HM CORONER FOR SOUTH YORKSHIRE (EAST) AND WEST YORKSHIRE (WEST)

Inquests into the Deaths Resulting from the Hillsborough Stadium Disaster

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GENERAL QUESTIONNAIRE FOR JURY DETERMINATIONS

Notes for the Jury

1. This questionnaire has been prepared by the Coroner after receiving submissions from interested persons. By answering the questions, you will give your determinations on the key general issues in the case. All are intended to address the central question: by what means and in what circumstances did the 96 people come by their deaths?

2. After the inquests, a completed copy of this questionnaire will form part of the record of inquest for each of those who died in the Disaster. You are also being asked to complete separate individual questionnaires dealing with matters specific to each of those who died.

3. Under most headings, you are asked questions which call for a "yes" or "no" answer, and you are then given the option to explain further in a box. You are not obliged to fill in the box. Factors are then listed which you may want to consider, although you should feel free to give your own answers (provided that you follow the legal directions in these Notes and the Coroner's summing-up).

4. For most of the questions, you are first asked whether there was some error, omission or circumstance that caused or contributed to the Disaster. If you have answered "no" to that, you are then asked whether the same thing may have caused or contributed to the Disaster. If answering the second part of such a question, you will need to consider whether there is a realistic possibility that an error, omission or circumstance as described caused or contributed to the Disaster.

5. You may only say that something contributed to the Disaster if you consider that it made a significant (rather than minimal) contribution.

6. You should only give an answer to a question if all of you agree upon the answer. If you find yourselves unable to agree on an answer to one question, you may move on to the next and return to the question later.

7. In general, you should give your answers in accordance with the "balance of probabilities"; what is more likely than not. However please note:
   (a) If you are deciding whether something may have caused or contributed to the Disaster, you should consider whether there is a realistic possibility that it did so (see note 4 above).
   (b) Question 6 (headed "Determination on Unlawful Killing Issue") can only be answered "yes" if you are sure of various matters. Further details are given in the section at the end of this Questionnaire headed "Legal Directions on Question 6 (Unlawful Killing)".

8. If you choose to give further explanation in any of the boxes where you are given the option to do so, please follow these directions when writing your responses:
   (a) Your responses should all be directed to answering the question by what means and in what circumstances the deaths occurred. You should not make any statement or comment which does not assist in answering that question.
   (b) It might help you at each stage to consider the cause(s) of the deaths; any defects in systems and practices which contributed to the deaths; and any other factors which are relevant to the circumstances of the deaths.
   (c) You should try to be brief and to the point.
   (d) If you wish to write more than the space in the box permits, you may continue on a separate sheet. At the top of the sheet, you should write the number of the question and the words "Answer Continued".
   (e) You should not make any comment on any circumstance, act, omission or event unless there is at least a realistic possibility that it caused or contributed to the deaths.
   (f) You should not say anything to the effect that a crime or a breach of a civil law duty of any kind has been committed. Note that this rule does not affect your answer to question 6. Because of this rule, when writing any explanations, you should avoid using words and phrases such as "crime / criminal", "illegal / unlawful", "negligence / negligent", "breach of duty", "duty of care", "careless", "reckless", "liability", "guilt / guilty".
   (g) However, you may use ordinary and non-technical words which express factual judgments. So, you may say that errors or mistakes were made and you may use words such as "failure", "inappropriate", "inadequate", "unsuitable", "unsatisfactory", "insufficient", "omit / omission", "unacceptable" or "lacking". Equally, you may indicate in your answer if you consider that particular errors or mistakes were <u>not</u> made. You may add adjectives, such as "serious" or "important", to indicate the strength of your findings.
   (h) If you are uncertain about what may be written, you may ask a question in writing to the Coroner during your deliberations.

9. When considering what should have been done on the day of the Disaster or beforehand, please bear in mind the following points:
   (a) You should apply the standards of conduct of the time. So, when deciding whether individuals should have acted differently in 1989, you should apply the standards of 1989, not those of today.
   (b) You should consider what those involved could and should realistically have done in the circumstances which they were facing.
   (c) You should not make judgments which are based on hindsight, but should consider what those involved could reasonably have been expected to do at the time.

Question 1: Basic Facts of the Disaster

Do you agree with the following statement which is intended to summarise the basic facts of the Disaster: *"Ninety-six people died as a result of the Disaster at Hillsborough Stadium on 15 April 1989 due to crushing in the central pens of the Leppings Lane terrace, following the admission of a large number of supporters to the Stadium through exit gates."* Answer "yes" or "no".	**YES**

If you would like to add to or amend that statement, or give any explanation for your answer, please do so in the box below.

Question 2: Police Planning for the Semi-Final Match

Was there any error or omission in police planning and preparation for the semi-final match on 15 April 1989 which caused or contributed to the dangerous situation that developed on the day of the match? Answer "yes" or "no".	**YES**
If your answer to the question above is "no", please answer the following question. Was there any error or omission in police planning and preparation for the semi-final match on 15 April 1989 which may have caused or contributed to the dangerous situation that developed on the day of the match? Answer "yes" or "no".	

If you would like to give an explanation for your answer, please do so in the box below:

The jury feel that there were major omissions in the 1989 Operational Order including:

- specific instructions for managing the crowds outside the Leppings Lane turnstiles;
- specific instructions as to how the pens were to be filled and monitored;
- specific instructions as to who would be responsible for the monitoring of pens.

Please go to the next page for matters which you may wish to bear in mind when answering.

In answering Question 2, you may wish to bear in mind the following considerations:

- Evidence of events at matches played at Hillsborough before 1989 (including previous FA cup semi-finals), including any evidence of (a) overcrowding at the turnstiles and on the terraces; (b) matches which were considered successful; and (c) police tactics used at previous matches to avoid safety risks.
- Evidence of intelligence and information available to the police before the match, including (a) as to any particular problems expected and (b) as to arrival patterns of supporters.
- Whether or not the Operational Order and/or briefings to officers ought to have included any further references to risks, such as that of overcrowding.
- Whether or not the Operational Order and/or briefings to officers ought to have included explicit reference to further tactics, such as –
  (a) use of cordons or checkpoints on Leppings Lane;
  (b) monitoring by police of the filling of the west terrace;
  (c) a tactical option of closing access to the central tunnel to the west terrace; and/or
  (d) contingency plans, including for delaying kick-off.
- Whether or not there could and should have been some different distribution of the supporters of the two teams within the Stadium, or some different turnstile arrangement, in order to increase the number of turnstiles available for Liverpool supporters.
- Whether or not the system of allowing supporters to "find their own level" on the west terrace (as opposed to filling the pens one after the other) was satisfactory, and whether or not it involved safety risks which should have been foreseen and managed.
- Whether or not the police arrangements for chain of command and for communications between officers were satisfactory.
- Whether or not the police, in planning for the match with Sheffield Wednesday FC, acted satisfactorily; for example in relation to signage, contingency plans and entrance arrangements.
- Whether or not police training at the time of the Disaster was adequate, and whether or not any inadequacy affected police planning for the match.
- Whether or not the selection of senior officers should have been different, and in particular whether arrangements should have been made for a different senior officer to act as match commander, in view of the experience of the match commander.
- Whether or not senior officers did enough to prepare themselves for the match, having regard to their experience.
- If there were any failures of planning and preparation, whether or not they contributed to the Disaster or the deaths.

Question 3: Policing of the Match and the Situation at the Turnstiles

Was there any error or omission in policing on the day of the match which caused or contributed to a dangerous situation developing at the Leppings Lane turnstiles? Answer "yes" or "no".	**YES**
If your answer to the question above is "no", please answer the following question. Was there any error or omission in policing on the day of the match which may have caused or contributed to a dangerous situation developing at the Leppings Lane turnstiles? Answer "yes" or "no".	

If you would like to give an explanation for your answer, please do so in the box below:

Police response to the increasing crowds at Leppings Lane was slow and un-coordinated.

The road closure and sweep of fans exacerbated the situation.

No filter cordons were placed in Leppings Lane.

No contingency plans were made for the sudden arrival of a large number of fans.

Attempts to close the perimeter gates were made too late.

Please go to the next page for matters which you may wish to bear in mind when answering.

In answering Question 3, you may wish to bear in mind the following considerations:

- Whether or not, in the situation which they faced, senior officers could and should have done more to direct and manage the policing of the supporters at the Leppings Lane turnstiles.
- Whether or not officers, including senior officers, could and should have done more to observe, control and organise the supporters in the area immediately outside the turnstiles (e.g. by arranging better queueing systems or closing off the area between the service road barriers and the outer perimeter gates).
- Whether or not senior officers could and should have done more to identify the risk of a dangerous build-up of supporters at the turnstiles (e.g. by calling for turnstile count numbers and/or by making better observation of the crowd gathering).
- Whether or not senior officers could and should have done more to prevent or reduce the effects of a dangerous build-up of supporters at the turnstiles (e.g. by calling up reinforcements, establishing cordons and/or having the kick-off delayed).
- Communications difficulties faced by the police, and whether or not senior officers could and should have done more to overcome those difficulties.
- What action the police in fact took to deal with the situation (including calling for reinforcements and attempting to control outer perimeter gates); at what time they took this action; and what happened as a result.
- If there were any failures by police which you have identified, whether or not they contributed to the Disaster or the deaths.

Question 4: Policing of the Match and the Crush on the Terrace

Was there any error or omission by commanding officers which caused or contributed to the crush on the terrace? Answer "yes" or "no".	**YES**
If your answer to the question above is "no", please answer the following question. Was there any error or omission by commanding officers which may have caused or contributed to the crush on the terrace? Answer "yes" or "no".	

If you would like to give an explanation for your answer, please do so in the box below:

Commanding officers should have ordered the closure of the central tunnel before the opening of gate C was requested, as pens 3 and 4 were full.

Commanding officers should have requested the number of fans still to enter the stadium after 2.30pm.

Commanding officers failed to recognise that pens 3 and 4 were at capacity before gate C was opened.

Commanding officers failed to order the closure of the tunnel as gate C was opened.

Please go to the next page for matters which you may wish to bear in mind when answering.

In answering Question 4, you may wish to bear in mind the following considerations:

- Whether or not commanding officers could and should have done more to ensure that the filling of the pens in the west terrace was properly monitored (e.g. by giving instructions for other officers to observe and report, or by making further observations themselves).
- Whether or not, in the period before the start of the match, it was or should have been obvious to those in the police control box that the central pens of the west terrace were unusually or dangerously overcrowded.
- Whether or not commanding officers could and should have taken any further action in response to the apparent density of packing in the central pens of the west terrace (e.g. having access to the central tunnel closed) and, if so, when that action should have been taken.
- Whether or not commanding officers ought to have received information that they did not receive about the situation in the central pens of the west terrace (e.g. from other police officers).
- If there were any failures by commanding officers in these respects, whether or not they contributed to the Disaster or the deaths.

Question 5: The Opening of the Gates

When the order was given to open the exit gates at the Leppings Lane end of the Stadium, was there any error or omission by the commanding officers in the control box which caused or contributed to the crush on the terrace? Answer "yes" or "no".	**YES**
If your answer to the question above is "no", please answer the following question. When the order was given to open the exit gates at the Leppings Lane end of the Stadium, was there any error or omission by the commanding officers in the control box which may have caused or contributed to the crush on the terrace? Answer "yes" or "no".	

If you would like to give an explanation for your answer, please do so in the box below:

Commanding officers did not inform officers in the inner concourse prior to the opening of gate C.

Commanding officers failed to consider where the incoming fans would go.

Commanding officers failed to order the closure of the central tunnel prior to the opening of gate C.

Please go to the next page for matters which you may wish to bear in mind when answering.

In answering Question 5, you may wish to bear in mind the following considerations:

- Whether or not the commanding officers in the control box could and should have (a) observed the west terrace and (b) concluded that the central pens were too full to admit further supporters.
- Whether or not the commanding officers in the control box could and should have understood that the order to open the exit gates would lead to large numbers of supporters entering and many of those supporters going down the central tunnel.
- Whether or not the commanding officers in the control box could and should have appreciated that permitting many more supporters to go down the central tunnel would give rise to foreseeable risk of injury and death.
- Whether or not the commanding officers in the control box could and should have given any further order (before, at the same time as or after the order to open the exit gates) to prevent more supporters going down the central tunnel.
- What, if any, further order the commanding officers in the control box could and should have given (e.g. to close access to the central tunnel or warn officers of the likely opening of the exit gates).
- When any such order could and should have been given, and what (if any) effects it would have had.

Question 6: Determination on Unlawful Killing Issue

Are you satisfied, so that you are sure, that those who died in the Disaster were unlawfully killed? Answer "yes" or "no".	**YES – by a majority of 7 to 2**

Important Note:
When answering this question, please refer to the section at the end of this Questionnaire which is headed "Legal Directions on Question 6 (Unlawful Killing" (pages 30-31). That section contains important directions which you must follow carefully when answering this question.

Note that, as with other questions, you should only give an answer to Question 6 if all of you agree upon the answer.[1]

[1] At 10.45am on Monday 25 April 2016 the coroner gave the jury a majority direction on this question.

Question 7: Behaviour of the Supporters

Was there any behaviour on the part of football supporters which caused or contributed to the dangerous situation at the Leppings Lane turnstiles? Answer "yes" or "no".	**NO**
If your answer to the question above is "no", please answer the following question. Was there any behaviour on the part of football supporters which may have caused or contributed to the dangerous situation at the Leppings Lane turnstiles? Answer "yes" or "no".	**NO**
If your answer to either of the questions above is "yes", please answer the following question. Was that behaviour unusual or unforeseeable? Answer "yes" or "no".	

If you would like to give an explanation for your answer, please do so in the box below:

Please go to the next page for matters which you may wish to bear in mind when answering.

In answering Question 7, you may wish to bear in mind the following considerations:

- Whether or not some supporters at the Leppings Lane turnstiles behaved in a way which was unusually forceful or resistant to police control.
- If so, whether or not such behaviour of supporters had any effect on the dangerous situation which developed at the turnstiles.
- Whether or not there were significant numbers of supporters without tickets in the area of the Leppings Lane turnstiles.
- If so, whether or not their presence or behaviour there had any effect on the dangerous situation which developed at the turnstiles.
- Whether or not the numbers of supporters attending at the Leppings Lane end of the Stadium, their arrival pattern and/or their behaviour were such as could not reasonably be foreseen by experienced police officers.
- If so, whether or not these factors had any effect on the dangerous situation which developed at the turnstiles.

Question 8: Defects in Hillsborough Stadium

Were there any features of the design, construction and layout of the Stadium which you consider were dangerous or defective and which caused or contributed to the Disaster? Answer "yes" or "no".	**YES**
If your answer to the question above is "no", please answer the following question. Were there any features of the design, construction and layout of the Stadium which you consider were dangerous or defective and which may have caused or contributed to the Disaster? Answer "yes" or "no".	

If you would like to give an explanation for your answer, please do so in the box below:

Design and layout of the crush barriers in pens 3 and 4 were not fully compliant with the Green Guide.

The removal of barrier 144 and the partial removal of barrier 136 would have exacerbated the "waterfall effect" of pressure towards the front of the pens.

The lack of dedicated turnstiles for individual pens meant that capacities could not be monitored.

There were too few turnstiles for a capacity crowd.

Signage to the side pens was inadequate.

Please go to the next page for matters which you may wish to bear in mind when answering.

In answering Question 8, you may wish to bear in mind the following considerations:

- Whether or not the entrance area at the Leppings Lane end of the Stadium should have been constructed with dedicated entrances for each section of the west terrace, so that the numbers entering individual pens could be precisely monitored (e.g. by use of the electronic counting system).
- Whether or not the entrance area at the Leppings Lane end of the Stadium had too few turnstiles for a capacity match for which segregation was necessary.
- Whether or not the signage giving directions from the inner concourse to the west terrace areas (especially the entrances at the north and south ends) was adequate.
- The presence in the particular circumstances of Hillsborough of pitch perimeter fencing and radial fencing creating the pens on the west terrace, and any contribution it made to the Disaster.
- Whether or not the gates in the pitch perimeter fencing and the area around each gate were unsafe, in view of their potential use as exits from the pens in certain kinds of emergency.
- Whether or not capacity figures for the west terrace were correctly calculated and set when the Safety Certificate for the Stadium was issued in 1979.
- Whether or not capacity figures for the central pens should have been set or more clearly set (e.g. by inclusion in the Safety Certificate), monitored and enforced.
- Whether or not barriers and barrier arrangement in the central pens of the west terrace were satisfactory, given the capacity figures which were set.
- Whether or not any defects you have identified contributed to the Disaster or the deaths.

Question 9: Licensing and Oversight of Hillsborough Stadium

Was there any error or omission in the safety certification and oversight of Hillsborough Stadium that caused or contributed to the Disaster? Answer "yes" or "no".	**YES**
If your answer to the question above is "no", please answer the following question. Was there any error or omission in the safety certification and oversight of Hillsborough Stadium that may have caused or contributed to the Disaster? Answer "yes" or "no".	

If you would like to give an explanation for your answer, please do so in the box below:

The Safety Certificate was never amended to reflect the changes at the Leppings Lane end of the stadium, therefore capacity figures were never updated.

The capacity figures for the Leppings Lane terraces were incorrectly calculated when the Safety Certificate was first issued.

The Safety Certificate had not been reissued since 1986.

Please go to the next page for matters which you may wish to bear in mind when answering.

In answering Question 9, you may wish to bear in mind the following considerations:

- Whether or not the capacity of the west terrace (and/or the pens on that terrace) should have been clarified, reconsidered and/or recalculated after any developments and changes to the Stadium between 1979 and 1989.
- Whether or not those responsible for safety certification and oversight of the Stadium (the local authorities and the members of the Officer Working Party and the Safety at Sports Grounds Advisory Group) could and should at any stage between 1979 and 1989 have raised concerns:
  (a) about any features of the Stadium (including the west terrace and barriers there);
  (b) about entrance arrangements at the Leppings Lane end;
  (c) in response to any of the developments and changes to the Stadium; and/or
  (d) about capacity figures for the west terrace (and/or the pens on that terrace).
- If any concerns ought to have been raised at any stage, who (of those referred to above) should have raised those concerns and to whom should they have been notified.
- If any concerns ought to have been raised at any stage, what could and should have been done in response (e.g. proposing changes to structural features and/or restricting the numbers of people who could be admitted to the Stadium or areas of the Stadium).
- Whether or not any failure to raise concerns and take appropriate action contributed to the Disaster or the deaths.

Question 10: Conduct of Sheffield Wednesday FC before the Day of the Match

Was there any error or omission by Sheffield Wednesday FC (and its staff) in the management of the Stadium and/or preparation for the semi-final match on 15 April 1989 which caused or contributed to the dangerous situation that developed on the day of the match? Answer "yes" or "no".	**YES**
If your answer to the question above is "no", please answer the following question. Was there any error or omission by Sheffield Wednesday FC (and its staff) in the management of the Stadium and/or preparation for the semi-final match on 15 April 1989 which <u>may have</u> caused or contributed to the dangerous situation that developed on the day of the match? Answer "yes" or "no".	

If you would like to give an explanation for your answer, please do so in the box below:

The Club did not approve the plans for dedicated turnstiles for each pen.

The Club did not agree any contingency plans with the police.

There was inadequate signage and inaccurate/misleading information on the semi-final tickets.

Please go to the next page for matters which you may wish to bear in mind when answering.

In answering Question 10, you may wish to bear in mind the following considerations:

- Whether or not the Club should have done more in preparing for the match (e.g. discussions with the police and contingency planning), having regard to its obligations under the Safety Certificate.
- Whether or not the tickets issued by the Club for the semi-final match (in particular the map on the reverse) were unclear or misleading.
- Whether or not signs directing supporters to the banks of turnstiles in Leppings Lane on the day of the semi-final match were confusing.
- Whether or not there could and should have been additional signage or direction for supporters from the inner concourse to each section of the west terrace.
- Whether or not any failure by the Club to take appropriate action contributed to the Disaster or the deaths.

Question 11: Conduct of Sheffield Wednesday FC on the Day of the Match

Was there any error or omission by Sheffield Wednesday FC (and its staff) on 15 April 1989 which caused or contributed to the dangerous situation that developed at the Leppings Lane turnstiles and in the west terrace? Answer "yes" or "no".	**NO**
If your answer to the question above is "no", please answer the following question. Was there any error or omission by Sheffield Wednesday FC (and its staff) on 15 April 1989 which may have caused or contributed to the dangerous situation that developed at the Leppings Lane turnstiles and in the west terrace? Answer "yes" or "no".	**YES**

If you would like to give an explanation for your answer, please do so in the box below:

Club officials were aware of the huge numbers of fans still outside the Leppings Lane turnstiles at 2.40pm. They should have requested a delayed kick-off at this point.

Please go to the next page for matters which you may wish to bear in mind when answering.

In answering Question 11, you may wish to bear in mind the following considerations:

- Whether or not the Club's secretary or its employees based in the Club control room had responsibility to assist in monitoring conditions at the turnstiles and the rate of entry.
- Whether or not the Club's secretary or its employees based in the Club control room had responsibility to observe the situation on the terraces and advise the police of any matters of concern (including as to density of packing), having regard to the responsibilities of the police and the presence of a police officer in the Club control room.
- Whether or not the Club's secretary or its employees based in the Club control room had responsibility to tell the police about any concerns they might have and to make suggestions for action to be taken (e.g. delaying kick-off because of a build-up of supporters outside the ground).
- If the Club's secretary or its employees based in the Club control room did have any of the responsibilities set out above, whether or not they acted appropriately on the day of the match.
- If the Club's secretary or its employees based in the Club control room failed to take appropriate action on the day of the match, whether or not such failure contributed to the Disaster or the deaths.

Question 12: Conduct of Eastwood & Partners

Should Eastwood & Partners have done more to detect and advise on any unsafe or unsatisfactory features of Hillsborough Stadium which caused or contributed to the Disaster? Answer "yes" or "no".	**YES**
If your answer to the question above is "no", please answer the following question. Should Eastwood & Partners have done more to detect and advise on any unsafe or unsatisfactory features of Hillsborough Stadium which may have caused or contributed to the Disaster? Answer "yes" or "no".	

If you would like to give an explanation for your answer, please do so in the box below:

Eastwoods did not make their own calculations when they became consultants for SWFC, therefore the initial capacity figures and all subsequent calculations were incorrect.

Eastwoods failed to re-calculate capacity figures each time changes were made to the terraces.

Eastwoods failed to update the Safety Certificate after 1986.

Eastwoods failed to recognise that the removal of barrier 144 and the partial removal of barrier 136 could result in a dangerous situation in the pens.

Please go to the next page for matters which you may wish to bear in mind when answering.

In answering Question 12, you may wish to bear in mind the following considerations:

- Whether or not Eastwood & Partners correctly calculated capacity figures for the west terrace areas in 1979, and the reasons for any errors of calculation.
- Whether or not Eastwood & Partners could and should have identified any defects which you may consider existed in the stadium (for example, any defects in barriers and their arrangement).
- Whether or not Eastwood & Partners could and should have given different advice to Sheffield Wednesday FC in 1985 about the various options for altering the structure of the entrance area at the Leppings Lane end of the Stadium; in particular, advice about the benefits of having dedicated entrances for each section of the west terrace.
- Whether or not Eastwood & Partners could and should have given different advice to Sheffield Wednesday FC, or given any further information to the Officer Working Party (or the Safety at Sports Grounds Advisory Group), after any of the developments in the Stadium between 1979 and 1989.
- When Eastwood & Partners reviewed Stadium capacity in February / March 1987, whether or not they could and should have advised Sheffield Wednesday FC (a) to re-assess or change capacity figures; and/or (b) to set formal capacity figures for each pen on the west terrace.
- If there were any failures by Eastwood & Partners, whether or not they contributed to the Disaster or the deaths.

Question 13: Emergency Response and the Role of the South Yorkshire Police

After the crush in the west terrace had begun to develop, was there any error or omission by the police which caused or contributed to the loss of lives in the Disaster? Answer "yes" or "no".	**YES**
If your answer to the question above is "no", please answer the following question. After the crush in the west terrace had begun to develop, was there any error or omission by the police which may have caused or contributed to the loss of lives in the Disaster? Answer "yes" or "no".	

If you would like to give an explanation for your answer, please do so in the box below:

The police delayed calling a Major Incident, so the appropriate emergency responses were delayed.

There was a lack of co-ordination, communication, command and control which delayed or prevented appropriate responses.

Please go to the next page for matters which you may wish to bear in mind when answering.

In answering Question 13, you may wish to bear in mind the following considerations:

- Whether or not police officers (including commanding officers) could and should have appreciated that a crush was developing, and taken steps to relieve it, at an earlier stage.
- Whether or not police officers stationed at the perimeter fence, and/or other officers with a view of the central pens of the west terrace, reacted appropriately and promptly to what they could see in those pens.
- Whether or not police officers (including commanding officers) initially perceived events at the west end of the ground as crowd disorder or a pitch invasion, in view of their experience.
- Whether or not police officers (including commanding officers) could and should have established more effective “command and control”.
- Whether or not police officers (including commanding officers) could and should have done more (a) to ensure the declaration of a Major Incident at an earlier stage and (b) to keep police headquarters informed of events.
- Whether or not police officers (including commanding officers) could and should have done more to ensure swift evacuation of the pens from the front and/or the rear, for example by obtaining cutting equipment more quickly.
- Whether or not police officers (including commanding officers) could and should have done more to arrange for the safe and proper treatment of those apparently injured and at risk of injury.
- Whether or not police officers (including commanding officers) could and should have done more to ensure effective liaison with other emergency services.
- If there were any failures by police officers in the emergency response, whether or not they contributed to the loss of lives in the Disaster.

Question 14: Emergency Response and the Role of the South Yorkshire Metropolitan Ambulance Service (SYMAS)

After the crush in the west terrace had begun to develop, was there any error or omission by the ambulance service (SYMAS) which caused or contributed to the loss of lives in the Disaster? Answer "yes" or "no".	**YES**
If your answer to the question above is "no", please answer the following question. After the crush in the west terrace had begun to develop, was there any error or omission by the ambulance service (SYMAS) which may have caused or contributed to the loss of lives in the Disaster? Answer "yes" or "no".	

If you would like to give an explanation for your answer, please do so in the box below:

SYMAS officers at the scene failed to ascertain the nature of the problem at Leppings Lane.

The failure to recognise and call a Major Incident led to delays in responses to the emergency.

Please go to the next page for matters which you may wish to bear in mind when answering.

In answering Question 14, you may wish to bear in mind the following considerations:

- Whether or not SYMAS officers at the Stadium who responded to events at the west end of the pitch could and should have done more to find out the nature and seriousness of the emergency and to react to it.
- Whether or not SYMAS officers at the Stadium could and should have taken action to establish an area on the pitch for assessment and treatment of the injured.
- Whether or not SYMAS officers at the Stadium could and should have established more effective "command and control".
- Whether or not SYMAS officers (including those at the Stadium and those in SYMAS Control) could and should have done more -
  (a) to ensure the declaration of a Major Incident at an earlier stage;
  (b) to ensure effective liaison with other emergency services;
  (c) to deploy cutting equipment from their ambulance to assist swift evacuation of the pens; and/or
  (d) to direct and employ St John Ambulance volunteers and other people with first aid and medical training.
- Whether or not SYMAS officers (including commanding officers) could and should have made different arrangements for ambulance access, including sending further ambulances onto the pitch.
- Whether or not SYMAS officers (including commanding officers) could and should have made different arrangements for transport of casualties to hospitals.
- What role SYMAS officers at the scene could reasonably have been expected to play at each stage of the emergency response, in view of (a) the number of such officers at the scene; and (b) the relative responsibilities of the police and ambulance service.
- Communications difficulties faced by SYMAS officers, and whether or not they could and should have overcome those difficulties.
- The overall number of casualties requiring assessment and/or treatment and the effect of the mass casualty situation on the arrangements that could reasonably be made.
- If there were any failures by SYMAS officers in the emergency response, whether or not they contributed to the loss of lives in the Disaster.

Legal Directions on Question 6 (Unlawful Killing)

Essential Matters

As a matter of law, you may only answer "yes" to Question 6 if you are sure of each of the following four matters:

1. **First, that Chief Superintendent Duckenfield owed a duty of care to the 96 people who died in the Disaster.**

2. **Second, that Chief Superintendent Duckenfield was in breach of that duty of care.**

3. **Third, that Chief Superintendent Duckenfield's breach of his duty of care caused the deaths.**

4. **Fourth, that the breach of Chief Superintendent Duckenfield's duty of care which caused the deaths amounted to "gross negligence."**

You should consider each of those points in turn. If you are not sure that any of those points is established, you must answer "no" to Question 6.

You should approach your task in accordance with the legal directions set out below.

Legal Directions

1. **First, you must be sure that Chief Superintendent Duckenfield owed a duty of care to the 96 people who died in the Disaster.**

   It is agreed by all (including Mr Duckenfield's representatives) that:

   (a) Mr Duckenfield owed a duty of care to people attending the semi-final at Hillsborough on 15 April 1989 (including the 96 who died);

   (b) the duty he owed was to take reasonable care to ensure that people attending the semi-final could attend, watch and depart reasonably safely; and

   (c) the standard of care he had to meet in carrying out that duty was that of a reasonably careful and competent match commander in 1989.

2. **Second, you must be sure that Chief Superintendent Duckenfield was in breach of that duty of care.**

You must be sure that Mr Duckenfield's actions were not those which a reasonably careful and competent match commander would have taken in 1989 so that the 96 people could attend, watch and depart reasonably safely.

You are deciding whether or not Mr Duckenfield complied with his duty of care, not whether anyone else made any mistakes. You should therefore concentrate upon his conduct.

If you are not sure that Mr Duckenfield breached his duty of care, then you must answer "no" to Question 6 in the Questionnaire. If you are sure he did, please consider paragraph 3 below.

3. **Third, you must be sure that Chief Superintendent Duckenfield's breach of his duty of care caused the deaths.**

Under this head, you should consider whether or not you are sure that Mr Duckenfield's breach of duty was a cause of the deaths. It need not be the only cause. It is enough if it contributed to the deaths in a significant and not merely minimal way.

If you are not sure that Mr Duckenfield's breach of his duty of care caused the 96 deaths in this sense, then you must answer "no" to Question 6 in the Questionnaire. If you are sure it did, please consider paragraph 4 below.

4. **Fourth, you must be sure that the breach of Chief Superintendent Duckenfield's duty of care which caused the deaths amounted to "gross negligence."**

Under this head you have to consider whether you are sure Mr Duckenfield's breach of his duty of care to the supporters was so bad, having regard to the risk of death involved, as in your view to amount to a criminal act or omission.

In other words, for gross negligence to be proved, you have to be sure, first, that Mr Duckenfield's breach of his duty of care was so bad in all the circumstances as to amount to a criminal act or omission and, second, that a reasonably careful and competent match commander in 1989 in Mr Duckenfield's position would have foreseen a serious and obvious risk of death to supporters in the central pens of the west terrace.

If you are not sure Mr Duckenfield's breach of his duty of care amounted to gross negligence, then you must answer "no" to Question 6 of the Questionnaire.

If you are sure of each of the matters set out in paragraphs 1-4 above, you should answer "yes" to Question 6 of the Questionnaire. Otherwise, you should answer "no".