

The legacy of Hillsborough: liberating truth, challenging power

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Abstract: In April 1989, ninety-six men, women and children, supporters of Liverpool Football Club, died in a severe crush at an FA Cup semi-final at Hillsborough Stadium, Sheffield. Hundreds were injured and thousands traumatised. Within hours, the causes and circumstances of the disaster were contested. While a judicial inquiry found serious institutional failures in the policing and management of the capacity crowd, no criminal prosecutions resulted, and the inquests returned 'accidental death' verdicts. Immediately, the authorities claimed that drunken, violent fans had caused the fatal crush. Denied legitimacy, survivors' accounts revealed a different story criticising the parlous state of the stadium, inadequate stewarding, negligent policing, failures in the emergency response and flawed processes of inquiry and investigation. Reflecting on two decades of research and contemporaneous interviews with bereaved families and survivors, this article contrasts the official discourse with those alternative accounts – the 'view from below'. It demonstrates the influence of powerful institutional interests on the inquiries and investigations. It maps the breakthrough to full documentary disclosure following the appointment of the Hillsborough Independent Panel, its research and key findings published in September 2012. The campaigns by families and survivors were vindicated and the fans, including those who died, were

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exonerated. The process is discussed as an alternative method for liberating truth, securing acknowledgement and pursuing justice.

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It was like a vice getting tighter and tighter. I turned Adam round to me. He was obviously in distress. There was a police officer just slightly to my right about five or six feet away and I started begging him to open the gate ... I was screaming, I literally mean screaming ... 'My lovely son is dying' and I was begging him to help. He just stood there looking at me. I realised he wasn't going to do anything so I grabbed hold of Adam ... and I tried to lift him over the fence, but the fence is about 10 feet or thereabouts with spikes coming in. I couldn't lift him ... No-one opened that gate. Right at the beginning, when I was begging the officer to open it, if he would have opened it then I know I could have got Adam out.¹

When Eddie Spearritt, survivor of the Hillsborough Disaster and grieving father, spoke with quiet dignity, the silence inside the packed coroner's court was reverential. He recalled taking his 14-year-old son, Adam, to Sheffield to support their soccer team, Liverpool, in the 1989 FA Cup Semi-Final against Nottingham Forest. It was one of the most important football matches of the year held at a neutral stadium, Hillsborough, the home of Sheffield Wednesday Football Club, hired by the Football Association and policed by the South Yorkshire Police.

Eddie recalled the 15th of April 1989, a beautiful Spring day on which along with 54,000 others he and Adam had anticipated an exhilarating, joyful afternoon. Arriving at the turnstiles they withdrew from the congestion as the crowd was channelled into a tightly confined area. Close by, the police opened an exit gate allowing the crowd to enter the stadium. They walked unstewarded through the gate, descending a 1 in 6 gradient tunnel into two already packed small, central pens behind the goal. Numbered 3 and 4, the pens were contained by lateral fences to the sides and an overhanging, perimeter fence at the front. A small locked gate in the front fence gave access to the perimeter track and the football pitch. The gates, one for each pen, were marshalled by police officers who had keys to the locks. At the front of Pen 4 the compression of bodies was unrelenting. In a final embrace, as Eddie attempted to protect Adam, they lost consciousness. Adam died and Eddie, himself close to death, lived. As he concluded his testimony one phrase reverberated in its unequivocal, purposeful delivery: 'I know because I was there'.

In her analysis of the visual and literal images of war-reporting by journalists and photographers witnessing the 'pain of others', Susan Sontag notes that 'memory is individual, unreproducible', yet 'collective memory' builds a story 'of how

it [an event] happened, with pictures that lock the story in our minds'.² For those 'who have no experience of others' suffering' it is impossible 'to imagine how dreadful, how terrifying war is' and survivors 'stubbornly feel that lack of understanding'.³ The 'images', however, bring closer proximity to 'identifying with the lives and suffering of others'.⁴ Understanding and identifying with the pain of others is not confined to acts of war. It extends to acts of violence or catastrophe involving the institutional abuse of power and subsequent denial of responsibility, particularly regarding state power.

Within advanced democratic states, Cohen notes that the 'unwillingness to confront anomalous or disturbing information' often involves a 'complex discourse of denial' employing a deeply institutionalised 'language of legalism'.⁵ In proclaiming their 'democratic credentials' and 'sensitive to their international image', states forsake 'crude literal denials' often opting for partial acknowledgement of responsibility.⁶ Yet they also avoid or deflect full responsibility through the mechanics and processes of 'interpretive denial - that what happened is really something else'.⁷ As Eddie Spearritt gave his testimony, his suffering, his experience and his 'truth' was evident to all who listened and imagined. Yet the forum in which it was delivered, the coroner's court, located his experience and that of others who survived the fatal crush - their 'collective memory' - within a contested terrain of interpretation and denial.

The pain of death and the politics of denial

Ninety-six men, women and children died, most in Pen 3, as a consequence of the 'vice-like' crush on Hillsborough's Leppings Lane terrace. Hundreds were physically injured, thousands traumatised and numerous bereaved relatives and survivors have died prematurely, some taking their own lives. The fatal crush developed immediately before kick-off, the screams of the dying and injured were lost in the roar of the crowd. Six minutes later the referee halted play and took the players from the pitch.

In addition to the crowd, the media coverage was international and instant - television cameras, live radio broadcasts, scores of journalists and press photographers. Scenes of congestion outside the stadium at the turnstiles, the passage of fans through the opened gate and down the tunnel, the overcrowded central pens and the under-populated side pens were transmitted via numerous CCTV cameras to the South Yorkshire Police (SYP) command team in the police control box. Situated above and adjacent to the terrace and its central pens, the box gave a clear and close view of the uneven distribution of the crowd in the pens. As the disaster unfolded, the Match Commander, Chief Superintendent David Duckenfield, misinformed senior officials from the Football Association that fans had forced entry causing an inrush into already packed pens. Yet he had ordered the opening of the gates to relieve the crush at the turnstiles. Within minutes the lie was broadcast internationally.

In Pens 3 and 4, unconscious fans were pulled through narrow gates onto the perimeter track and laid on the pitch. Survivors used advertising hoardings as makeshift stretchers, carrying the dead and dying the length of the pitch to where ambulances had access to the stadium. They were directed to lay bodies on the stadium's gymnasium floor where eventually eighty-two people were certified dead. Several hours later the South Yorkshire Coroner, Dr Stefan Popper, in consultation with Detective Superintendent Addis, the South Yorkshire officer responsible for organising the identification procedure, designated the gymnasium a temporary mortuary. Interviewed later, Addis commented that he wanted 'to keep all the eggs in one basket'.⁸ The gymnasium was divided into three sections using sheets hung from netting: an area for holding bodies laid out in body bags; an area for police officers to eat; and an area for police officers to conduct interviews.

Each deceased person was numbered, placed in a body-bag – their face cleaned by a police officer using a sponge or rag. Polaroid photographs were taken, numbered and posted on a board near the entrance of the gymnasium. Relatives and friends searching for their loved ones were held at a disused Boys' Club close to the area's main police station. At 9.30pm, six hours after the evacuation of the pens, the process of identification began. Through the night families were bussed from the Boys' Club to the gymnasium, queuing at its entrance to view the photographs. On recognition, the numbered body was wheeled on a trolley to the gymnasium door. The body-bag was unzipped, the identification made and the body returned to the gymnasium floor. The bereaved were prohibited from touching their loved ones and were escorted to the interview area by police officers ostensibly to answer routine questions and formalise identification. Within a month of the disaster, the Hillsborough Family Support Group (HFSG) was formed to represent and progress the interests of all bereaved families. Their experiences on the night of the disaster indicated that an agenda was forming that focused on fans' behaviour.⁹

Barry Devonside had travelled to Hillsborough with his son, Christopher. Unable to find Christopher, he searched the stadium and hospitals. Returning to the stadium he recognised a photograph. Having demanded to be granted a moment to touch and kiss his dead son, Barry was taken to a table where 'two CID blokes and a policeman in uniform ... wanted a formal statement of identification'. He was asked their time of arrival in Sheffield and whether they had 'stopped for a drink'. The questioning focused on alcohol, pubs, off-licences and supermarkets, and whether he had witnessed heavy drinking or bad behaviour. Barry voiced his 'disgust' that minutes after identifying his dead son he was being subjected to what 'felt like an interrogation, like we had done something terribly wrong'.

Watching coverage of the disaster at home in Liverpool, Jimmy Aspinall travelled to Sheffield. He identified his son, James, between 3am and 4am the following morning. 'When I went up there [the gymnasium] to identify James from the

picture there was a woman screaming ... sitting on the steps screaming ... I remember those screams all the time. Then the police fella took the statement from you ... and asked how many drinks, and that type of thing.’ Doreen and Les Jones also recalled the scenes of anguish inside the gymnasium. Their son, Richard, his fiancée Tracey Cox and their daughter, Stephanie, had been in Pen 3. Stephanie survived, Richard and Tracey died. Les objected to giving a statement so soon after identifying Richard and Tracey. He was told by the police that he had no option.

He was ‘fuming with rage but thought okay we’ve got to do it, I suppose they need identification, so let’s get it over with’. The questions followed a pattern: ‘Do you know whether he had a drink on the way up here?’; ‘What did he do the night before?’ ‘Do you know whether he went for a drink the night before?’; ‘Did he usually have a drink before the match?’ Having just completed a double identification and dealing with the trauma experienced by their young daughter who had survived, Les ‘was like a zombie, just staring ahead’. The questioning ‘wasn’t anything to do with identification, they were more like allegations’.

They were instructed to give two statements to different police officers, one for Richard and one for Tracey. ‘The whole time this guy, in civvies, alongside me was tut-tutting, making noises ... I just tried to blot him out but he was getting on my nerves.’ When they had answered the questions the plain-clothes officer demanded ‘an overall statement’. Les ‘was so mad’ and ‘he sort of threw the statement at me and said, “Here you are, get that signed”. I said “No. I’m going to read it first”. I started reading it and he had everything wrong, it was unbelievable, he had his [Richard’s] age wrong, everything wrong’. Doreen recalls the plain-clothes officer ‘rocking his chair on its back legs tapping his pen on the table ... he kept saying, “I’ve just said sign it. I’ve just said sign it”’. Stephanie was there, actively taking a part. I wasn’t ... I was sitting there just saying I wanted my son.’

Searching for her son, Andrew, and waiting for her son-in-law to view the photographs, Teri Sefton asked two police officers why it was taking so long. She described Andrew and one of the officers ‘asked me which pub would he have stopped at on the way over’. She replied, ‘he wouldn’t have done because he was driving and besides which he doesn’t drink and, not that it makes any difference, but he doesn’t smoke either’. The officer ‘turned to the other officer, asking me how old Andrew was. I told him he was 23. He said, “She’ll be telling us next he’s a bloody virgin!” I was not in a position to say anything and went back and sat with Colin [her husband].’

Teri recalled that ‘all that could be heard was the screams of women, usually mums’ and ‘the police had total control. They handled everything and gave nothing.’ Following identification, they were asked which pub Andrew would have stopped at en route. Teri replied, ‘None’. Then, ‘they turned to Leo and I, and said, “Which pub did you stop at on the way here?” We had literally raced there from home. These were not the sort of questions you ask if you’re filling in a sudden death form.’

These harrowing examples are typical of families' experiences on the evening of the disaster. Held in a disused, damp and unheated Boys' Club, bussed to the gymnasium where they queued, blankets around their shoulders against the chill of the night, subjected to a process that used poor quality Polaroid photographs and prevented from touching, holding or kissing their loved ones, they experienced a hostile, accusatory process. According to the police, their 'procedures were the right procedures' and they 'worked very well'.¹⁰

Other professionals in the gymnasium disagreed. A social worker considered the officers' 'primary concern' was 'statement taking' and 'intelligence gathering'. The questions 'were unacceptable and clearly were about fans' behaviour'. The Deputy Chief Ambulance Officer considered that 'CID officers sat at tables ready to take statements seconds after identification [it] was awful ... the screams and crying could be heard everywhere. It will be with me forever.' In the immediate aftermath of the disaster a standard police procedure of identification was used to focus on the personal reputations of those who died. From Duckenfield's earlier lie through to questions about criminal records, alcohol consumption and violent behaviour, a prevalent theme had emerged.

The following day Prime Minister Margaret Thatcher and her Home Secretary, Douglas Hurd, visited the stadium. Reflecting on the briefing by the South Yorkshire Police Chief Constable, the Prime Minister's Press Secretary, Sir Bernard Ingham, recalled: 'I visited Hillsborough on the morning after the disaster. I know what I learned on the spot. There would have been no Hillsborough if a mob, who were clearly tanked up, had not tried to force their way into the ground.'¹¹ The briefing was consistent with allegations that surfaced in the print media in the days that followed.

On Monday 17 April the Sheffield-based *Star* claimed that 'up to 40 people died in the tunnel, the rest trampled underfoot' as a consequence of a 'crazed surge'.¹² Similarly, the *Yorkshire Post* reported that 'thousands of latecomers tried to force their way into the ground' having set off a 'fatal charge'. In the *Evening Standard* Peter McKay concluded that the deaths were the consequence of 'the tribal passions of Liverpool supporters' who 'literally killed themselves and others to be at the game'. Jacques Georges, the UEFA President, condemned the 'beasts waiting to charge into the arena'.¹³ Writing in the *Liverpool Daily Post*, John Williams claimed that 'gatecrashers' had 'wreaked their fatal havoc'; the 'uncontrolled fanaticism and mass hysteria' of 'gatecrashers' had 'literally squeezed the life out of men, women and children'. It was 'yobbism at its most base' as 'Scouse killed Scouse'.¹⁴

These fierce, unsubstantiated claims pre-empted more sinister allegations that Liverpool fans had attacked police officers and rescue workers, and stolen from the dead: 'Fans in Drunken Attacks on Police: Ticketless thugs staged crush to gain entry'.¹⁵ The police, the *Star* claimed, were 'piecing together' a 'sickening story' focusing on how 'yobs' had 'attacked an ambulance man, threatened firemen and punched and urinated on policemen as they gave the kiss of life to

stricken victims'.¹⁶ On 19 April the story was carried in national newspapers: 'Dead Fans Robbed by Drunk Fans'; 'They were drunk and violent and their actions were vile'; 'Police Accuse Drunken Fans: Police saw "sick spectacle of pilfering from the dying"'; 'Fury as police claim fans robbed victims'; 'Police tell MP of attacks on them as they helped injured'.¹⁷

The *Sun*, however, devoted its front page to the story: 'THE TRUTH': 'Some fans picked pockets of victims; Some fans urinated on the brave cops; Some fans beat up PC giving life kiss'.¹⁸ A 'high-ranking police officer' alleged that a dying young woman had been the target of fans' verbal sexual abuse: 'fans were just acting like animals. My men faced a double hell – the disaster and the fury of the fans who attacked us.'

Inquiry, inquest, scrutiny

The relationship between 'truth' and 'justice' is complex, not least when the media produces a daily diet of allegations and counter-allegations. Conceptually, the 'truth' of an event combines perception and interpretation of those involved, influenced by personal histories, knowledge and understanding. In the immediacy of the moment neither the underlying context nor the circumstances are evident. In establishing 'the truth' of what happened, distinct and contrasting versions are presented from different physical, intellectual and emotional standpoints. The weighting and credibility given to versions reflects their ascribed status, forming what Becker named 'hierarchies of credibility'. Further, establishing the 'facts' of what happened invariably indicates culpability and the presumption that accountability will follow. 'Justice' anticipates outcomes predicated on accountability, determining whether or not social, moral and/or legal codes have been breached and, if so, publicly holding perpetrators responsible. Within democratic states the expected outcome of a judicial process once guilt has been established is some form of retributive punishment. In seeking redress for harm, however, victims or survivors do not necessarily demand criminal prosecutions, retribution or punishments but invariably they expect acknowledgement.

In controversial cases of wider significance and profound public interest, the investigation of wrongs done and harm caused has also been pursued via official inquiries and commissions. In these formal, inquisitorial forums, it is anticipated that what consolidates as collective 'truth' through documentary disclosure, shared experiences and personal accounts provides a more fully developed foundation for findings of what happened, leading to informed recommendations for future prevention. According to Thomas, government-appointed commissions and inquiries are presented as 'democratic pluralism at work'; as mechanisms of a 'neutral state operating by popular consent' thus demonstrating a 'commitment to heed public opinion'.¹⁹

Public inquiries, convened in the aftermath of major incidents such as disasters or tragedies, or to address alleged irregularities or failures in the administration

of justice, should not, argues lawyer Louise Christian, be considered a 'panacea' but provide an opportunity 'speedily and without delay' to 'ensure that management failings are exposed to public scrutiny'.²⁰ Gilligan notes they 'are popularly perceived to be objective, politically independent and of high status' carrying 'authority in the public consciousness'.²¹ Also, they have the potential to 'act as a convenient mechanism of legitimation for the state'. For Maclean, the 'trigger' for public inquiries 'is usually the need to restore public confidence in a service or organisation, or even the government as a whole'.²² Chaired by judges or lawyers, supported by professional consultants, they are guided by precise terms of reference anticipating an evidence-based diagnosis of the issues under consideration, specifying responsibilities, proposing remedies and establishing an agenda for reform mindful of preventing a recurrence of the event/s under review.

In their definitive analysis of official discourse, Burton and Carlen note how government-initiated inquiries are a 'routine political tactic directed towards the legitimacy of institutions'.²³ Wrongful imprisonment, unlawful policing and internment without trial, they argue, are each examples of abuse of state power that undermine public confidence in the 'administration of judicious control' producing 'crises in the popular confidence in the impartiality of legal state apparatuses'. Such 'crises in legitimacy' challenge political and ideological representations of state institutions as 'just'. In such circumstances, the primary motivation for inquiries is to 'represent failure as temporary, or no failure at all', thus reaffirming the *status quo*.²⁴ They demonstrate clearly how inquiries have the capacity to incorporate dissent, legitimise institutional authority and restore public confidence.

Such political and socio-legal dynamics shape public inquiries, coroners' inquests and other forms of judicial scrutiny. They stand apart from criminal prosecutions and civil litigation, ostensibly offering to those seeking 'truth' and 'justice' forums in which diverse accounts are presented and questioned without liability being attributed. They produce a form of 'aggregated' truth. This is an ideal that cannot be realised without recognising that, in highly controversial and contested cases, such forums do attribute, however obliquely, responsibility and culpability. In such cases culpability and the potential for criminal prosecution or civil liability is never far from the surface.

The Taylor Inquiry

Within twenty-four hours of the disaster, the South Yorkshire Police initiated an internal inquiry and the West Midlands Police were invited to conduct a full investigation. A judicial inquiry, chaired by Lord Justice Taylor, was established by the Home Secretary. While the Judicial Inquiry, the criminal investigation and the coroner's inquiry were each considered 'independent', they were serviced by the West Midlands Police investigation, thus relying on a shared source of primary information. The Inquiry's terms of reference were: 'To inquire into the events at Sheffield Wednesday Football Ground on 15 April 1989 and to make

recommendations about the needs of crowd control and safety at sports events'.²⁵ It processed 2,666 telephone calls, 3,776 written statements and 1,550 letters. It met in session on thirty-one days hearing primary evidence (not under oath) from 174 witnesses; a 'small fraction' from the pool of thousands, yet 'sufficient in number and reliability to enable me to reach the necessary conclusions'.²⁶

Lord Justice Taylor's Interim Report, delivered in less than four months, responded to 'urgent questions of safety, especially at football grounds'. Five months later, the Final Report broadened the scope to a general discussion of stadium safety and crowd control in the context of football.²⁷ Focusing on the circumstances of the disaster, the Interim Report concluded that overcrowding in the central pens was the main cause. The main reason was a profound failure in police control. While directing its most damning conclusions towards the South Yorkshire Police it also criticised Sheffield Wednesday Football Club (the stadium owners), its safety engineers and Sheffield City Council.

Senior police officers had been 'defensive' and 'evasive' in giving evidence; their 'handling of problems on the day' failed to demonstrate 'the qualities of leadership to be expected of their rank'. It was 'a matter of regret that the South Yorkshire Police were not prepared to concede that they were in any way at fault for what had occurred'.²⁸ Duckenfield's 'capacity to take decisions and give orders seemed to collapse'. He failed to give 'necessary consequential orders' following his decision to open the exit gate, losing control of the situation. His 'lack of candour' had 'set off a widely reported allegation' that fans had broken into the stadium and caused a fatal crush.

Many families attended the hearings held in Sheffield. Coming within months of the disaster, the Inquiry's key findings appeared unequivocal in raising an expectation that criminal prosecutions and inquest verdicts of 'unlawfully killed' would follow:

We came away from Taylor feeling he was listening and it was clear to us then that we had a chance that the lies that were being told by senior officers would be brought into the open, that there were strong grounds for prosecutions and individuals would be brought to account.

When the Report came out, so soon after it all happened we were made up. We thought 'This is it, heads will roll'. They'd not only caused the deaths through their incompetence but they'd lied to a Judge and were caught out!

There's no joy in all this, nothing can bring back our children, our husbands. But what the Judge said in his Report at least brought some satisfaction that all that had been reported in *The Sun* and other papers was lies and that incompetence caused the disaster. What I couldn't get over was how these senior officers, including the Chief Constable, could stand there and tell lies to a Judge! They think they're above the law.

When the Final Report was published, however, the specifics of Hillsborough were absent and the broader issue of football-related violence had returned to the agenda.

The inquests

Following publication of the Interim Report, the bereaved families anticipated criminal prosecutions, yet wanted the inquests to proceed to establish the specific circumstances in which each of their loved ones died. They also sought explanation of the Coroner's decision to record blood alcohol levels from all who died. Given hostile media coverage, they argued his decision had further impugned the reputations of the deceased and supported police allegations of widespread drunkenness. Following discussions with the Director of Public Prosecutions (DPP), the Coroner proposed to proceed with individual preliminary hearings with each family. Between 18 April and 4 May 1990, in Sheffield before a jury, the Coroner held ninety-five limited hearings, or 'mini-inquests'.²⁹ Each family heard the medical evidence on their loved one, including the recorded blood alcohol level, presented by the pathologist who had conducted the post mortem. This was followed by a synopsis of evidence on the deceased, including witness statements, summarised and presented by West Midlands investigating officers. These unprecedented 'third party' presentations could not be examined.

On the advice of their lawyers, the families accepted the format as an 'information dissemination exercise', their lead solicitor advising that the Coroner was 'to be applauded' in taking the initiative. The Coroner informed the families that the preliminary hearings would be 'non-adversarial', the evidence 'non-controversial'. Yet, in setting the context, 'expert' witnesses gave broad evidence, including the 'scientific' analysis of blood alcohol levels and the fatal injuries suffered by the deceased, focusing particularly on asphyxia. Each family then attended the coroner's court to hear evidence specific to their loved one. Eight families were processed each day and had minimal opportunity to reflect on the evidence put to the jury. The medical pathology on each of the deceased was presented as incontrovertible, and the summarised evidence compiled by a West Midlands Police officer was untested, despite many families identifying inaccuracies and inconsistencies. On completion of the preliminary hearings, the inquests were adjourned to await the DPP's decision on criminal prosecution.

In agreeing to preliminary hearings, families were concerned about restrictions placed on questioning the evidence heard by the jury. Their concerns were profound. A bereaved mother considered the mini-inquest was 'theatre': 'It was that rehearsed ... It was blatantly obvious that when the pathologist was asked the questions he already knew what he was going to be asked.' A bereaved sister questioned the veracity of the medical pathology as the senior pathologist 'assured us that [her brother] would have felt no pain as he would have fallen unconscious within seconds'. Unbeknown to the family, however, 'the Coroner

had in his possession a statement from a witness which stated that [he] was conscious for some time. This evidence was not put before the jury.'

Having been instructed that questions raised could not be controversial, a bereaved mother asked why her son had not been taken to hospital. She stated, 'The Coroner replied, "In an ideal world they would have all ended up in hospital". Dear God! In an ideal world my son would have not ended up dead! The answer did nothing to alleviate my fears. It just made them worse.' Her increased anxiety was reflected in two further responses:

Before the mini-inquest I trusted that those dealing with summaries would do so without prejudice and with integrity.

How is it possible to gauge the truthfulness of the evidence given in the summaries when no opportunity was given to cross-examine the individuals who were the source of the information?

All families stated that they expected the preliminary hearings to provide a comprehensive understanding of the precise circumstances in which their loved ones died. They rejected the opinions, interpretations and words of investigating officers presented to the jury without examination as a denial of their right to test evidence. This was the only opportunity for the bereaved to hear and question evidence relevant to their loved one, yet it was denied by an unprecedented *ad hoc* procedure agreed by their lawyers.

I felt it was all very theatrical at the start. Dr Popper going out and coming in for the cameras. This offended us greatly, and continued to do so throughout the inquest.

Really speaking to face the mini-inquests on the day was to say the least most upsetting. The whole proceedings were for us unreal and to be quite frank impersonal. No-one should ever be subject to such proceedings.

That night I felt I had just lost him all over again. I couldn't stop crying thinking about him. They played on our emotions and our illness – it was so cruel.

I came away from the mini-inquest totally distressed and bewildered.

Any trust I had went out the window and like many other families I thought the mini-inquests insufficient.

On 30 August 1990, a year after the Taylor Interim Report's publication, the DPP announced there was no evidence to justify criminal proceedings against the South Yorkshire Police, Sheffield Wednesday Football Club, Sheffield City

Council or the Club's safety engineers. Further, he considered there was insufficient evidence to justify proceedings for any offence against any individual including South Yorkshire Police officers.³⁰ The Police Complaints Authority (PCA) decided to pursue disciplinary action against the two most senior officers for 'neglect of duty'. Having been on long-term sick leave, C. S. Duckenfield, the Match Commander, retired on medical grounds and the PCA decided not to proceed with the case against his assistant, and disciplinary proceedings closed.³¹

Meanwhile, the inquests were resumed in generic form on 19 November 1990, concluding on 28 March 1991, having heard evidence from 230 witnesses. The Coroner decided that no evidence would be heard relating to events beyond 3.15pm on the day of the disaster. By that time, he argued, 'the real damage was done' – as the 'chest was fixed ... respiration could no longer take place, the irrevocable brain damage could occur between four and six minutes'.³² He maintained that the 3.15pm cut-off was consistent with the medical evidence and 'each individual death' was 'in exactly the same situation', as crushing was the sole cause of all deaths. The 3.15pm cut-off was the Coroner's most controversial decision as those most directly concerned with rescue, evacuation and medical treatment were not called to give evidence.

The Coroner selected witnesses including local residents and police officers who repeated the previously discredited accounts of senior officers. Allegations of ticketless, drunk and abusive fans determined to force entry into the stadium resurfaced. Following 'expert' evidence from those associated with Sheffield City Council, the Sheffield Wednesday Football Club and the Health and Safety Executive, a small number of survivors gave personal accounts. In conclusion, and following legal submissions by all parties, the Coroner directed the jury on two possible verdicts: unlawful killing and accidental death. He advised that 'accident' encompassed a 'spectrum of events from something over which no-one has control' where 'no-one could be blamed – to a situation where ... there has been carelessness, negligence, to a greater or lesser extent'. A verdict of accidental death did not mean that individuals were absolved from 'all and every measure of blame'.³³ Following two days of deliberation, on the eightieth day of the generic hearings, the jury returned a majority verdict of 'accidental death'.

The bereaved families were profoundly distressed, criticising the Coroner's direction:

The inquests were a farce from beginning to end. We were totally misled by West Midlands Police, legal representatives and by the Coroner himself ... The Coroner clearly directed the jury to an accidental death verdict.

I cannot be totally objective but it would seem that the jury could only arrive at one verdict after the Coroner's performance.

Families questioned the accidental death verdict given 'the overall emphasis on negligence so prominent in Lord Justice Taylor's Report'. They considered inquests as a forum for thorough investigation to be limited:

We do not believe that (a) the Coroner was proficient enough to control the proceedings, (b) the inquest is the format most efficient to look into mass deaths especially where the Police are implicated.

In a case of this magnitude, coroner's courts are not adequate places to deal with inquiries into deaths.

I think it [inquest procedure] needs serious reviewing and alterations made to most areas of the procedure, especially in the case of multiple deaths as in a disaster.

The coronial system is not really suitable for handling a major incident involving multiple deaths.

Despite the apparent broad scope of the inquests, the universal view was that specific questions relevant to the deaths of loved ones, particularly regarding the possibility of survival, had been ignored. A bereaved father commented that his family 'will never know what happened to our son between 3.15pm and 4.25pm when he was certified dead' as the 'Coroner put up a wall in front of all the families.' Another bereaved father stated, 'every door is closing on us' but he 'didn't expect anything else. It was too big an issue, too many top people, too much to lose. The inquest was a farce but we all went along with it – we had to, there was no choice.'

On 6 April 1993 the High Court granted leave to six families to apply for a judicial review of the inquest verdicts. Grounds for appeal included: irregularity of proceedings; insufficiency of inquiry; the emergence of new facts or evidence.³⁴ On 5 November 1993, Lord Justice McCowan rejected the families' submission, ruling that the inquests had been properly conducted and evidence had not been suppressed.³⁵ The Coroner's direction had been 'impeccable' and there had been 'no error'. He considered that liability was not an issue as the police 'had admitted fault and paid compensation'. The 3.15pm cut-off was appropriate as all were 'brain dead by that time' and further 'examination of the last minutes of their lives' would provide no further information, but would be 'harrowing' and involve 'large numbers of witnesses ... lasting if not for 96 days, for not far short'. While accepting that bereaved families were motivated by a 'deep instinct to know the circumstances in which their relatives died', his role was 'to take an objective view and ... consider the interests of all concerned including those of all the witnesses who would have to come along five years later and try to cast their minds back to events they must have been trying to forget'. He ruled that 'this was not a case in which it would be right to order fresh inquests'.

While the Taylor Inquiry was considered unequivocal in attributing responsibility, its investigation had been rushed and narrowly focused. Given its time-frame and narrow terms of reference it did not have the capacity to research in detail the context and circumstances in which the disaster occurred. Apart from its implications for criminal and civil proceedings, foreseeability was central to the concerns of the bereaved and survivors. Taylor did not question the effectiveness and appropriateness of rescue, evacuation and the emergency response. Reviewing the medical pathology used empirically to establish that death was instantaneous and evaluating the treatment of the bereaved and survivors in the immediate aftermath were matters outside his remit. In the longest inquests in English legal history, the fans had been vilified and in the public consciousness the verdicts of accidental death appeared to clear the South Yorkshire Police and other organisations of culpability.

The judicial scrutiny

In late June 1997, soon after the election of the Labour Government and following a concerted campaign by families, the Home Secretary Jack Straw acknowledged that their grief had been 'exacerbated by their belief that there are unresolved issues which should be investigated further'. He proposed an unprecedented judicial 'scrutiny' of any 'new' evidence and appointed senior appeal court judge and former MI6 Commissioner Lord Justice Stuart-Smith to review 'further material that interested parties wished to submit'.³⁶ The Scrutiny's terms of reference were limited to 'new' evidence 'of such significance' that it could lead to criminal prosecutions or disciplinary actions. Stuart-Smith would 'advise whether there is any other action which should be taken in the public interest'.

Supported by a Home Office team, Stuart-Smith viewed the South Yorkshire Police Archive that held the documents gathered by the West Midlands Police in their investigation. He also visited Sheffield Wednesday Football Club. On 6 October 1997, in Liverpool, he met the bereaved families emphasising that they should restrict their submissions to the Scrutiny to 'fresh evidence'.³⁷ From all material reviewed and submitted he would establish any grounds 'for a new public inquiry, new inquest or any other kind of legal proceedings or action by the authorities'.

Stuart-Smith accepted Taylor's findings that the failure to close the tunnel once exit Gate C had been opened was 'a blunder of the first magnitude'. He noted that Taylor had been 'highly critical of the police operation' and had criticised Sheffield City Council, Sheffield Wednesday Football Club and the safety engineers. While accepting the Taylor Report's findings, he told families the accidental death verdicts were not inconsistent with deaths caused by a degree of negligence or breach of public duty.

Thirty-four families made written submissions, eighteen attended family meetings with Stuart-Smith. He interviewed fourteen further witnesses, and drew on sixteen others for assistance 'on various aspects' of his work. His report was

published in February 1998.³⁸ In the House of Commons, the Home Secretary stated that the Scrutiny had been ‘thorough’ and ‘impartial’ but had found no new evidence of substance.³⁹ It rejected allegations that video evidence had been suppressed and false evidence given, denied that the 3.15pm cut-off had limited the scope of the inquests and dismissed the suggestion that the process of review and alteration of police statements within the South Yorkshire Police constituted an ‘improper attempt’ to ‘alter the evidence’ of witnesses. Thus, concluded the Home Secretary, there was ‘no basis for a further public inquiry’ or ‘for a renewed application to quash the verdict of the inquest’ and ‘no material’ to interest the DPP or police disciplinary authorities. Stuart-Smith had been ‘dispassionate’ and ‘objective’, delivering ‘an independent, thorough and detailed scrutiny of all the evidence that was given to the committee’.

Realising that the Stuart-Smith Scrutiny was the last opportunity for a full review of all archived material, the families were devastated by the Report and the conclusions drawn by the Home Secretary:

From the moment he talked to us in Liverpool it was clear what he was about. He made that awful comment about families arriving late ‘like the fans did at Sheffield’ and I knew then it was going nowhere.

We met with him and it was a battle just to get him to understand what we were saying. What more could we have done? His mind was made up.

He came to Liverpool after a few days in Sheffield. How could he have gone through all the documents there in that time? He was guided – by the Home Office police department and by the South Yorkshire Police. It was a show by Straw to get us off his back. I’m telling you now, we’re not going anywhere.

Determination, disclosure and acknowledgement

Undeterred by the High Court’s ruling against their challenges to the sufficiency of inquiry, conduct and verdicts of the inquests and by Stuart-Smith’s rejection of new evidence, the families sought redress in a private criminal prosecution for manslaughter of the Match Commander, David Duckenfield, and his assistant, Bernard Murray.⁴⁰ In July 2000, after a seven-week trial and a sixteen-hour deliberation, the jury acquitted Murray and was unable to reach a verdict on Duckenfield. The judge refused a retrial. As the families, many in tears, left Leeds Crown Court they were filmed by West Yorkshire Police whose police support units in riot gear were on stand-by:

After all we’d been through, and we had behaved throughout with dignity to honour our loved ones, what did they think we were going to do? That was the last straw.

We were walking in small groups, huddled together supporting each other, most of us bereaved parents and they treated us like criminals. It was all a show for the TV cameras. But what did it tell the world? The same slurs against those who died were now put on us. We had to relive the allegations they made against our kids – in the inquiries, the inquests, the papers and at the trial. Their reputations, ours as well, were dragged through the mud.

I looked around at the faces of the families – so much sadness – and I was deeply dismayed to see armed police behind us ... was there any need for that and to this day I ask myself why, what on earth they thought we could or would do. It left a bitter taste. I felt utterly dejected and wanted to sit in a corner. I thought this would last a short while but I was on my knees for a long time. It left me feeling inadequate and I had a deep feeling of despair.

Following the private prosecution the expectation was that ‘the end of the road had been reached’. Interviewed in 2008, a bereaved mother stated, ‘I think we were expected to go away, to move on and we were told endlessly that closure would be for our own good’.⁴¹ This advice underestimated the impact on families and survivors not only of their loss and trauma but also of experiencing inadequate investigations, unreliable evidence, flawed inquests and an inconclusive private prosecution, compounded by hostile media coverage. Their emotions were a complex mix of loss, anger, guilt, failure and inadequacy. Another bereaved mother commented, ‘They took away our children and they took away our grandchildren, what they would have become ... you can’t stop that hurt or that anger’. A third bereaved mother was adamant that fans had ‘died so unnecessarily’ and the investigation, inquests and lawyers ‘let us down’.

As the twentieth anniversary of the disaster approached, families remained committed to finding an avenue to challenge the previous rulings and inquest verdicts. Universally they expressed the ‘smouldering anger’ they felt whenever Hillsborough was misrepresented in the media. A bereaved father noted how that brought ‘depression and despair ... and I can’t sleep at night until I put it right’. A bereaved mother rejected the notion of ‘justice ... there’s no justice for a life ... I still cry over the way we were all treated and the way the dead were treated. They had no rights, we had no rights, so don’t talk to me about justice!’ A bereaved sister ‘would never again hand the responsibility for justice to the police, the coroner or the judiciary ... Hillsborough shows how when dealing with powerful vested interests against the likes of us the judicial system fails to its core’. A bereaved father reflected that ‘given all the evidence, it’s impossible to believe or bear’ that ‘twenty years on no-one is held responsible for one of sport’s biggest disasters’. At the first memorial service he met Prime Minister Margaret Thatcher, ‘She tried to reassure us by saying there would be no cover-up, no whitewash ... she should have continued by saying there will be no justice.’

Twenty years on, what were the families seeking? A bereaved mother stated: 'I don't want vengeance, I don't believe in an "eye for an eye"'. Nineteen years ago it was different ... but not now. I felt vengeance then and realised it was eating me up'. A bereaved sister stated that 'if the source of the anger doesn't disappear, then the anger won't disappear'. It could only be resolved through 'full acknowledgement of and responsibility for the disaster'. A bereaved mother agreed, 'My loss is constant, you learn to live a different life ... the authorities all thought we were after money, big claims, but all we wanted was the truth and for someone to say "We made a terrible mistake, 96 died and we are sorry"'. A bereaved father stated, 'we have been through the pain barrier so many times and we continually hope that one day someone will stand up and admit their mistakes'. Another mother stated, 'there can be no conclusion to my grief but we demand acknowledgement and accountability ... for them to stand up and say "We got it wrong." All I want now is the truth to come out, from them.'

A bereaved sister broadened the focus to include those who had died in the two decades following the disaster:

I'm just upset that so many parents and other family members are passing away without ever having had an apology or any other form of justice. The names of our loved ones remain tarnished, with some members of the public still believing it was fans that caused their deaths. The insight we've had over the past 20 years into the cover ups that have gone on is appalling and still needs addressing. They say time heals ... but in our case it hasn't.

On the anniversary, invited by the Hillsborough Family Support Group (HFSG), Minister for Health Andy Burnham MP addressed over 30,000 people attending the annual memorial service at Liverpool FC's Anfield stadium. He praised the 'dignity', 'resolve' and 'remarkable courage' of the bereaved families in coping with their loss while campaigning for justice, noting that as a city Liverpool had 'unified in a simple statement of defiance' demonstrating a 'spirit of community and solidarity never to be broken no matter how great the adversity'. After his address he stated that he confirmed his claim that Hillsborough represented 'a major injustice'.⁴² And since the bereaved and survivors had not had access to the facts, supported by Liverpool MPs, he 'called for full disclosure of any further documents that have not been put in the public domain and are held by any public body'. For, 'the public interest lies very clearly in full disclosure of all such information, so that the families and others can make their judgement on all the facts'.

As a consequence of Burnham's statement, the HFSG submitted a proposal to the Home Office on truth recovery and acknowledgement providing a comprehensive overview of the issues to be addressed by full disclosure of documents generated by all inquiries and investigations.⁴³ Primary concerns centred on the context and circumstances of the disaster, how families had been treated in the

immediate aftermath, the failures in emergency response, the conduct of the investigations, the medical evidence and the 3.15pm cut-off and insufficiency of inquiry by the Coroner and the Scrutiny. The HFSG proposed that disclosure should increase public awareness and understanding of the circumstances and immediate aftermath of the disaster, emphasising that the 'right to truth' and the 'right to remedy' were fundamental to the 'public interest'. It requested that all statutory and non-statutory agencies should release documents to families without redaction to be analysed by an independent research team.

In December 2009, following the HFSG's unrelenting campaign, the Bishop of Liverpool, James Jones, was appointed by Alan Johnson, Home Secretary, to chair the Hillsborough Independent Panel (HIP) supported by a full-time secretariat and by an independent research team. Disclosure was negotiated primarily with the South Yorkshire Police and with contributing organisations including Sheffield-based agencies, public authorities, private companies and individuals. The Panel met on thirty-six occasions between February 2010 and the launch of its report in September 2012. Its terms of reference committed to 'maximum public disclosure' of all documents held by central and local government and other public agencies, and to publishing a comprehensive report demonstrating how the disclosed material 'adds to public understanding' of the disaster, its context, circumstances and aftermath.⁴⁴ Documents were to be disclosed 'initially to families', thus establishing at the outset the principle of 'families first'. The Panel would also oversee the establishment of the Hillsborough Archive as a repository for all primary documents disclosed.

Over eighty organisations and many individuals released documents and other materials. Following consultations with the HFSG and reflecting the central 'unanswered' questions and anomalies identified by previous alternative accounts, the scope of disclosed material prioritised: the decade prior to the disaster, specifically the structural condition of the stadium, crowd safety and crowd management; the circumstances prior to the 1989 semi-final including debriefings from 1987 and 1988; the 'moment' of the disaster; the immediate aftermath; and the investigations and inquiries that followed.

Presented first in closed session to the bereaved families at Liverpool's Anglican Cathedral on 12 September 2012, the twelve chapters within the 395-page report presented 153 key findings.⁴⁵ Detailing analysis of all relevant contextual documentation for the decade prior to the disaster, the research demonstrated that the safety of the crowd had been compromised by institutional complacency and neglectful custom and practice. The research found that access to the stadium, crowd management by the Club managers, their stewards and the South Yorkshire Police, structural alterations to the stadium, access to the central pens via the 1 in 6 gradient tunnel, emergency egress from the pens and the monitoring of crowd capacity within the pen, were each known deficiencies. Given a near disaster on the terrace at an FA Cup Semi-Final in 1981, the research concluded that the risks were known and the crushing on the terraces was foreseeable.

Following that near tragedy, the stadium had not been hired for FA Cup semi-final matches until 1987. During that fallow period, the documents revealed a breakdown in the relationship between Sheffield Wednesday Football Club and the South Yorkshire Police. The stadium failed to meet minimum safety requirements, inspections were inadequate and Sheffield City Council's safety certificate was out of date. Following the installation of pens on the Leppings Lane Terrace, there was no method for monitoring crowd distribution between the pens, rendering the designated capacity for each pen meaningless.

In the months following the disaster, the Health and Safety Executive (HSE) investigated the technical aspects of the incident.⁴⁶ It concluded that the maximum pen capacities had been set too high, particularly in Pen 3 where most deaths occurred. The structural alterations to the terrace between 1981 and 1985, introducing lateral fencing, had not been evaluated and the safety barriers, in location and height, were structurally deficient. Access through the turnstiles was between 2.9 and 3.5 times higher than in other areas of the stadium, making congestion at the bottleneck approach to the turnstiles inevitable at capacity-crowd matches. The HSE reports revealed the terrace to be structurally unsafe on every significant safety factor: restricted access and inadequate turnstile provision; the 1 in 6 gradient tunnel into the central pens; overestimation of safe capacity; deficiencies in safety barriers; inhibited egress at the front of each pen.

The institutional tension between the club's management and the police, particularly ambiguity concerning responsibilities for the safety of the crowd, contributed to the failure to respond quickly and effectively to the developing crush in the central pens. A regulatory mindset prevailed, anticipating crowd disorder while compromising crowd safety. Yet documents showed there had been crushing at the turnstiles and in the central pens in 1987 and 1988, remedied by closure of the feeder tunnel into the central pens and the redirection of fans to the sparsely populated side pens. None of these issues had been recorded in the police debriefings. On taking the decision to open exit gates in 1989 to relieve the crush at the turnstiles, it did not occur to the Match Commander, in post for only twenty-one days, or to the police officers on the concourse, to close the tunnel. Yet it was clear that the central pens were packed.

The research examined all available documentation concerning the emergency response. As stated previously, the inquest was denied the opportunity to hear and examine evidence from the emergency services. Yet analysis of the disclosed documents shows that the emergency services failed to instigate the agreed major incident plan, there was a failure by senior Ambulance Service personnel in the stadium to recognise the crisis in the pens and an initial breakdown in leadership, co-ordination of the incident and prioritisation (triage) of casualties.

The significance of the effectiveness of the emergency response and its potential to have saved lives hinged on the Coroner's position, supported by the team of pathologists who conducted the post mortems, that death due to asphyxia was inevitable within four to six minutes after receiving their injuries. Reappraising

the medical evidence from the contemporaneous records revealed the fallacy underpinning this assumption. Those who suffered partial asphyxiation did not die swiftly and the research concluded that a better focused and properly equipped response could have saved lives. This endorsed the opinion of several doctors and nurses who were spectators and attempted resuscitation.⁴⁷ While, as discussed earlier, the Judicial Review unreservedly supported the Coroner's interpretation of the medical evidence and his decision not to consider the emergency response, the research demonstrated the fallacy of assuming a consistent pattern of injury and death applicable to all cases.

All ninety-six post mortem reports were reassessed. In twenty-eight cases there was no evidence of traumatic asphyxia obstructing blood circulation and death would have taken significantly longer to occur than stated in evidence at the inquests. In thirty-one cases the heart and lungs had continued to function after the crush, in sixteen for a prolonged period. The analysis showed conclusively that in forty-one of the deceased the asphyxia was potentially reversible. Further, once pulled from the pens, if placed in a position that restricted their airways, the chances of recovery were compromised. Thus the Coroner's decision to eliminate evidence after 3.15pm regarding the emergency response, and its endorsement by the High Court, despite contrary medical evidence submitted, were predicated on a flawed interpretation of the initial pathology. Further, the Coroner's interpretation and gathering of medical evidence was also controversial in his unprecedented decision to record and publish blood alcohol levels of all who died, including children.

At the inquests, 'expert' evidence was presented correlating the deceaseds' time of arrival in the pens and the amount of alcohol consumed. The widely reported inference was that those who arrived later or minutes before kick-off were drunk and their impetuous behaviour in forcing entry into the stadium had contributed to the disaster. The research re-analysed the data and concluded that alcohol levels among those who died were unremarkable and the suggested correlation was inappropriate and misleading. However, the disclosed documents also revealed that that criminal record checks on all who died and had any recorded blood alcohol level were conducted via the Police National Computer. Clearly the initial, widely reported police allegations that fans were drunk and aggressive influenced the Coroner in ordering the recording and publication of blood alcohol levels and the subsequent attempts by the police to use criminal records in support of those allegations.

Following the criticisms levelled against the South Yorkshire Police in the Taylor Report, its Chief Constable stated publicly that a contrasting interpretation of events would emerge at the inquests. This was the tenor of the inquests and the accidental death verdict was interpreted as a reversal of Taylor's findings. Despite the endorsement of the inquests in the High Court ruling and the Stuart-Smith Scrutiny, the disclosed documents expose fundamental flaws in procedure including: preliminary hearings before a jury without the possibility

of examining synopsis evidence presented to the Court by investigating police officers; differential access between parties to information gathered by the criminal investigation; the imposition of the 3.15pm cut-off. Taken together, the families' concerns regarding insufficiency of inquiry were justified. Politically and ideologically, the inquests were used as a vehicle to revive the spectre of fans' extreme behaviour. Senior police officers repeated unsubstantiated allegations previously rejected and criticised by Taylor. The renewed allegations were reported widely in the press.

In establishing how the disclosed documents add to public understanding of the context, circumstances and aftermath of the disaster, the research analysed the channels through which unsubstantiated allegations, after their rejection by the judicial inquiry, resurfaced and came to be widely disseminated. The research showed that in the days following the disaster four police officers, the local Police Federation Secretary and Irving Patnick, a Sheffield constituency Conservative MP, were the sources of the allegations. Their conduit was a local press agency, White's, and, as detailed earlier, the allegations were reported in newspapers, most notoriously the *Sun*. The allegations, however, were not made in a vacuum. At a Police Federation meeting four days after the disaster, the Chief Constable stated the 'truth could not come from him' yet he gave his officers a 'free hand' to engage the media, stating that his senior team was 'preparing a defence ... a rock solid story'.⁴⁸ He commented, 'the Inquiry team could be directed but if we sit back and let them collect the evidence, we would lose it. We have to do it ourselves'. The Force, he assured the meeting, was to be 'exonerated' for, 'if anybody should be blamed, it should be the drunken ticketless individuals'.

The Chief Constable's assurance reflected his confidence in the statement-taking procedure already initiated with his senior staff. Aware that the West Midlands Police would be leading the investigation, South Yorkshire senior officers took the unusual decision to abandon pocket-book entries and 'make records of their recollections'.⁴⁹ The Chief Constable was determined that his officers should be 'the authors of most of the information fed' to the investigations. Within five days of the disaster, the South Yorkshire Police adopted a process through which all officers on duty submitted handwritten accounts of their full experiences on the day. These 'self-taken statements' were typed, submitted for 'review' to the Force solicitors, Hammond Suddards, and returned to a senior officer with recommendations for their alteration. Officers were visited by a member of the South Yorkshire Police review team and advised to change their statements. The statements were duly completed and signed to comply with Criminal Justice Act Rules. The documents record legal counsel for the South Yorkshire Police stating that the process 'couldn't be better. They can put all the things in that they want and we will sort them out.'⁵⁰

First revealed in submissions to the Stuart-Smith Scrutiny and published in detail in 1999, the review and alteration process was not only accepted by the West Midlands Police but also by Lord Justice Taylor.⁵¹ The HIP research established six review and alteration categories: grammatical clarification; informal or coarse

language; criticisms of the police response or inadequate leadership; poor communications or inadequate radio contact; deletion of references to ‘chaos’, ‘fear’, ‘panic’ or ‘confusion’ among officers; abusive criticism of supporters. Central to the process was a determination to alter or delete statements ‘unhelpful to the Force’s case’ and this occurred in 116 of the 164 statements identified for substantive amendment.

The Hillsborough Independent Panel’s Report concluded that there was ‘no evidence among the vast number of disclosed documents’ and supporting material ‘to verify the serious allegations of exceptional levels of drunkenness, ticketlessness or violence among Liverpool fans’.⁵² Further, there ‘was no evidence that fans had conspired to arrive late at the stadium and force entry and no evidence that they stole from the dead’. What was clear, however, was that previous investigations and inquiries had failed to reveal the full extent of the stadium’s structural deficiencies and the institutional complacency and negligence in managing and policing the venue.

While Taylor had criticised the South Yorkshire Police and other agencies, the primary causes of the disaster remained under-researched. This extended to the inadequacies of the emergency response, the flawed pathology and the unreliability of medical evidence presented to the inquests as incontrovertible. The criminal investigations were limited and evidence presented as factually accurate, from police and ambulance officers, had been reviewed and altered. Despite their length and complexity, the inquests procedurally were irregular and evidentially insufficient. Finally, senior police officers and the Police Federation purposefully manipulated the media in an attempt to deflect responsibility onto the fans.

The bereaved families and survivors were overwhelmed by the unqualified exoneration of those who died and survived, and the clear attribution of responsibility for the disaster to profound, foreseeable institutional failings within the custom and practice of the public and private agencies involved. Their response was immediate:

We have campaigned for 23 years for this but we never thought it would happen. It’s unbelievable – not the findings – but that it was all there and is now made public. All along we’ve been lied to, even our own lawyers let us down, but now it’s there for all to see.

Deep down I knew it, I was there [at the stadium] and saw what happened with my own eyes. However much I had faith in the Panel, I never thought the truth would come out. But now the Government has to listen.

We’ve been in this situation so many times. Lawyers, politicians, journalists – they all told us they believed the system had failed, that there was no justice and they made their promises. Yet there was always a ‘but’. Today it was all said, straight out, and there were no ‘buts’.⁵³

On the release of the Report, Prime Minister David Cameron responded in detail to a packed House of Commons. He made: 'a proper apology to the families of the 96 for all they have suffered over the past 23 years' for they had 'suffered a double injustice'.⁵⁴ The first was 'injustice of the appalling events – the failure of the state to protect their loved ones and the indefensible wait to get to the truth'. This was followed by 'the injustice of the denigration of the deceased – that they were somehow at fault for their own deaths'.

Within a month, the Director of Public Prosecutions announced the Crown Prosecution Service (CPS) would 'consider' the material disclosed by the HIP, 'whether there is now sufficient evidence to charge any individual or corporate body with any criminal offence'.⁵⁵ Two days later, the Independent Police Complaints Commission (IPCC) stated its intention to investigate the broad range of potential police misconduct as the HIP Report had 'revealed extremely serious and troubling issues for the police'.⁵⁶ Debated in the House of Commons, Home Secretary Theresa May stated that the findings were 'shocking and disturbing', the Report was 'comprehensive' and gave the government's commitment to, 'in the words of some of the families, move from truth to justice'.⁵⁷ Simultaneously the Secretary of State for Health, Jeremy Hunt, apologised for 'the part that the NHS played in their grief, both at the time and in any attempt to conceal those failings in the 23 years since'.⁵⁸ He had initiated a review of all procedures concerning emergency response to disasters, including ambulance services, hospital responses and medical pathology.

Responding to the detailed critique of the inquests and 'in the public interest', the Attorney General applied to the High Court to quash the verdicts to enable new inquests to be held.⁵⁹ The High Court concluded in the 'interests of justice' the 'combination of circumstances ... makes inevitable the order for a new inquest'. A fresh inquest was necessary to cast 'light' on the 'truth' thus 'the families of those who died in this disaster will be vindicated and the memory of each victim will be properly respected'.⁶⁰

Seeking the 'echo and the answer'

Throughout the campaigns, the Hillsborough bereaved and survivors reiterated their demands for truth, for accountability, and for acknowledgement. This was neither vengeful nor an abandonment of potential prosecutions. They had endured three manifestations of injustice: loss or trauma as a consequence of a foreseeable and avoidable tragedy; transference of culpability to the dead and survivors by those institutionally responsible; abject failure of the partial investigations. Cohen notes that the state operates three well-rehearsed 'techniques of denial': literal – nothing happened; interpretive – what happened is really something else; implicatory – what happened is justified.⁶¹ These techniques underpin a 'strategy of turning a defensive position into an attack on the critic'.

The disclosed documents show that institutional responsibility for crowd management and safety at Hillsborough was unresolved. Its consideration was absent from match planning, operational orders and post-event debriefings. The priority was regulation and control. In the immediate aftermath of the disaster, however, senior officers were aware that their planning, organisation, responsibilities and decision-making would be scrutinised. They reconstructed events, reviewed and altered statements and, via a press agency, blamed the deceased and survivors. Within hours this 'interpretive denial' influenced both the Coroner's decision to record blood alcohol levels and the conduct of the medical pathology. It also constituted the briefing given to the Prime Minister. Turning a 'defensive position into an attack', it spun the story that a 'mob tanked up on drink' had conspired to force entry, their recklessness killing others. In presenting this reconstruction of 'what really happened' as 'something else' the police deflected collective and individual culpability. They argued that opening Gate C without closing the tunnel was justified to deal with a 'drunken', 'violent', 'ticketless' mob determined to enter.

Given the negative reputation ascribed to soccer fans, the portrayal and condemnation of their behaviour at Hillsborough was not difficult to exploit within popular discourse. Labelled 'beasts' or 'animals', the imagery was dehumanising and demonising. Their humanity and morality negated, any dreadful act, for example the alleged sexual, verbal abuse directed at a dying young woman, was attributed and believed. Such de-contextualisation, to paraphrase Cohen, neutralises the acts and omissions of those responsible. Thus the condemners – those fans who bore witness and testified – became the condemned.

The dead and the survivors were demonised through Duckenfield's initial deceit, the recording of blood alcohol levels, the 'ticketless' conspiracy theory, the callous treatment of the bereaved and the promotion of vituperative allegations using a complicit print media as a conduit. These were the foundations on which the 'truth' was reconstructed, actively promoted and propagandised. Structural and institutional deficiencies in crowd safety and management alongside egregious failures in the duty of care were deflected and neutralised by a public discourse and formal defence that the disaster was self-inflicted.

Hillsborough illustrates the capacity within state institutions to engage in discourses of deceit, denial and neutralisation that protect and exonerate those in positions of power, those who stand highest in established hierarchies of credibility. Politically and ideologically the 'view from below' was subordinated and disqualified. Official discourse and legal defences were orchestrated to protect powerful public and private interests responsible for the disaster. As Foucault argues, these constitute the 'mechanisms', 'means', 'techniques' and 'procedures' underpinning the state's 'régime of truth'.⁶²

Analysis of the documents reveals that the disaster's investigation and inquiry were tainted by 'mechanisms' and 'procedures' through which the truth was reconstructed. Throughout two decades, captured in families' and survivors' interviews, an alternative discourse has exposed the mendacity within institutions

and their professional cultures, the abuse of discretionary powers, and the collective deficit of state investigations, judicial inquiries and coroners' inquests in delivering justice.

The suffering of bereavement and survival has been exacerbated by the continual torment of injustice embedded in the failures of formal inquiry and criminal justice. As families' accounts show, their collective 'view from below' memorialised loved ones while laying the foundation for independent research of documents. Their persistent campaign has provided a template for others to follow. The research, however, should not be represented as 'truth recovery' because the documents were never lost. They lay in un-catalogued archives, unfiled cabinets and in personal collections across numerous organisations, each with institutional interests to safeguard. They were available to, but neutralised by, the processes of investigation, inquiry and scrutiny. This allowed their powerful evidence to remain hidden while myth prevailed. In bringing them together as the Hillsborough Archive, in placing them in a public space curated and referenced, online and in hard copy, their 'truth' has been liberated.⁶³

Ariel Dorfman's play, *Speak Truth to Power*, is prefaced by his acknowledgement of the endurance and survival of those who had witnessed and testified against acts of violence and torture inflicted by state agents on loved ones, friends and communities:

They found a way of speaking out, the men and women whose voices have now reached us decided that they could not live with themselves if they did nothing, they could not stain their lives by remaining silent. They understood that if they witnessed this suffering inflicted on themselves or on others, and did nothing, they were, in some twisted way, being turned into accomplices ... They had to face the long nights when it seemed nobody cared, when the darkness of apathy seemed to surround them, when their voices did not seem to receive the echo and answer that they needed.⁶⁴

'Remaining silent' was not on Eddie Spearritt's agenda when he addressed the inquest. At that moment, however, neither he nor the families and survivors present in court anticipated it would take over twenty years for the 'echo and answer' to be received, thus breaking the silence of a state indifferent to their suffering.

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