that WMP sought to deflect blame for the disaster away from fellow police officers. As set out in chapters 14–17, the IOPC has identified a number of issues for which WMP's investigations could be—and, in some cases, have been—criticised. None of these offer evidence that WMP deliberately attempted to deflect blame away from the police, nor that it was instructed to.

21.48 A large number of Liverpool supporters have made complaints about aspects of WMP's evidence collection in Merseyside shortly after the disaster (see paragraphs 14.55–14.94). While such complaints paint a picture of an approach that lacked compassion, they do not suggest a deliberate attempt on the part of those officers to deflect blame from the police. In particular, the recording of large numbers of criticisms of SYP indicates a willingness on WMP's part to accept there were flaws in the police operation at the 1989 Semi-Final.

21.49 However, WMP's approach to its work may have made it easier for SYP to shape its case and control the story. In particular, WMP's decisions not to take statements from SYP officers, and to allow SYP and its legal team to amend officer accounts, meant that some potentially relevant evidence from officers was not presented to the Taylor Inquiry (see paragraphs 14.95–14.124).

21.50 Though WMP knew that SYP officers' accounts were not sufficient to be used as evidence for a criminal prosecution, it continued to refer to them throughout its criminal investigation and the file of evidence it submitted to the DPP for a charging decision. This was one of several flaws the IOPC has identified in WMP's criminal investigation; others included the small number of investigative actions it undertook and the decision not to interview suspects under caution before submitting the file.

21.51 Though these were significant shortcomings in the investigation, they did not directly deflect blame for the disaster away from the police and the IOPC has not found evidence that this was WMP's intention. However, there is evidence that the two officers leading WMP's work—ACC Jones and, in particular, D Ch Supt Foster—did hold the view that the Taylor Inquiry underestimated the importance of the behaviour of supporters (see paragraphs 14.150–14.164).

21.52 This serves as a possible explanation for why WMP repeatedly referred to aspects of alleged supporter behaviour in the file of evidence it submitted to the DPP and, in its analysis, focused on how supporter behaviour may have affected police actions on the day.

21.53 D Ch Supt Foster rejected this suggestion and denied that this—or any other failing identified by the IOPC—was a result of bias or part of an attempt to cover up SYP's part in the disaster. This view was echoed by other WMP senior officers including CC Dear and ACC Jones, who stated to the IOPC that he completely refuted such allegations.

The case for a statutory duty of candour

21.54 The evidence in this investigation, and indeed in other investigations conducted or overseen by the IOPC, demonstrates the impact on individual lives and confidence in the police service when the police do not act with candour, transparency and frankness in their dealings with inquiries and investigations into their actions.

21.55 SYP's persistent defensive approach to the various investigations and the fact that it did not put forward potentially relevant evidence are among the reasons why it has taken considerably longer than it should have done for the full circumstances of the disaster to be brought to light. Complaints made against officers at the time have had to be reinvestigated decades later. New inquests were required, and became the longest in English history, running for 308 days, spread over two years, and hearing evidence from more than 1,000 individuals. Having heard the evidence, the jury at the Goldring Inquests concluded that those who died in the disaster were unlawfully killed—a significant change from the conclusion of the Popper Inquests, which had been a verdict of accidental death in all cases.

21.56 The impact of this has been significant, on multiple fronts. While 15 April 1989 was the date of the disaster, the trauma and distress associated with it have been prolonged unnecessarily. The families of those who died have repeatedly been compelled to defend themselves and their loved ones against allegations that have never been proven and have had to wait years for the outcomes of their complaints and the investigations. Similarly, individuals under investigation and, in some cases, facing prosecution, have faced prolonged waits for decisions.

21.57 Collectively, these factors have damaged public confidence in the police and the justice system and cost the public purse substantial sums of money. These outcomes may have been avoided if SYP and its legal team had approached the initial investigations into the causes of the disaster with openness and transparency.

21.58 The Public Office (Accountability) Bill was introduced by the Government to address these kinds of issues. Reflecting the campaigns of Hillsborough families and others, it will impose a duty on all public authorities and public officials, including police officers, to act with candour, transparency and frankness in their dealings with inquiries and investigations. This will be reinforced by potential criminal sanctions for those who fail to do so.

21.59 If such a duty had existed in 1989, it may have helped bring the full facts of what occurred to light far sooner. The years and costs of multiple investigations could have been avoided, and the families of those who were unlawfully killed would have experienced a far less traumatic fight for answers about what happened to their loved ones at Hillsborough.

Glossary

Appropriate Authority

In police complaints, the Appropriate Authority is the police chief officer or policing body (such as PCC) that is responsible for recording the complaint and making the final decision on it.

Association of Chief Police Officers (ACPO)

A forum for chief police officers in England, Wales and Northern Ireland. It was replaced in 2015 by the National Police Chiefs' Council.

Body continuity

The formal process by which police officers and others ensure that as the body of a person who has died is moved, identified and where necessary examined, all those involved are dealing with the same body. The process should be fully documented so that there is no unauthorised contact with the body.

Case to answer

In police complaints and conduct matters, an officer has a case to answer when there is enough evidence that a reasonable misconduct meeting or disciplinary hearing panel, could find misconduct or gross misconduct proven on the balance of probabilities.

Civil litigation

A term used to describe for non-criminal legal disputes.

CJA statements

Statements are made in the majority of criminal investigations by police officers and other witnesses. They are made under the provisions of the Criminal Justice Act (CJA) 1967 and include a signed declaration of truth. They are sometimes referred to as CJA statements.

Complaint

The IOPC defines a complaint as any expression of dissatisfaction with a police force expressed by or on behalf of a member of the public.

Conduct matter

Any matter which is not and has not been the subject of a complaint, where there is an indication (whether from the circumstances or otherwise) that a person serving with the police may have committed a criminal offence or behaved in a manner which would justify disciplinary proceedings.

Conspiracy to pervert the course of justice

Where two or more people agree to commit an act, or series of acts, intended to pervert the course of justice. To prove the offence, there must be evidence of both the agreement and the intent of that agreement.

Covert activity

Surveillance activities carried out in a calculated way to ensure that people who are under surveillance are unaware that it is taking place.

Crown Prosecution Service (CPS)

The CPS prosecutes criminal cases that have been investigated by the police and other investigative organisations in England and Wales. The CPS makes decisions independently of the police and the Government.

Decision maker

The IOPC decision maker is responsible for setting out their opinion about what action should be taken regarding a complaint or conduct investigation. The decisions and opinions that the IOPC decision maker can make are set out in law.

Director of Public Prosecutions (DPP)

The head of the CPS.

Disclosure

Providing interested parties with copies of, or access to, all material for a court procedure. In this report, it may relate either to disclosure before criminal trials or disclosure in relation to the Goldring Inquests.

Discreditable conduct

Under paragraph 1 of the 1985 Code of Conduct, discreditable conduct was committed where a member of a police force acted in a disorderly manner or in a manner prejudicial to discipline or reasonably likely to bring discredit on the reputation of the force or the police service.

Floppy disk

A computer storage medium used in the 1980s, 1990s and early 2000s.

GEN 18 form

A form used by SYP for recording details of all sudden deaths, whether suspicious or not.

Generic hearing

The second phase of the Popper Inquests, which examined the circumstances leading up to the deaths during the disaster. The generic hearing is sometimes referred to as the “resumed inquests”.

Goldring Inquests

The inquests into the disaster that were opened in 2013, after the Lord Chief Justice quashed the verdict of the original inquests. The new inquests were led by Lord Justice Goldring.

Green Guide (Guide to Safety at Sports Grounds)

The Green Guide was the official Government publication 'The Guide to Safety at Sports Grounds'. First published in 1973, it was recognised as the core guidance for all football grounds to follow.

Gross misconduct

A breach of the Standards of Professional Behaviour so serious that dismissal would be justified.

Ground commander

The senior police officer who was responsible for overseeing the events inside the football ground and the officers deployed there. The ground commander was part of the senior command team managed by the match commander.

Health and Safety Executive (HSE)

Britain's national regulator for workplace health and safety.

Hillsborough Independent Panel (HIP)

The HIP was set up in 2009 to oversee maximum public disclosure of all documents relevant to the disaster held by central government, local government and other statutory bodies. The HIP was also tasked with producing a report that explained "how the information disclosed [added] to public understanding of the tragedy and its aftermath".

Hillsborough Steering Committee

The Hillsborough Steering Committee was set up on 16 April 1989 to act as a focal point for the large number of solicitors' firms instructed to represent the bereaved families and/or those injured in the Hillsborough disaster.

HOLMES (Home Office Large Major Enquiry System)

An IT system designed to support large police investigations and follows the processes used in major incident rooms. It provides a standard and controlled means of storing, categorising and linking the information gathered by police—letters, emails, transcripts, statements, reports etc.—as well as the actions investigators took. A new account is typically created for each investigation. Both the IOPC and Operation Resolve used HOLMES in their investigations; SYP and WMP did the same.

Inquest

Inquests are legal inquiries into the cause and circumstances of a death. Their parameters are clearly defined in law.

Interested person (IP)

In the IOPC's work, an IP is someone who has a legitimate reason to be kept informed about another person's complaint or conduct matter. In the Hillsborough investigations, the families of those who died in the disaster were offered IP status for a number of complaints and conduct matters that investigators identified as being of probable interest and relevance to them.

Interview under caution

A police interview with an individual suspected of a criminal or police disciplinary offence, where at the start of the interview, the interviewee is cautioned about their rights. The caution can be for a criminal offence or police misconduct.

Major Incident Room (MIR)

The purpose of an MIR is to serve as the hub for the collection of evidence related to a major incident. MIRs operate to a standard administrative process (MIRSAP), which helps bring order to the information gathered and the use of investigative resources.

Manslaughter by gross negligence

Where a death is a result of a grossly negligent (though otherwise lawful) act or omission on the part of the defendant.

Match commander

The officer in charge of the police operation at a football match.

Medico-Legal Centre (MLC)

A purpose-built centre in Sheffield designed to provide the facilities and services required for the investigation of a sudden or unexpected death. It comprises the offices of HM Coroner for South Yorkshire (West) District and the public mortuary. It opened in 1978.

Misconduct

Misconduct is defined in the Police Reform Act 2002 as “a breach of the Standards of Professional Behaviour”. However, where a matter is being dealt with under the Police (Conduct) Regulations 2020, the following definition applies: “a breach of the Standards of Professional Behaviour that is so serious as to justify disciplinary action”.

Misconduct in public office (MIPO)

A criminal offence that can only be conducted by public office holders while they are carrying out the duties of that office. It is committed when the office holder “wilfully neglects to perform his duty and/or wilfully misconducts himself to such a degree as to amount to an abuse of the public’s trust in the office holder, without reasonable excuse or justification.”

Negligence

A civil wrong or tort that defines any conduct or failure to act that breaches an established duty of care.

Operational order

A document that links information regarding an event or incident with the structure of the police response and the operational resource requirement.

Pen

An area of a terrace that was completely fenced in so that access in and out was controlled. There were seven pens on the West Terrace in 1989.

Perverting the course of justice

A serious offence which is committed when a person intentionally carries out an act which could interfere with ongoing or anticipated judicial proceedings, whether it has that effect or not.

Popper Inquests

The original inquests into the Hillsborough disaster. They were led by the then Coroner for South Yorkshire (West District) Dr Stefan Popper.

Prepared statement

Section 34 of the Criminal Justice and Public Order Act 1994 gives anyone interviewed as a suspect the right to be silent when being interviewed. However, at the start of the interview suspects are cautioned that an adverse inference may be drawn if they choose not to answer questions and so do not provide evidence that they later rely on in court. If the suspect reads out a prepared statement (or their lawyer does so on their behalf) then no adverse inferences can be drawn in respect of matters dealt with in the statement.

Professional standards

The Standards of Professional Behaviour that apply to all police officers in England and Wales.

Referral

A submission from an appropriate authority about an incident that is serious enough to be sent to the IOPC. It can be in the form of a complaint or conduct matter, or it could involve death or serious injury after contact with the police.

Regulation 16 Notice

This is a notice of the alleged breach of the Standards of Professional Behaviour, served under Regulation 16 of the Police (Complaints and Misconduct) Regulations 2012 (for people no longer serving with the police).

Safety Certificate

The Safety of Sports Ground Act 1975 introduced a requirement for larger stadia to obtain a ‘Safety Certificate’ from the local authority and comply with the terms and conditions of that Certificate.

Salmon letter

A letter sent to a person or organisation who may be subject to criticism when a public report is published. The purpose of the letter is to give the person or organisation the opportunity to prepare a response.

Stuart-Smith Scrutiny

An independent judicial scrutiny of evidence related to the disaster which was not made available to previous investigations. It began in 1997 and was led by Lord Justice Murray Stuart-Smith.

Telex

A method of sending simple written messages over the telephone network. Messages were printed out on specialist printers. It was discontinued in 2008.

Terms of reference

Terms of reference set out the scope and objectives of the IOPC and Operation Resolve's investigations.

The Taylor Inquiry

An independent inquiry led by Lord Justice Peter Taylor into the Hillsborough disaster. It was a non-statutory departmental inquiry, not a statutory public inquiry.

Treasury Solicitor's Department

A government department that provided legal services to central government and other public bodies. It changed its name to the Government Legal Department in 2015.

Appendix A: Terms of reference

Operation Resolve

Operation Resolve was set up to investigate events leading up to the day of the disaster as well as the disaster itself. Its investigation covered:

- All decisions made (or not made) and actions undertaken by those agencies/ organisations who had responsibility for a duty of care to those attending the match on 15 April 1989.
- The planning and preparation for the match, including organisational and individual decision making. The investigation examined whether the arrangements were sufficient to host the event.
- Comparing the way the 1989 Semi-Final was run against the standards that existed in the 1980s, together with the command and control, resourcing levels and threat and risk assessment, including mitigation of the threat at Hillsborough Stadium.
- The planning and decision making that went into the ground's design, engineering, alterations and final layout, including the condition and adequacy of the turnstiles, the siting of barriers and 'pen' design.
- The emergency services' response and activation of any pre-planned responses to such disasters. It examined in detail the police actions on 15 April 1989, both before and as the disaster unfolded, specifically their responses to the plight of the injured, dying and deceased, and to the witnesses, relatives and friends.

In its managed investigation under the direction of the IOPC, Operation Resolve focused on the actions of police officers and investigated complaints and alleged police misconduct in relation to planning for the match and the events of the day itself. The full terms of reference for the managed investigation were:

1. Issues relating to the stadium, including any role played by the police in:
   - **a)** suitability and choice of the stadium to host the event
   - **b)** the planning and decision making in relation to the ground's design, alterations and final layout, including the siting and condition of barriers, fences, and gates within the fences
   - **c)** the design and layout of the pens
2. Planning and preparation for the match by the police, including organisational and individual decision making in relation to:
   - **a)** the resourcing of the event
   - **b)** any role played by the police in allocation of areas within the ground to the visiting teams' supporters
   - **c)** the arrangements for the policing of the match, including arrangements for the arrival of supporters and their management outside the stadium
   - **d)** the arrangements (or lack of) for precise monitoring of the crowd numbers and their safety within the pens at the Leppings Lane end

3. Actions of the police on 15 April 1989 prior to the disaster, including:

   a) actions of police officers outside the football ground, including the alleged failure by the police to prevent supporters entering the Leppings Lane end, failure to prevent build-up of supporters outside the Leppings Lane turnstiles and filter supporters away from those turnstiles

   b) the decision not to postpone the kick-off of the match

   c) the monitoring of crowd numbers in the pens—both the alleged failure to prevent the pens from becoming overcrowded and the alleged failure to act once the pens became overcrowded

   d) the opening of Gate C

   e) the actions (or lack of) to direct supporters once Gate C was opened

4. Response of the police to the disaster, including:

   a) the early police response to the crush at the Leppings Lane end, including allegations that the police were slow to respond/failed to act when it was obvious the people were in distress

   b) alleged failures/refusals on the part of the police to open perimeter gates, and allegations that officers pushed supporters back when they were trying to climb to safety—this aspect of the investigation will specifically consider complaints made against PC Peter Smith and PC David Illingworth, as well as any other officers who may have been involved

   c) subsequent police command and control of the disaster

   d) the communication between the police and the other emergency services

   e) the activation and implementation by the police of any pre-planned responses and emergency procedures to such disasters

   f) the actions of police officers in the gymnasium, in particular whether the treatment and questioning of relatives was appropriate. The actions of police officers at Hillsborough Boys' Club, and any other complaints about the treatment of friends or relatives on the day. The time parameters will be from 3.06pm on 15 April 1989 to the time when the last of the facilities shown below closed down—this will cover events between the match being stopped and the completion of arrangements to assist families at the following locations:

      The gymnasium, Northern General Hospital, Royal Hallamshire Hospital, Ecclesfield Casualty Bureau, Merseyside Casualty Bureau, Hammerton Road Police Station, Hillsborough Boys' Club, Forbes Road Church Hall, Meade House, Kelvin Centre, Burngreave Vestry, and the Medico-Legal Centre

   g) whether any police officer abused their authority, used excessive force or was uncivil during the unfolding disaster

The IOPC investigation

The IOPC's independent investigation focused on the actions of police officers after the disaster. Its terms of reference were first published by the IPCC in 2013, before the IOPC was established. The IOPC retained the terms of reference once it took on responsibility for the investigation. The final terms of reference for the IOPC to investigate were:

1. The interactions of police officers with the press and politicians, in particular:
   - a) whether any police officer was involved in the passing of inappropriate or inaccurate information to a journalist, including whether any police officer was involved in passing written accounts to the press
   - b) whether any police officers passed inappropriate or inaccurate information to any Member of Parliament—whether individually or at meetings. This will include investigation of the actions of Chief Inspector Norman Bettison in visiting Parliament and the evidence he presented, its content and subsequent use by others
   - c) whether the briefing which was given to the Home Secretary and Prime Minister on the day after the disaster contained any inaccurate or inappropriate information
   - d) whether the evidence demonstrates that such interactions were directed or encouraged by SYP
2. The actions of police officers and those providing legal advice to police officers in relation to the collection of evidence, in particular:
   - a) the role of the teams led by Chief Superintendent Terry Wain and Chief Superintendent Donald Denton
   - b) the direction given to officers not to complete notebooks or duty statements
   - c) the process of obtaining handwritten accounts, and the way some of those accounts were subsequently amended, including:
     - i. the actions of officers who agreed to amend their accounts
     - ii. the actions of any officer involved in asking them to do so
   - d) whether amended accounts were put forward on behalf of any police officer which they had not agreed and/or signed
   - e) whether the amendments were made in an attempt to deflect blame from the police
3. The evidence that was put forward on behalf of SYP, or by individual officers, to the WMP investigations, Lord Justice Taylor's Inquiry, the contribution proceedings, and the inquests, or in the immediate aftermath of the disaster, considering:
   - a) whether any police officer gave or produced evidence that was inaccurate, false or deliberately misleading (or was involved in attempts to do so)
   - b) whether such evidence contained inaccurate, misleading or irrelevant criticism of supporters' behaviour
   - c) whether the 'Wain Report' was an accurate and complete picture of the evidence
   - d) whether any police officer was party to, or directed the production or selection of, evidence that was inaccurate or misleading, including irrelevant criticism of supporters' behaviour and evidence regarding operational police tactics/actions to control supporters

4. The checking of blood alcohol levels of those who died and survivors, and what influence, if any, any police officer may have had on the Coroner's/any other person's decision to do this.

5. The carrying out of Police National Computer checks on those who died and others to establish, if possible, which police force or police officer was responsible for this, the reasons why it was done, and whether it was justified.

6. The conduct of officers involved in WMP's investigations. This will include:

   a) the involvement of WMP in the decisions taken about how to gather evidence/obtain witness accounts

   b) whether police officers involved in this investigation put inappropriate pressure on any witnesses to alter their accounts or influence the content of those accounts

   c) whether the summaries of evidence WMP presented at the individual inquests were accurate

   d) whether there is any evidence of bias in favour of SYP on the part of those involved in or leading the investigation

   e) whether any accounts provided were deliberately lost, inaccurately recorded, amended, or mishandled (including not following up on key witnesses)

   f) investigating other recorded complaints or conduct matters about the actions of WMP in the gathering or presenting of evidence

7. Whether there is evidence to suggest that there may have been a general attempt by officers within SYP and/or WMP to deflect or minimise blame for the disaster from the police service, including by focusing on the behaviour or alleged behaviour of supporters.

8. Complaints and recordable conduct matters about police surveillance and covert activity linked to the Hillsborough disaster involving family members of those who lost their lives, survivors and other complainants linked to Hillsborough.

9. The following specific complaints/conduct matters relating solely to Sir Norman Bettison and not already covered elsewhere in the terms of reference:

   a) whether Sir Norman Bettison was deliberately dishonest in relation to his involvement in the Hillsborough investigation during the application and appointment process for the post of Chief Constable of Merseyside Police in 1998

   b) the nature and extent of various statements by Sir Norman Bettison to the press and any other actions after publication of the Hillsborough Independent Panel Report, based on allegations that this was part of a continued effort to deflect blame away from SYP towards others, particularly Liverpool supporters

10. The allegation that SYP may have been involved in the removal of video tapes from the Sheffield Wednesday Football Club (SWFC) CCTV room between 15 April 1989 and 16 April 1989, and the following specific conduct matter regarding the investigation conducted by WMP Detective Chief Inspector Kevin Tope (DCI Tope):

    a) that DCI Tope failed to conduct an effective, thorough, and complete investigation into the alleged theft of two video tapes from the SWFC CCTV control room and, in doing so

    b) that DCI Tope failed to secure and preserve evidence, pursue relevant and obvious lines of enquiry and interview key witnesses

11. The following specific complaints arising in the aftermath of the Hillsborough disaster that are not addressed elsewhere within these terms of reference, namely:

a) the allegation that on the final day of the original inquests two uniformed police officers were observed carrying crates of alcohol into the office of the Coroner, Dr Popper, at Sheffield Town Hall, and other officers were seen inappropriately laughing and joking in the room

b) the allegation that a member of the Hillsborough Family Support Group, while in conversation with the SYP Chief Constable Peter Wright at Barnsley police station, was assaulted by a police officer who was also present

c) allegations that a police sergeant took a telephone call from a member of the public responding to the disaster and that he:

i. failed to record a complaint in respect of allegations of incivility by two uniformed constables at the Hillsborough Stadium prior to the disaster unfolding

ii. made veiled threats to the caller, a publican, in connection with the liquor licence he held

12. Whether any subject of the investigation may have committed a criminal offence and, if appropriate, make early contact with the DPP. On receipt of the investigations' report, the decision maker will determine whether the report should be sent to the DPP.

13. Whether any subject of the investigation would have had a case to answer for misconduct or gross misconduct, or no case to answer, had they still been serving.

The IOPC will also consider and report on whether there is any organisational learning, including:

a. whether any change in police or practice would help to prevent a recurrence of the conduct and complaints investigated

b. highlighting any good practice that should be shared

Appendix B: Police Discipline Code 1985

All police officers and police staff must follow the official Standards of Professional Behaviour. The standards that applied in 1989 were set out in the Police Discipline Code 1985, which was published as a Schedule to the Police (Discipline) Regulations 1985. For the purposes of both the IOPC's and Operation Resolve's police misconduct investigations, the conduct of officers was assessed against this Code, which set out the professional standards that officers were expected to follow at the time when any breaches of those standards may have been committed.

SCHEDULE 1: DISCIPLINE CODE

1. **Discreditable conduct**, which offence is committed where a member of a police force acts in a disorderly manner or any manner prejudicial to discipline or reasonably likely to bring discredit on the reputation of the force or of the police service.
2. **Misconduct towards a member of a police force**, which offence is committed where-
   - a) the conduct of a member of a police force towards another such member is oppressive or abusive, or
   - b) a member of a police force assaults another such member.
3. **Disobedience to orders**, which offence is committed where a member of a police force, without good and sufficient cause-
   - a) disobeys or neglects to carry out any lawful order, written or otherwise;
   - b) fails to comply with any requirement of a code of practice for the time being in force under section 60 or 66 of the Act of 1984; or
   - c) contravenes any provision of the Police Regulations containing restrictions on the private lives of members of police forces, or requiring him to notify the chief officer of police that he, or a relation included in his family, has a business interest within the meaning of those Regulations.
4. **Neglect of duty**, which offence is committed where a member of a police force, without good and sufficient cause-
   - a) neglects or omits to attend to or carry out with due promptitude and diligence anything which it is his duty as a member of a police force to attend to or carry out, or
   - b) fails to work his beat in accordance with orders, or leaves the place of duty to which he has been ordered, or having left his place of duty for an authorised purpose fails to return thereto without undue delay, or
   - c) is absent without leave from, or is late for, any duty, or
   - d) fails properly to account for, or to make a prompt and true return of, any money or property received by him in the course of his duty.
5. **Falsehood or prevarication**, which offence is committed where a member of a police force-
   - a) knowingly or through neglect makes any false, misleading or inaccurate oral or written statement or entry in any record or document made, kept or required for police purposes, or

b) either wilfully and without proper authority or through lack of due care destroys or mutilates any record or document made, kept or required for police purposes, or

c) without good and sufficient cause alters or erases or adds to any entry in such a record or document, or

d) has knowingly or through neglect made any false, misleading or inaccurate statement in connection with his appointment to the police force.

6. **Improper disclosure of information**, which offence is committed where a member of a police force-

a) without proper authority communicates to any person, any information which he has in his possession as a member of a police force, or

b) makes any anonymous communication to any police authority, or any member of a police force, or

c) without proper authority, makes representations to the police authority or the council of any county or district comprised in the police area with regard to any matter concerning the force, or

d) canvasses any member of that authority or of such a council with regard to any such matter.

For the purposes of this paragraph the Isles of Scilly shall be treated as if they were a county.

7. **Corrupt or improper practice**, which offence is committed where a member of a police force-

a) in his capacity as a member of the force and without the consent of the chief officer of police or the police authority, directly or indirectly solicits or accepts any gratuity, present or subscription, or

b) places himself under a pecuniary obligation to any person in such a manner as might affect his properly carrying out his duties as a member of the force, or

c) improperly uses, or attempts so to use, his position as a member of the force for his private advantage, or

d) in his capacity as a member of the force and without the consent of the chief officer of police, writes, signs or gives a testimonial of character or other recommendation with the object of obtaining employment for any person or of supporting an application for the grant of a licence of any kind.

8. **Abuse of authority**, which offence is committed where a member of a police force treats any person with whom he may be brought into contact in the execution of his duty in an oppressive manner and, without prejudice to the foregoing, in particular where he-

a) without good and sufficient cause conducts a search, or requires a person to submit to any test or procedure, or makes an arrest; or

b) uses any unnecessary violence towards any prisoner or any other person with whom he may be brought into contact in the execution of his duty, or improperly threatens any such person with violence; or

c) is abusive or uncivil to any member of the public.

9. **Racially discriminatory behaviour**, which offence is committed (without prejudice to the commission of any other offence) where a member of a police force-

   a) while on duty, on the grounds of another person's colour, race, nationality or ethnic or national origins, acts towards that other person in any such way as is mentioned in paragraph 8 (abuse of authority);

   or

   b) in any other way, on any of those grounds, treats improperly a person with whom he may be brought into contact while on duty.

10. **Neglect of health**, which offence is committed where a member of a police force, without good and sufficient cause, neglects to carry out any instructions of a medical officer appointed by the police authority or, while absent from duty on account of sickness, commits any act or adopts any conduct calculated to retard his return to duty.

11. **Improper dress or untidiness**, which offence is committed where without good and sufficient cause a member of a police force while on duty, or while off duty but wearing uniform in a public place, is improperly dressed or is untidy in his appearance.

12. **Damage to police property**, which offence is committed where a member of a police force-

   a) wilfully or through lack of due care causes any waste, loss or damage to any police property, or

   b) fails to report as soon as is reasonably practicable any loss of or damage to any such property issued to, or used by him, or entrusted to his care.

13. **Drunkenness**, which offence is committed where a member of a police force renders himself unfit through drink for duties which he is or will be required to perform or which he may reasonably foresee having to perform.

14. **Drinking on duty or soliciting drink**, which offence is committed where a member of a police force, while on duty-

   a) without proper authority, drinks, or receives from any other person, any intoxicating liquor, or

   b) demands, or endeavours to persuade any other person to give him, or to purchase or obtain for him, any intoxicating liquor.

15. **Entering licensed premises**, which offence is committed where a member of a police force-

   a) while on duty, or

   b) while off duty but wearing uniform,

   without good and sufficient cause, enters any premises in respect of which a licence or permit has been granted in pursuance of the law relating to liquor licensing or betting and gaming or regulating places of entertainment.

16. **Criminal conduct**, which offence is committed where a member of a police force has been found guilty by a court of law of a criminal offence.

17. **Being an accessory to a disciplinary offence**, which offence is committed where a member of a police force incites, connives at or is knowingly an accessory to any offence against discipline.

Appendix C: The role of the IOPC

The Independent Office for Police Conduct (IOPC) oversees the police complaints system in England and Wales and sets and monitors the standards by which the police should handle complaints.

We investigate the most serious matters, including allegations of serious corruption, and cases where someone has died or been seriously injured following contact with the police. We also consider certain types of reviews from people who are dissatisfied with the way their complaint has been dealt with by a police force.

We play a vital role in improving police practice by ensuring the police are accountable for their actions and lessons are learnt. Working with our partners, service users and communities, we use evidence from our work to influence and drive changes in policing, particularly on issues that we know are affecting community and public confidence. Examples of this include our focus on race discrimination in policing and on the police response to violence against women and girls.

As part of our wider oversight work, we provide guidance to help the police handle complaints at a local level. We also monitor the performance of police force professional standards departments and we hold them to account for their performance in complaint handling.

Along with His Majesty's Inspectorate of Constabulary and Fire and Rescue Services and the College of Policing, we assess and respond to super-complaints. Super-complaints are made by a range of organisations about broad or systemic issues that could affect public confidence in policing. We also have powers in relation to a number of other organisations that are not police forces but have police-like powers, and we investigate criminal allegations against police and crime commissioners and their deputies.

Our mission is to improve policing by independent oversight of police complaints, holding police to account and ensuring learning effects change. We use learning from our work to influence changes in policing, so that everyone is able to have trust and confidence in the police. We make our decisions completely independent of, and separate from, the police and the Government.

Timeline of the IOPC's investigations

12 September 2012 Publication of the HIP Report.

19 December 2012 Popper Inquests verdicts quashed and new inquests ordered. Operation Resolve investigation announced.

10 June 2013 Lord Justice Goldring confirmed that Operation Resolve and the IOPC would support the inquests.

31 March 2014 First day of Goldring Inquests.

26 April 2016 Goldring Inquests' jury returns verdict of unlawful killing in all cases.

19 December 2016 Operation Resolve referred 15 suspects to the CPS for charging decisions.

28 June 2017 The CPS announced its decision to charge six people in relation to the disaster and its aftermath.

14 January 2019 The trial of Ch Supt Duckenfield and Mr Mackrell began.

7 October 2019 The retrial of Ch Supt Duckenfield began.

19 April 2021 The trial of Ch Supt Denton, DCI Foster and Mr Metcalf began.

27 March 2025 The majority of those who had made complaints to the IOPC and Operation Resolve relating to the disaster were informed of the outcomes of their complaints. Officers under investigation were also informed. Details of the remaining outcomes were then published on 30 July 2025.

2013

2014

2015

2016

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2018

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2020

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2026

12 October 2012 IOPC investigation announced.

13 February 2013 Lord Justice Sir John Goldring appointed as Coroner for the new inquests.

17 September 2013 IOPC launched major witness appeal to support its investigation of WMP.

6 January 2017 IOPC referred eight suspects to the CPS for charging decisions.

3 April 2019 The jury advised it was unable to reach a verdict on Ch Supt Duckenfield but found Mr Mackrell guilty of an offence contrary to the Health and Safety at Work etc. Act 1974.

28 November 2019 The jury found Ch Supt Duckenfield not guilty of manslaughter.

26 May 2021 The judge announced that the defendants had no case to answer.

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Rydym yn croesawu galwadau ffôn yn y Gymraeg

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