Learning from 'near-misses': a case study

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Introduction

According to Professor Brian Toft (1992) one of the ways to build a safer physical environment is to learn and apply the lessons of past disasters. In Britain such 'isomorphic learning' has provided for safer building structures (following the Summerland fire of 1973), for better controls on drugs (following the Thalidomide medical scandal in the 1960s) and for better management of industrial waste (following such acute and chronic disasters as Aberfan in 1966 and the ongoing contamination of the Irish Sea with nuclear waste products). Following the Southall train crash of September 19, 1997 and Paddington rail disaster of October 5, 1999, isomorphic learning may even provide for a safer rail transport system in the United Kingdom after years of lazy government, sloppy management and under-investment in basic safety infrastructure. It should not be forgotten, however, that equally important lessons can be learned from near misses - provided, of course, that they are recorded (a prerequisite being that participants are willing and able to talk about their experiences), analysed and acted upon. This article is based on the premise that we can learn as much (if not more?) from near misses as we can from full-blown disasters.

The case study

The case study is of a near miss crowd disaster in the early 1980's. The data is derived from the personal testimony of a police officer present at the event in question. (This officer has since been promoted to a senior position in the same Police force). Despite the passage of time, and much intervening safety legislation, the event described below is relevant and significant even today. First, because it seems to corroborate the accusation that, at this time in the United Kingdom, the Police (regardless of the County in question) were more concerned with issues of public order than public safety at major gatherings. Secondly, because it demonstrates the potential negative consequences of didactic, uniplex, hierarchical command structures. Thirdly, because it shows how police officers (and, potentially, other officials) can become so wedded to a strategy that they fail to notice (or choose to ignore?) its disintegration or complete collapse. And fourthly, because it demonstrates the need for effective communication and coordination between the organisers of an event, the Police and attendees.

What is perhaps most interesting from a historical perspective is that some of the potential lessons of the near miss described below appear to have been applied (coincidentally, it must be said) later in the decade by Greater London's Metropolitan Police Service (MPS). Thus in 1988 the MPS embarked on a very successful innovation at the trouble-prone Notting Hill Carnival - that of policing the event with the consent and cooperation of the Carnival's 'steakholders' (the event's organisers, local traders, the London Borough of Kensington and Chelsea, the emergency services, London Underground Limited, musicians, vendors, attendees and other interested parties). The initiative, known to the MPS as 'The Way Forward', achieved a 92% reduction in crime at the Carnival. Its major feature is its 'corporatism' — the inclusion in the event's year-round planning cycle of anyone who might have a contribution to make to assessing the risks and opportunities of Carnival.

Despite the fact that the near miss described below took place some twenty years ago, the persistence of certain dysfunctional organisational behaviours and traits means it is still relevant; Even today, event organisers can fail to communicate effectively with the Police, and vice-versa. Even today, rigid command structures inhibit the multiplexing of valuable intelligence. Even today, Officers may 'construct' behaviour born of fear and/or panic as behaviour born of criminal intent. It can only be hoped that the organisers of today's global sporting events have the imagination to examine and learn from not only the high-profile disasters of the past, but also such near misses as that described below.

Current UK guidelines

According to the British Health and Safety Executive's (HSE's) recent publication *The Event Safety Guide* (HSE: 1999), it is the responsibility of the organisers of an event '... to provide an arena in which the audience can enjoy the entertainment in a safe and comfortable atmosphere' (p.12). To this end careful consideration should be given to entrances and exits, 'the available space for the audience' (p.12), barrier design, stewarding, public address systems and 'holding areas' to minimise the risks of tripping and crush-related injuries. Special attention should be paid 'to the needs of children and those with mobility difficulties' (p.51). Indeed, the Guide goes as far as to say that 'It may not be appropriate to allow young children ... to attend certain events because they may be trampled or crushed' (p.50). This and similar good advice contained in The Event Safety Guide deserves the widest possible audience. Certainly, the impacts of such well-known crowd-related disasters as Ibrox Park (in Scotland) and Hillsborough (in England) might have been mitigated had this advice been available at the time.

Learning from near misses

In my view it is not so much the well-publicised disasters of the recent past that make *The Event Safety Guide* and related HSE publications so important, but the - often unpublicised - near misses. Had these near misses developed into full-scale disasters, the loss of life at major public gatherings over the past thirty years would have been much greater. The fact that they did not evolve into full-scale disasters owes much to the efforts of numerous unsung heroes and heroines, many of them junior police officers. To illustrate this point, and to emphasise the importance of the work of the HSE and similar agencies in other countries, I reproduce below an account of a near miss. The account is taken from a narrative produced by one of the junior police officers who was on duty on the day of the event in question. For reasons of confidentiality, neither his name nor the exact location and details of the event can be revealed — the narrator is now a senior officer in the same northern English city that experienced the near miss.

The officer's narrative has received only superficial editing (to clarify certain points). The facts of the event (as recalled by the officer), and the tenor of the officer's narrative, have not been altered. The account is consequently reproduced below in the first person.

The testimony

'It was during the 1980s that the local football team returned from a major triumph at Wembley. The team paraded through the city in an open-top bus, to a civic reception held at the Town Hall. Outside thousands of people waited in the Central Square, to cheer the team as they appeared on the balcony.

In the Square, rigid and substantial barriers had been sunk into the ground. Police officers were situated in front of these barriers. As at Hillsborough, it was the more family-oriented groups who were at the front, pressed against the barriers, so that the young children could see better. The more vociferous and rowdy elements arrived later. Many were intoxicated.

For us this was a public-order operation. Our rules were dictated by our experience of football crowds. Unfortunately, this experience was tainted by a concentration on managing the aggressive and violent minority. Our attitudes towards crowds had been forged in the 1960s and 1970s during efforts to prevent hooliganism. We saw football fans as constituting a homogenous group. Discretion was rarely used in dealing with crowds, and not encouraged. Public safety was not a major issue in dealing with such events.

As the crowds became larger, the children at the front began to be pressed against the barriers. This caused distress amongst the children and their parents. We patrolled the barriers at a distance. This meant we could not hear the children crying. The crowd was not to be trusted or communicated with. Individually, we blocked our minds to what was occurring. This minimised the anxiety that can be produced when duty and conscience come into conflict. The acknowledgement of distress by those set in a confrontational, enforcement role can generate personal anxiety.

In my view the enforcement role needs to be balanced against a Police Constable's primary duty — the protection of life and property. This primary duty came to the fore during the celebration. Along the line of the barriers, police officers, on their own initiative, began to communicate with the parents. They then began lifting the smaller children out of the crowd, placing them in front of the barrier at their parents' feet.

Initially, the Sergeants, who were nearby, directed against the action taken. However, they quickly recognised the need to remove the children. The Police Inspector, who was further away from the crowd, issued similar commands until being persuaded by his Sergeants that the action was correct. However, the Police Superintendent (who had drafted the Operational Order), standing further away from the crowd, saw the action only as a disregard of his directions. The Superintendent approached the Constables, and ordered that the children be returned over the barrier. Our concerns [as Constables] were disregarded. The children were placed back over the barrier, causing great distress to the families. It should be noted that there was nowhere else for the families to go. The weight of the crowd was so great that they could not have retreated back through the crowd, and evacuating a family from the area by bringing them over the barrier would not have been considered. The barriers in the Square performed the same function as the crowd barriers that might be found in a stadium.

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The level of distress amongst the children became so great that, once the Superintendent had left, the Constables lifted them back over the barrier. This unauthorised action brought the Superintendent back again. (Why he chose not to follow the chain of command, and issue his orders through the Inspector and Sergeants, is a matter for speculation). On this occasion, he put the children back into the crowd himself. On voicing their concerns for the safety of the children, the Constables were told; 'It is against the [Operational] Order'. When it was suggested that the Operational Order could result in a fatality, the Superintendent replied; 'It is not your responsibility'. I find it difficult to be certain exactly what that remark meant. Perhaps the Superintendent was suggesting that Constables, in general, should not assume responsibility or use discretion, but should rather obey orders without question? Or, alternatively, was the Superintendent implying that the welfare of the children was not the concern of the Police? Whatever the answer, it is not my purpose to lay the blame solely at the feet of the Superintendent. All the Officers involved had commenced the operation with the same world view as he, but the exposure of the Constables to the distress at the barriers had persuaded them to use their initiative. It is possible that distance from the crowd played a part in the different forms of behaviour exhibited by police officers.

After the Superintendent left the area the children were again lifted out of the crowd and placed in front of the barriers. If the barriers had failed, and caused the crowd to fall onto the children, the Constables would undoubtedly have been pilloried for their actions, but their view was that fatalities may have occurred if they had not acted.

As the day progressed, the Square became very congested, with surges from the rear of the crowd causing intense pressure against the barriers at the front. The 'show' on the Town Hall balcony increased in pace and energy. The Officers adjacent to the barriers were now removing adults who were suffering from distress and crush-related injuries. So great was the pressure at the front of the crowd that injured or fainting persons could not be removed without forcing back the people around them — they were gripped vice–like by the crowd and unable to move. The act of pushing people back to make the necessary space caused further injury.

The injured parties, who were suffering from suffocation, dehydration, fractured ribs and leg injuries, were taken to ambulances. After the event there was no de-brief and no attempt was made to learn from the day's events. This would tend to indicate that the event was seen only in terms of public order issues.

There are a number of similarities between the incident above and the Hillsborough disaster; for example, the delay in recognising the physical distress of some of the crowd. But there are also important differences between the two events. At Hillsborough there was the potential for aggression between rival supporters. This was not the case in the Square. This may have facilitated communication between police officers and

the public. At Hillsborough the supporters and police officers came from different cities. There was no shared civic identity. Again this was not the case in the Square. This might have made it easier for Constables to empathise with the crowd'.

Discussion

Of especial interest in this incident was a) the emphasis placed by the Officer Commanding on the maintenance of public order and b) the emphasis placed by the Officer Commanding on the need for strict adherence to his Operational Order regardless of the potential negative impacts on public safety. In this respect there are similarities between the aetiology of this near miss and the aetiology of the Hillsborough disaster. Having said this, however, there is one very significant difference between the two incidents - while the former ended without loss of life (although there were injuries to attendees), the latter saw 95 people killed and 400 seriously injured. The former developed into a crisis. The latter into a disaster. The most pertinent question, of course, is why the two incidents ended so differently. The answer may lie in the initiative shown by junior officers at the earlier incident. As the testimony recounts; 'Police officers, on their own initiative ... began lifting the smaller children out of the crowd ...'. It might be said that junior officers present at the earlier event were more flexible in their understanding of the reasons for and dynamics of the situation than those at Hillsborough. This may explain the different outcomes.

Other lessons can also be drawn. For example;

- the need to understand and plan for the public safety aspects of 'spontaneous' civic celebrations (while not dampening public enthusiasm and enjoyment and not offending civic pride, of course). Given that the football team at the centre of the celebration stood a reasonable chance of winning their Cup match, the most propitious course of action would have been for the Police, civic authorities, football club and other relevant parties to have got together well before the putative day of celebration to make contingency plans.
- the need for flexibility (but not formlessness) in command structures, and for effective and respectful two-way communication between upper and lower echelons. It is interesting to note that at both this incident and at the Hillsborough disaster potentially useful risk assessment information obtained by those closest to the incident was either ignored or discounted by senior officers. While various intelligence-gathering technologies like CCTV can provide control room staff with potentially useful information, such images are, by definition, never more than a *mediation* of reality. They provide, at best, only an indication of the sociological and physical dynamics of an event. In light of such a limitation it would seem foolhardy to summarily exclude other intelligence-gathering mechanisms.
- the desirability, where appropriate, of delegating authority and responsibility to junior ranks (within a predetermined procedural 'envelope'). If this incident and Hillsborough show us anything it is that senior officers are often too far removed from the locus of an offence or safety threat to be able to make informed and timely decisions. Delegating an appropriate measure of authority is one way of overcoming this structural/institutional barrier to effective control and timely decision-making. Of course, this is not to say that senior commanders should eschew all structural constraints. That way lies anarchy. But, as Toffler points out in his seminal *War and Anti-War*, the delegation of an appropriate measure of authority to, in this case, front-line troops, encourages initiative and flexibility and enhances responsiveness to novel situations, with consequent improvements in performance.
- the need to solicit intelligence from both the organisers of an event and the public when making ongoing risk assessments of a developing situation. This is an extension of the previous point. Again, it would seem churlish to ignore the advice of anyone - even stewards and attendees - who might be able to make a contribution to 'the big picture'.
- the need to be able to control the 'pace' of the entertainment to (in some degree) influence the mood and behaviour of the crowd. At the Hillsborough Inquiry it was commented that the event might have been better controlled had the kick-off time been delayed. The ability to make adjustments to the timetable of an event is an important resource for those responsible for public order and safety.

Conclusion

It is clear from the above testimony that we have as much to learn from 'near-misses' as from actual disasters. The key, of course, is to persuade people to talk about actions and events that may, because of their potentially catastrophic outcomes, be painful and/or professionally compromising to recall. In the case described above, police officers were given no opportunity to discuss their experiences.

Consequently, the opportunity for isomorphic learning was lost. Perhaps the most alarming consequence of this missed opportunity is the thought that, had this incident been investigated, discussed *and acted upon*, it might have impacted the behaviour of the Police and other public and private authorities at subsequent sporting events—including Hillsborough.

References

Centre for Studies in Crime and Social Justice 1995, *No Last Rights: The Denial of Justice and the Promotion of Myth in the Aftermath of the Hillsborough Disaster,* Liverpool City Council/Alden Press, Liverpool.

Emergency Planning College 1994, *A Digest of Some Well-Known Disasters,* Home Office Emergency Planning College, Easingwold, York.

Taylor, The Right Honourable Lord Justice 1990, *The Hillsborough Stadium Disaster 15 April 1989. Final Report* (Cm.962), HMSO, London.

Toffler A. 1993, *War and Anti-War: Making Sense of Today's Global Chaos*, Warner Books, London.

Toft B. 1992, 'The Failure of Hindsight', *Disaster Prevention and Management: An International Journal*, Vol. 1, No. 3, November/December.

(UK) Health and Safety Executive 1999, *The Event Safety Guide*, HMSO, London.

Acknowledgement

My sincere thanks to the senior officer who gave permission to use his narrative in this article. The officer has lived alone with the events of that day for too long.

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