HILLSBOROUGH 23 YEARS ON

CELIA WELLS

Disasters take place in specific socio-economic, historical and cultural contexts. The continuing debate about the causes and cover ups of the deaths of 96 football supporters at the Hillsborough Stadium in April 1989 is ample evidence of this simple observation.[1] Hillsborough was not the first time there had been deaths from crowd crushes at a sports event, nor the first time the issue of the safety of football stadia had arisen (Ibrox 2007).[2] During the 1980s and 90s concerns about the safety of workers and of members of the public prompted a campaign for corporate accountability in the now familiar, but then unusual, guise of corporate manslaughter. This reflects significant cultural changes in risk perception. A broad definition of disaster is 'an event that occurs suddenly, unexpectedly, and uncontrollably, that is catastrophic in nature, involves threatened and or actual loss of life or property, disrupts the sense of community, and often results in adverse psychological consequences for the survivors (McCaughey 1984). Leaving aside the somewhat circular 'catastrophic in nature' phrase, this definition captures the key features of the Hillsborough disaster and other events that caused the cultural shift towards blaming corporate bodies, including the police and other emergency services, rather than accepting them as 'natural' or part of life's fate.

The tipping point—literally and metaphorically—came in 1987 when a car ferry left the Belgian port of Zeebrugge with its doors open and capsized with the loss of nearly 200 lives. Powerful, graphic images of the ferry 'Herald of Free Enterprise' on its side in the shallow harbour waters soon dominated television and other media. The Hillsborough disaster, which unfolded on live television, occurred after this but before the prosecution of P&O European Ferries, the first

[1] http://hillsborough.independent.gov.uk/

[2] See http://news.bbc.co.uk/onthisday/hi/dates/stories/january/2/newsid_2478000/2478305.stm, "The fatalities at the Ibrox disaster of 1902" (PDF). *The Sports Historian* (British Society of Sports History) 18 (2): 148–155,:10.1080/17460269809445801, http://www.la84foundation.org/SportsLibrary/SportsHistorian/1998/sh182k.pdf.902, and the Bradford fire, http://www.telegraph.co.uk/sport/2359453/Bradford-fire-forgotten-tragedy-of-the-Eighties.html.)

against a corporation in modern times.[3] That case foundered on the interpretation of corporate liability, with judge-directed acquittals abruptly ending the case before the jury had even heard all the witnesses.[4] But something quite different happened after Hillsborough. The Sheffield Wednesday Football Club, the owner of the Hillsborough stadium, and the police and emergency services, successfully deflected attention away from them and on to the victims. This is the essential difference between Hillsborough and other disasters in that decade. No-one blamed the football fans who died in the Bradford fire or the passengers on Herald of Free Enterprise.

But victim blaming or silencing is not uncommon. At the same time that the Police Independent Police Complaints Commission announced the launch of an inquiry in to the allegations of misconduct by South Yorkshire Police and West Midlands in the Hillsborough cover up, revelations about sexual abuse of children and vulnerable adults by Jimmy Savile have emerged.[5] With hindsight it is hard to believe that no-one questioned his charitable interest in institutions that existed to protect such people. What are the connections, other than temporal coincidence, between these two sets of revelations? Both relate to events more than 20 years ago. Both involve suppression (deliberate or negligent) of complaints about institutions or individuals that carried Establishment respect. Both have emerged at a time when information that has previously been protected has been released (in the case of Hillsborough, documents in the form of police and other records were released when the Government waived the 30 year rule on setting up the Independent Panel in 2009, while Savile's death last year removed the protective veil that had been drawn round his activities). These superficial observations are merely opening points for a more sophisticated future analysis.

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[3] The High Court assumed in a review of the inquest that there was such an offence, *R v HM Coroner for East Kent, ex parte Spooner* (1989) 88 Cr App R 10; this was confirmed in *R v P&O European Ferries (Dover) Ltd* (1991) 93 Cr App R 72.

[4] *R v Stanley and others* (1990) Central Criminal Court, 19 October 1990. The ruling that a corporation is capable of committing manslaughter is reported at R v European Ferries (Dover) Ltd (1991) 93 Cr.App.R. 72

[5] http://www.guardian.co.uk/football/2012/oct/12/hillsborough-disaster-biggest-inquiry-police http://www.independent.co.uk/news/uk/crime/340-lines-of-inquiry-14-police-forces-12-sex-abuse-allegations--and-one-big-mess-for-the-bbc-8209888.html

The 'cultural shift' towards blaming collective institutions for the misfortunes that befall us led to a quantum leap in legal discourse.[6] This, in turn, affected the perception of health and safety laws, which became more politicized and associated with punitive ideas. This explains the confusion in many of the contemporary arguments about corporate manslaughter. It is viewed by some proponents as reinforcing health-and-safety-at-work legislation,[7] ensuring that companies take safety more seriously. For others, however, it has a more symbolic and less instrumental appeal. Unlike health-and-safety regulation (which operates through a model of shared responsibility between employers and employees; and through a partnership between the specialist regulators and the industries they oversee) the use of mainstream criminal law would be a clear denunciation in the form of a naming and shaming of corporate negligence that has caused death. This is what lies behind the calls for retrospective actions against the South Yorkshire and West Midlands Police Forces. We can question whether the symbolic denunciation sufficiently justifies a corporate prosecution. The arguments in relation to the individual Chief Constables and other officers, are different. 200 of the officers on duty that day at the stadium are believed to be still serving members of the South Yorkshire police. [8]

There are multiple potential targets of blame in relation to negligently caused disasters such as that at Hillsborough. Blame can be placed on one, or a combination of potential defendants, those responsible for the stadium, those responsible for crowd control, those responsible for the emergency response. There has been an increase in the fines imposed for health and safety offences which are brought against employers (which may or may not be companies) and also an increase in the number of fatal cases referred to the Crown Prosecution Service for parallel manslaughter investigations.[9] As a result, there have been more work-related manslaughter prosecutions against both individuals and companies. Although only running at two or three a year, this is nonetheless a significant increase from the total of ten in

[6] See generally Mary Douglas Risk and Blame: Essays in Cultural Theory (1992).
[7] Health and Safety At Work Act 1974, Ch 37.

[8] http://www.guardian.co.uk/football/2012/oct/12/ipcc-hillsborough-inquiry-vindication-families
[9] The Work Related Deaths Protocol for Liaison introduced in 1998 sought to improve inter-agency cooperation.

the fifty years up to 1998.[10] Because of the restrictive identification principle, these few manslaughter prosecutions were successful mainly against small enterprises, or sole traders. I consider below whether the Corporate Manslaughter and Corporate Homicde Act 2007 has introduced more flexibility.

A further contextual factor in relation to the Hillsborough campaign's demand for manslaughter prosecutions of corporations, institutions and individuals, is the development of international human rights standards. David Held notes the 'growing aspirations for international law and justice' which is told in 'a narrative which seeks to reframe human activity and entrench it in law, rights and responsibilities.'[11] In this respect, the Government is obliged, under art 2 of the European Convention on Human Rights, to establish a legal framework in which those responsible for homicides may be brought to justice and which acts as a deterrent against the commission of such offences.[12] The European Court of Human Rights in the recent case of *Öneryildiz v Turkey* confirmed that

> '[t]he positive obligation to take all appropriate steps to safeguard life for the purposes of Art. 2 entails above all a primary duty on the state to put in place a legislative and administrative framework designed to provide effective deterrence against threats to the right to life'.[13]

There is now a better understanding that, while disasters may be triggered by human error, they arise from complex causes and system failures.[14] It is not unreasonable that organizations should be under a duty to reduce the chances of those errors taking place and to minimize the

[10] As reported by the Centre for Corporate Accountability, available at http://www.corporateaccountability.org/Newsletter/Summer%202002.htm#record (last accessed on 7 April 2006).

[11] David Held 'Violence, law and justice in a global age' in *Social Science Research Council Essays on Globalization after September 11* (2001), available at *http://www.ssrc.org/sept11/essays/held.htm* (last accessed on 10 September 2006).

[12] *Keenan v UK* (2001) 33 EHRR 38 ECHR para 89.

[13] (2005) 41 EHRR 20 para 89 (footnotes omitted).

[14] See generally J T Reason *Human Error* (1990).

consequences when they do. Health and safety offences are not the sole answer. The offences themselves are not dependent on proof of a particular outcome or result. They are not designed as an ex post facto response to a death and, it is argued, cannot on their own have sufficient symbolic impact, nor satisfy Article 2 of the European Convention on Human Rights.

Yet the debate seems to have become confused in two ways—one, by over emphasizing the safety-enhancing capacity of such an offence and, two, through a lack of clarity in distinguishing individual liability from that of the legal entity or organization. It is easier to deal with the first confusion than with the second, which is the true kernel of the debate about the reform of corporate manslaughter. What is the vision underlying corporate blame? We are not much forward, and in many ways have taken steps back, with the long-awaited Corporate Manslaughter and Corporate Homicide Act 2007. The opposing forces of trades unions, relatives and survivor pressure groups on the one hand and business interests on the other have led to a strange and compromised statute that confounds and confuses in an area already bedevilled by the metaphysical challenges of envisaging organisations as legal persons. Any prosecution in relation to Hillsborough would have to be under the common law as the 2007 Act is not of course retrospective. Nonetheless it is instructive to look at this hypothetically. Would there have been liability on the part of the police, the Club or the emergency services had Hillsborough arisen after the commencement of the Act in 2008? While the operational decisions of Sheffield Wednesday Football Club and the South Yorkshire Police might be covered, the emergency response would become ensnared in the exceptions which bedevil the Act.

An *organisation* will commit the offence *if the way in which it manages or organises its activities* both *causes a death* and amounts to *a gross breach of a relevant duty of care* owed by the organisation to the deceased.[15] The Act would require the prosecution to prove that the deaths were caused 'by the way that an organisation managed or organised its activities.' The difficulty is that of course organisations act through individuals, through frontline workers as well as through managers. Did either the Club or the police, or both, cause the deaths by the way that their activities were managed or organised? In anticipation of the potential difficulties in

[15] CMCH Act, s 1 (1)

showing how an organisation *causes* a result, the Law Commission in its draft Bill on corporate killing had included an explanatory provision that a management failure 'may be regarded as a cause of a person's death *notwithstanding that the immediate cause is the act of omission of an individual*.'[16] In its wisdom, the government argued that causation is no longer a difficult issue in criminal law.[17] This was an extraordinary statement. Both in civil and in criminal law causation is fraught with problems as any medical lawyer can tell us. Causation may be difficult to prove - and will certainly be give rise to legal argument - in large public authorities or corporations. It is curiously under defined in an Act which over defines many other elements of the offence.

Consistent with the common law manslaughter standard of gross negligence, it must be shown that there was *a gross* breach of a relevant duty. A departure from a standard of care is 'gross' under s 1 (4) b) if the 'conduct … falls far below what can reasonably be expected of the organisation in the circumstances'. The Act provides some factors for the jury to take into account, which seem to complicate rather than clarify. To begin with, the 'the jury must consider whether the evidence shows that the organisation failed to comply with any health and safety legislation that relates to the alleged breach…' and if so how serious was the failure and how much of a risk it posed.[18] Section 8 continues that a jury *may* also consider the extent to which the evidence shows that there were 'attitudes, policies, systems or accepted practices within the organisation' that were likely to have encouraged, or produced tolerance of, the failure to comply with such legislation. They may also have regard to any health and safety guidance relating to the breach. These are effectively instructions to the trial judge. She must instruct the jury to take into account breaches of health and safety legislation. But how that is taken into account will be left to the mysteries of the jury room. She must instruct the jury that they may take into account company culture, and/or breaches of guidance. It is also explicitly stated that none of this prevents the jury from having regard to other matters they consider relevant. This is odd. In one sense section 8 states the obvious for it must be reasonable to expect an organisation to have regard to health and safety legislation and guidance. The rest is not mandatory. And none of this actually helps the jury decide whether the failure is 'gross', or falls 'far below' what can be reasonably expected.

[16] Law Commission, Draft Involuntary Manslaughter Bill, Report No 237, cl. 4 (4), emphasis added.

[17] During the scrutiny of the draft Corporate Manslaughter Bill in 2005.

[18] CMCH Act, s 8(2)

A further hurdle is that the offence would only be committed if the way *senior management* have managed or organised activities has played *a substantial* role in the gross breach.[19] This in turn means we need to know to whom or what 'senior management' refers. 'Senior management' means the persons who play *'significant roles'* in making decisions about, or in actually managing, the *'whole or a substantial part'* of the organisation's activities.[20] It might appear that the more definitions we are given the better but the adjectives 'significant' and 'substantial' leave much room for debate. What does 'substantial' mean? It is used twice - once to define the extent to which senior management is involved in the breach, and once to define those within an organisation who might be regarded as 'senior' management. Often in criminal law the word substantial has a broad *de minimis* denoting something, but not much more than minimal. In common usage, it can mean something much more restrictive, more like 'a large part of'. In relation to its use to define who within an organisation might be regarded as part of the *senior* management, it could well be interpreted as including only a narrow range of people whose responsibilities are central to the organisation's decision making. The reasoning here is that 'substantial' is not used as a stand alone word, it supplements 'the whole', suggesting that it means something close to the whole if not the whole itself. This could be problematic especially in large organisations. And this still leaves the question of 'significant' role. Far from addressing the difficulties in capturing organisational fault, the Act slips between two grammatical uses of the word management. 'Management' can mean either 'the action or manner of managing', or the 'power of managing', or it could function as a collective noun for 'a governing body'.[21] By requiring the substantial involvement of 'senior management' and then defining this body as 'those persons who play significant roles' the Act gives the lie to the Government's claimed commitment to an organisational version of fault that is not derivative on the actions of specified individuals. This is a considerable maze through which the prosecution must weave its way, one that becomes increasingly difficult the larger the organisation involved.

Emergencies provide a further set of (complicated) exceptions that would be relevant to the Hillsborough case. The broad thrust of section 6 (which covers a whole raft of fire, rescue and

[19] CMCH Act, s.1 (3).

[20] S. 1 (4) (c)

[21] That is, it can be an adjectival or collective noun, Shorter Oxford English Dictionary 1977.

medical emergency situations) is that any duty of care owed by organisations *'in the way in which they respond to emergency circumstances'* is not a 'relevant duty of care' under the Act unless it is owed as an employer or as an occupier of premises. The exemption applies to ambulance services among others.[22] However, there are exceptions within the exception in relation to medical treatment. 'The way in which an organisation responds to emergency circumstances' does not include the way medical treatment is carried out or decisions as to the carrying out of medical treatment.[23] An ambulance or NHS organisation responding to emergency circumstances ('present or imminent circumstances causing or likely to cause serious harm or worsening of harm or are likely to cause death[24]) will not be liable for deaths caused in breach of any duty of care *unless* it involves the treatment itself or decisions about the treatment. But then in an exception within an exception within an exception, the organisation is not liable if the negligence relates to a triage decision ('decisions as to the order in which persons are to be given treatment[25]). For example, if an ambulance crew at the scene of a motorway crash involving multiple victims administer first aid to a victim with minor injuries, leaving a victim, with more serious injuries, to suffer without tending to them, the organisation will not be responsible.[26] All of this detailed definition seems unnecessary since the offence is only committed when an organisation's senior management plays a substantial role in the gross breach of care which causes death. It is hard to imagine why an organisation whose senior management organises emergency response in such a way that minor non life threatening injuries are prioritised over serious ones should be exempt from the Act.

From a distance of 23 years, the scandal of Hillsborough coalesces around a number of factors, ante and post, suggesting that it is too simplistic to think corporate manslaughter as an appropriate answer. It is the law in its broadest terms and the institutions associated with it that have failed the victims:

[22] CMCH Act s 6 (2)
[23] CMCH Act s 6 (3)
[24] CMCH Act s. 6 (7). 'Serious harm' is then further defined to cover serious injury or illness (including mental illness) in the same subsection.
[25] CMCH Act s 6 (4)
[26] It is not clear why the Act needs to spell this out since it is hard to imagine that this could ever be attributed to the way the ambulance service is 'managed or organised' by its senior management under section 1.

> Failures of risk and emergency planning (responsible newspapers were asking within hours of reporting Hillsborough why the lessons of Ibrox and Bradford had not been learnt)[27]; failures of emergency response; failures of the coronial system (which is patchy at the best of times, and is ill—equipped to ask the right questions in disaster aftermath); failures and corruption in the police; failures in police accountability especially at the senior and collective levels; failure in the prosecution system; and failures in the substantive law.

The Independent Panel has done more than uncover an extraordinary and woeful tale, shining a light in to a distasteful world of individual impunity within the police, it has vindicated the bereaved and survivors of Hillsborough who have maintained all along that they were vilified by willing sections of the tabloid press. What should follow? I would not argue for corporate manslaughter cases to be brought now. That would serve little purpose. Its time has passed. Instead now is the time for individual accountability of those whose desire to shift on to the victims blame that attached to the multiple failures that led to the disaster and did so knowingly and corruptly.

[27] David Lacey, 'Why were the lessons never learned?' The Guardian, 17 April 1989; Richard Faulkner, 'Lessons of Hillsborough' The Times, 17 April 1989.