Rulings

Introduction

1. It is agreed the jury should give their determinations by answering a general questionnaire. Before it can be finalised I needed to rule on several issues of principle. Everyone agreed it was sensible to do so now, albeit we have not completed the evidence about the individuals who died or heard the evidence of the pathologists and intensivists. That necessarily means that the rulings are based on the evidence as it presently is. On 6 August 2015 I gave my decisions. I indicated I would later provide reasons for them. I said too I would deal with one matter upon which I heard argument but did not rule (namely the topic of the behaviour of the crowd outside the turnstiles in Leppings Lane). In this document I set out my reasons and, in the one respect indicated, my ruling.

2. In order better to understand the general context of my decisions I attach a copy of the "*Draft General Questionnaire for Jury Determinations*" produced and circulated by Mr Hough QC, Counsel to the Inquests, following the decisions I expressed. I emphasise, first, it is no more than "*a basis for discussions with interested persons ("IPs")*" and, second, it is Mr Hough's, not my, document. Furthermore, as Mr Hough has made plain, it is necessarily provisional in that Question 7 assumes a question concerning fan behaviour and questions 13 and 14 (emergency response) cannot be fully addressed until the expert evidence has been given. That said, the document is helpful in setting out a general picture of the possible practical implications of some of the submissions and my decisions.

3. I shall take each issue in the order of the list prepared by Mr Hough.

Unlawful killing

4. It is agreed that unlawful killing could only be left to the jury on the basis of gross negligence manslaughter by the match commander, Chief Superintendent Duckenfield (although Mr Duckenfield could not be named or otherwise identified in the jury's determinations). I ruled that unlawful killing should be left to jury.

The law

5. Lord Mackay of Clashfern set out the law on gross negligence manslaughter in the well known case of *Adomako* [1995] 1 AC 171 at page 187B:

> "*…the ordinary principles of negligence apply to ascertain whether or not the defendant has been in breach of a duty of care towards the victim who has died. If such a breach…is established the next question is whether that breach…caused the death of the victim. If so, the jury must go on to consider whether that breach of duty should be characterised as gross negligence and therefore as a crime. This will depend on the seriousness of the breach of duty committed by the defendant in all the circumstances in which the defendant was placed when it occurred. The jury will have to consider whether the extent to which the defendant's conduct departed from the proper standard of care incumbent upon him, involving as it must have done a risk of death…was such that it should be judged criminal.*
> *…how far conduct must depart from accepted standards to be characterised as criminal…is necessarily a question of degree…The essence of the matter, which is supremely a jury question, is whether having regard to the risk of death involved, the conduct of the defendant was so bad in all the circumstances as to amount in [the jury's]…judgment to a criminal act or omission.*"

6. In *R v Misra and Srivastava* [2005] Cr. App. R. 21 at paragraph 52 Lord Judge CJ, giving the judgment of the Court of Appeal, emphasised the importance of proving a risk of death. As he put it:

> "*…where the issue of risk is engaged…it is now clearly established that it relates to the risk of death…the offence requires gross negligence in circumstances where what is at risk is the life of an individual to whom the defendant owes a duty of care. As such it serves to protect his or her right to life.*"

7. Ordinary principles of negligence apply when deciding whether a duty of care has been breached. The skill and care expected is that of an experienced and competent professional of the same rank and with the same professed specialisation. Inexperience cannot lower the standard: see *R v Prentice and others* [1994] QB 302 at page 327D and following. Applying the ordinary principles of negligence, injury or harm of the relevant type (here crushing) must have been foreseeable to the experienced and competent professional.

8. The breach must have been causative of death. It need not have been the sole or primary cause. It must "*more than minimally, negligibly or trivially [have] contributed to the death*:" see for example *R v Coroner, ex parte Douglas-Williams* [1999] 1 All ER 344 at page 350f.

9. Whether, having regard to the risk of death, the negligence of the defendant was gross is a matter for the jury. It may take all the circumstances into account (including the defendant's inexperience: see *Prentice and others (above)*).

Galbraith; Galbraith plus

10. No question can arise of leaving gross negligence manslaughter to the jury if there is insufficient evidence upon which it could be sure it is made out. That is the well-known and standard test in *R v Galbraith* [1981] 1 WLR 1039. In the context of inquests however a broader approach is appropriate. As Lord Woolf CJ put it in *R v Inner London Coroner, ex parte Douglas Williams* [1991] 1 All E R 344 at page 348:

> "*There is no prosecutor…and while an inquest is a court, the coroner's role is more inquisitorial, even when sitting with a jury, than that of a judge. A prosecutor has a considerable discretion as to what charges he prefers and a trial takes place on those charges. There are no charges in an inquest and a coroner must decide the scope of inquiry which is appropriate and the witnesses to be summoned. He must, at least indirectly, have a greater say as to what verdict the jury should consider than a judge at an adversarial trial…*
>
> *…a coroner should adopt the Galbraith approach in deciding whether to leave a verdict. The strength of the evidence is not the only consideration and, in relation to wider issues, the coroner has a broader discretion. If it appears there are circumstances which, in a particular situation, mean in the judgment of the coroner acting reasonably and fairly it is not in the interest of justice that a particular verdict should be left to the jury, he need not leave that verdict. He, for example, need not leave all possible verdicts just because there is technically evidence to support them. It is sufficient if he leaves those verdicts which realistically reflect the thrust of the evidence as a whole…*"

11. At the time of the *Douglas-Williams* decision, a choice of short-form verdicts was generally left to the jury. A narrative decision was unusual. That that was the context

of the decision is apparent from the decision of Leveson J (as he then was) in *The Queen on the application of Neil Sharman v Her Majesty's Coroner for Inner North London*, [2005] EWHC 857, when he said that Lord Woolf was saying no more than:

> "*…that the coroner should, within the spectrum of different verdicts open to the jury, decide which "realistically reflected the thrust of the evidence" rather than be required to indulge in an analysis of each and every possible permutation…*
>
> *I agree…that the need for the coroner to act "as a filter to avoid injustice" is of vital importance…*" (see paragraphs 9 and 10)

12. In *The Queen on the application of Bennett v HM Coroner for Inner South London and another* [2007] EWCA Civ 617, Waller LJ, giving the judgment of court, with which Keene and Dyson LJJ agreed, said (at paragraph 27) that:

> "*…the authorities recognise that there is some (if small) distinction between the position of the coroner deciding what verdict to leave a jury after hearing all the evidence and that of a judge considering whether to stop a case after the conclusion of the prosecution case…*
>
> *… 29 The emphasis seems to be on the safety of leaving a particular verdict to the jury…*
>
> *…30… I would understand that the essence of what Lord Woolf was saying [in Douglas-Williams] is that coroners should approach their decision as to what verdicts to leave on the basis that the facts are for the jury, but [coroners] are entitled to consider the question whether it is safe to leave a particular verdict on the evidence to the jury i.e. to consider whether a verdict, if reached, would be perverse or unsafe and refuse to leave such a verdict to the jury.*
>
> *31. I would…agree with the judge that the question is an evidential one and, that considerations as to whether an inquest is a satisfactory form of process in identifying whether criminal conduct has taken place or whether some evidence might or might not have been admissible at a criminal trial, are irrelevant.*"

13. In short, the *Galbraith plus* test is evidential. It reflects the need to provide an extra layer of protection in the context of the inquisitorial process of an inquest. In the present context, if, having been properly directed on gross negligence manslaughter, the jury's finding of it on the basis of the evidence before them would not be safe, then gross negligence manslaughter should not be left in the first place. What

Galbraith plus could not be, as it seems to me, is a justification for the coroner to withdraw from the jury an issue upon which there is sufficient evidence for them safely to reach a verdict.

14. It is agreed that for present purposes I should take the facts at their highest.

The application of the law to the facts of this case

15. In order to keep this ruling within bounds, I shall not separately summarise the evidence going to gross negligence manslaughter. Much which is relevant for present purposes will become apparent from what follows. I have borne in mind counsel's exhaustive and helpful summaries, including the lengthy schedule prepared by Mr Duckenfield's own representatives and the schedules of various teams (see for example page 35 and following of the schedule prepared by Ms Williams QC and Ms Gallagher on behalf of Mrs McBrien). I will confine myself to those admissions rightly described by Mr Weatherby QC, on behalf of 22 of the families, as very significant. He quoted an interchange between Mr Duckenfield and Mr Beggs QC on behalf of Mr Duckenfield.

> "*Mr Greaney and others have, over the last few days, taken you through a large number of failures by yourself leading up to and on 15 April 1989, and you have accepted a large number of failures have you not? I have, sir.*
> *You have also accepted that some of them, in particular, were grave failures, serious failures? Yes, sir.*
> *Might I suggest that, although it is possible to subdivide them, perhaps the three failures that will most exercise this jury are: first, failing to prevent congestion building up to dangerous levels at the turnstiles. Would you agree that that was a serious failing on your part? Yes sir.*
> *Second, and perhaps the bronze medal position of the three was failure at any appropriate time to delay the kick-off. That was a failure wasn't it. It was sir.*
> *And a serious failure in the light of what might have been achieved? It was sir.*
> *Third, and I am going to suggest…the most serious failure was that of failing to ensure the closing of the central tunnel prior to giving the order for the exit gates to be opened. Would you agree with that? Yes sir…*

...I want to ask you whether it has been easy for the last five and a half days to admit that your professional failings led to the deaths of 96 innocent men, women and children, and the injuries to many more?...[I]t has been the most difficult period of my life."

Mr Beggs' submissions on behalf of Mr Duckenfield

General points

16. In both oral and written submissions, Mr Beggs QC submitted that it would be unsafe and/or unfair to leave the issue of unlawful killing to the jury. I shall try and summarise his more important points.

17. Mr Beggs submitted that many factors over years contributed to the disaster. It has resulted in a lengthy and very complex hearing. Leaving gross negligence manslaughter would effectively be ascribing a multifactorial disaster to one man, or have that danger. That would be unfair and unrealistic. I should exercise a discretion which I have to withdraw any questions which may seek criminally to stigmatise. Exceptional care is required in the management of matters to be left to the jury.

18. Any failings by Mr Duckenfield have to be set into the context of many failings by many others; also, against the climate of a fear of hooliganism at the time. He was not responsible for planning. Others, much more experienced than him, were.

Galbraith plus

19. Mr Beggs relied on *Galbraith plus*. As I understood his argument, it came to this. There was a particular need in this case for me to act *"as a filter to avoid injustice."* Mr Duckenfield did not have the protection he would have had in a criminal trial. There has been opinion and hearsay evidence impugning him. He was questioned by teams of advocates. Many key witnesses important to Mr Duckenfield had died and could therefore not give evidence (although substantial evidence from these witnesses was read to the jury). Emotion has been high throughout the case. It would be novel and unattractive for Mr Duckenfield to be stigmatised with a very serious criminal offence in those circumstances.

Negligence and gross negligence

20. Mr Beggs questioned whether in all the circumstances Mr Duckenfield could safely be said to have been negligent. He plainly submitted that it could not safely be said that any negligence was gross. There were substantial mitigating features.

21. Mr Duckenfield had no training. He had little relevant experience. It is unrealistic to suggest he could have refused the role of match commander. The radio system was defective. The behaviour of the fans was reprehensible. No-one contemplated death or death by crushing. The police at the time were pre-occupied by the danger of crowd disorder. Although generally thought to be good, Mr Duckenfield inherited a defective operational order. He cannot be blamed, for example, for the absence of cordons (which more experienced officers were against). The arrival pattern of fans was very different from that of 1988 and unusual. He could not be criticised for failing to check turnstile figures or the numbers of those yet to come in. It was not suggested in the operational order. He did not appreciate the problem outside until Superintendent Marshall radioed in at 14.47 and told him of it. He opened Gate C to save lives. Throughout his period in the control box Mr Duckenfield had also to consider other matters.

22. Others, much more experienced than him, could see what he saw from the control box. They were aware of the instructions he gave. No-one suggested he should act otherwise than he did at any stage of the events. That hardly suggests that anything he did amounted to "*a blunder of the first magnitude*". Although he sought advice, no-one suggested the kick-off should be delayed or warned Mr Duckenfield of any risks in opening Gate C. He was assured (wrongly) by the very experienced Superintendent Murray at about 14.30 that all the fans outside could get in by 15.00. The evidence (including the expert evidence) is that at 14.52, when Gate C was opened, the density of people in Pens 3 and 4 was well below that in the Green Guide and not out of the ordinary. Putting aside hindsight, a risk of death by crushing in consequence of opening Gate C was not obvious.

23. Mr Beggs emphasised how important it was not to confuse what could be seen on the CCTV footage with what Mr Duckenfield could see.

My conclusions

Duty of care

24. There is no doubt Mr Duckenfield owed a duty of care to the fans who attended the match to take reasonable care to ensure that they could attend, watch and leave reasonably safely. Mr Beggs accepted as much. Whether that is a matter of law for me upon which to direct the jury, or something for the jury to decide (with an

indication making it plain that no one disputes that such a duty existed), does not matter for present purposes.

Negligence

25. In my judgment the jury could find the evidence of negligence is clear. In particular, the jury would be entitled to conclude that to order exit Gate C to be opened, permitting some 2000 fans to enter the stadium without taking any steps at all to manage their ingress, amounted to a very serious breach of duty. As Mr Hough put it, Mr Duckenfield ordered the exit gates to be opened without either having given instructions for the tunnel to be closed off or giving such instructions in the minutes following the order. To adopt Mr Duckenfield's own admissions, the jury would be entitled to conclude that was a "*grave mistake*" and a "*blunder of the first magnitude*".

26. Fundamentally, the jury could find that a competent match commander would have:
    (1) Appreciated from the time of Superintendent Marshall's first request to open exit gates until the order (some minutes later) to open Gate C, how many fans were outside;
    (2) Appreciated, had he a basic understanding of the stadium, it was highly likely that once Gate C was opened, unless prevented, fans en masse would follow the obvious route to the terrace: through the tunnel into pens 3 and 4;
    (3) Checked before giving the order to open Gate C how full pens 3 and 4 were; in particular, whether there was room for the number of fans outside;
    (4) Noticed that the pens could not take significant numbers of additional fans;
    (5) Warned officers in the concourse he was about to take the unprecedented step of opening exit Gate C;
    (6) Taken steps to close the tunnel or have fans diverted away from it.

27. Furthermore, the jury could find that the competent match commander would have done a number of things to try and prevent the need to open Gate C in the first place. He would have:
    (1) Ensured that effective means were employed at an early stage to prevent the build up of the crowd as an uncontrolled mass outside the turnstiles, for example by the use of cordons;

(2) Identified early on, and certainly sooner than was the case, the increasing danger as the crowd built up and the pressure on the turnstiles worsened;
(3) Regularly obtained turnstile figures to know how many fans had yet to come in;
(4) Obtained information from those outside to determine whether fans could enter in time.
(5) Delayed the kick-off. (The jury may think Mr Duckenfield's failure to take this step was a very significant failure).
(6) Continually monitored the conditions and density of the crowd in pens 3 and 4.

28. The jury could plainly find (as Mr Duckenfield accepted) that his breaches were causative of death in the sense I have indicated above. It could similarly find that serious injury and death was reasonably foreseeable. Permitting the admission of a large uncontrolled mass of fans very shortly before kick-off into an area effectively fenced off at the front and sides and already substantially full of people, carried, as the jury could infer, a grave risk of serious injury and death by crushing. Indeed, the danger of crushing and death was apparent from the events outside the turnstiles. That was why Gate C was opened in the first place.

29. As to Mr Beggs' submissions it seems to me:
(1) With appropriate warnings from me, the jury would well be able to put emotion and prejudice to one side. I would too make it plain there can be no question of ascribing the failings of others to Mr Duckenfield. The possible failings of others will be apparent to them from the questionnaire. The background to and context of Mr Duckenfield's actions, which have been covered extensively in evidence, would be made apparent and spelled out. So too would the limits of the CCTV evidence. The jury would be left in no doubt of the need to be fair to Mr Duckenfield.

I would too observe that given what Mr Duckenfield himself admitted, criticisms of him by others may be thought by the jury to be peripheral.

(2) The jury could conclude that the fact others did not appreciate the risks, while possibly some mitigation, does not exculpate Mr Duckenfield. He accepted ultimate command responsibility for the safety of thousands of

fans. He alone took the key decision to open the gate. He could see what was happening both inside and outside the ground. Taking steps to divert fans or close the tunnel was not, to use Mr Hough's phrase, a complex or recondite tactic. It had been used in the past (although Mr Duckenfield did not know that). It was hardly more than a matter of common sense. As the expert witness Mr Hopkins said, to fail to close the tunnel was a serious and basic mistake.

(3) While Mr Duckenfield's inexperience is relevant to the jury's assessment of the grossness of his conduct, it could conclude a failure to acquire sufficient knowledge before undertaking a role of such responsibility did not lessen to any significant extent the seriousness of his failings; that such preparation as he carried out before the match was woefully inadequate.

(4) While the jury might well conclude there were other, possibly significant, features relevant to negligence and/or gross negligence as Mr Beggs highlighted, these are essentially, it seems to me, matters of fact for them to consider in all the circumstances.

(5) As I have set out in paragraph 28 above, it does seem to me the risk of death was foreseeable, or at least the jury could safely find it was.

(6) *Galbraith plus* is essentially an evidential test, as I have indicated in paragraphs 10- 13 above. It does not, as it seems to me, provide a general discretion to withdraw from the jury's consideration a decision which, on the basis of the evidence before it, it could safely reach. In my view, for the reasons I have indicated above, there is such evidence.

Moreover, were *Galbraith plus* to provide a more general discretion to withdraw manslaughter from the jury, I would see no justification for it. There is no reason why these inquests should not be a forum for resolving an issue of criminal responsibility. Indeed, given as I have concluded, the sufficiency of evidence, to withdraw manslaughter might reasonably be thought an abdication of responsibility. With appropriate directions, I have no doubt the jury could fairly assess the manslaughter issue.

30 In short, it is my view the jury could safely conclude that as match commander Mr Duckenfield accepted ultimate responsibility for the safety of many thousands of fans. He failed in the ways set out above in fulfilling that responsibility with the skill and care reasonably to be expected of him. Having regard to the risk of death involved, the jury would be entitled safely to conclude that the way in which he sought to fulfill that responsibility, fell so short of accepted standards as to be characterised as criminal. As Lord Mackay said in *Adomako*, that is "*supremely*" a matter for them.

How the issue of unlawful killing should be left to the jury

31 As Mr Weatherby put it, this is a matter for my discretion to be exercised in addressing the most effective way of eliciting the jury's conclusions. Different suggestions have been made. I will touch upon some, but not all of them. I of course have taken all the submissions into account.

32 Mr Beggs (assuming for the sake of argument I was against him on manslaughter) opposed a finding of unlawful killing being left to the jury without other short-form verdicts being left as alternative conclusions, namely accidental death, misadventure and an open verdict.

33 Mr Hough submitted I should elicit the jury's finding on the issue of unlawful killing by means of a closed question, and without offering alternative short-form verdicts. I indicated that is what I would do. The following were my reasons.

34 As Mr Hough (and others) submitted any of the short-form verdicts potentially available would be a poor and inadequate account of the disaster. A finding of unlawful killing without more would characterise the entire disaster as the product of Mr Duckenfield's failures, which would be misleading.

35 A finding of accident would be entirely uninformative. It would not tell the families or the public anything about what the jury thought were the real causes and circumstances of the deaths (apart from the fact they were not unlawful). It might well convey the false impression the jury regarded the disaster as involving no human error or systemic flaws, when that was not their view.

36 A headline choice between unlawful killing and accidental death would present the jury with a false choice as to how the disaster happened. It would also run the risk of encouraging them to return a verdict of unlawful killing. For they might well think a verdict of accident would be misleading or uninformative and feel encouraged to return a more informative and significant verdict.

37 Misadventure would be entirely uninformative. To seek to distinguish between misadventure (an archaic word by no means easy to understand) from accident would in this case be difficult and tend to confuse.

38 An open verdict would be wholly uninformative.

39 The suggestion was made that it would be unfair not to leave the alternative possible short-form verdicts if unlawful killing, were left (by whatever means). I do not accept that. The jury, as often happens in a criminal case, is perfectly well able to decide on appropriate directions whether it is sure an allegation is made out. It does not need an alternative. Moreover, in this case, the issue of unlawful killing would be part of a series of topics left for the jury to consider.

40 I have no doubt that whether 96 people were unlawfully killed needs clearly and publically to be resolved. This should be done by a suitably closed question being asked within the general questionnaire. Where it appears in that questionnaire remains an issue, although I indicated that my very provisional inclination was to place it in chronological order within that part of the questionnaire which deals with the events of the day. I also, again very provisionally, indicated the jury should be provided with a route to verdict in a separate document. However, as I emphasised, these are matters upon which I will hear submissions if necessary.

Narrative conclusions: causation issue

41 Adopting Mr Hough's written submissions, this issue can be encapsulated in the following way. Where an event or circumstance *might* have caused or contributed to the death(s) but cannot be proved *probably* to have done so, have I the power to elicit conclusions about that event or circumstance? I ruled that I had and rejected the submissions that the power was limited to conclusions that might assist in a report to prevent future deaths.

42 The importance of this issue to the inquests and the families may be apparent if I indicate how this issue arises or may arise.

43 There has been considerable evidence suggesting defects in the design, construction and layout of the stadium. At question 8 of Mr Hough's draft general questionnaire he suggests posing for the jury the question, "*Were there any features of the design, construction and layout of the stadium which you consider were defective and which contributed to the disaster?*" However it may be impossible to say of a specific defect that it *probably* contributed to any particular death.

44 There are also proposed questions concerning a possible contribution to the disaster by failures of licensing and oversight by the local authority, and possible design flaws by Eastwood and Partners, Sheffield Wednesday Football Club's engineering consultants.

45 Very importantly for the families, there has been much evidence in these (although not the original) inquests about the emergency response of the South Yorkshire Police and the South Yorkshire Metropolitan Ambulance Service (SYMAS). The need to explore that emergency response was one of the key reasons why these new inquests were ordered. Mr Hough's draft questionnaire poses (at questions 13 and 14) the question, "*After the crush in the west terrace had begun to develop, should police officers/ambulance officers have done more which would or might have saved the lives of some of those who died?*"

46 I indicated during argument that for the purposes of the present ruling I would await the pathological evidence before deciding whether there was sufficient evidence that lives *might* have been saved to leave the matter to the jury. However, not surprisingly, and as was emphasised to me, the families regard this as matter of great potential importance.

The statutory provisions

47 Section 5 of the Coroners and Justice Act 2009 deals with the "*Matters to be ascertained*" in an inquest. Subsection (1) provides:

> "*The purpose of an investigation under this Part into a person's death is to ascertain-*
>
> *…(b) how, when and where the deceased came by his or her death…*

…(2) Where necessary in order to avoid a breach of any Convention rights…the purpose mentioned in subsection (1)(b) is to be read as including the purpose of ascertaining in what circumstances the deceased came by his or her death.

(3) Neither the senior coroner conducting an investigation under this Part into a person's death nor the jury (if there is one) may express any opinion on any matter other than-

(a) the questions mentioned in subsection (1)…(b) (read with subsection (2) where applicable)…

This is subject to paragraph 7 of Schedule 5 [the power of the coroner to make a report to prevent future deaths]."

48 Section 10 deals with "*Determinations and findings to be made*." Section 10(1) provides:

"*After hearing the evidence at an inquest into a death, the senior coroner (if there is no jury) or the jury (if there is one) must-*

(a) make a determination as to the questions mentioned in section 5(1)…(read with section 5(2) where applicable)…"

49 Section 6(1)(c) of the *Fatal Accidents and Sudden Deaths Inquiry (Scotland) Act 1976* provides in terms that the Sheriff in Scotland, has the duty, among other things, to set out:

"*…the reasonable precautions, if any, whereby the death and any accident resulting in the death might have been avoided*."

The authorities

50 In *R (Middleton) v West Somerset Coroner* [2004] 2 AC 182 (paragraphs 36 and 37), Lord Bingham of Cornhill, giving the Opinion of the Committee, said that in an inquest in which Article 2 is engaged:

"*It would be open to parties appearing or represented …to make submissions to the coroner on the means of eliciting the jury's factual conclusions and on any questions to be put, but the choice must be that of the coroner and his decision should not be disturbed unless strong grounds are shown…*

…A verdict…embodies a judgmental conclusion of a factual nature, directly relating to the circumstances of death…"

51 *R (Lewis) v Mid and North Shropshire Coroner* [2010] 1 WLR 1836 was a prison suicide case. The coroner did not leave for the jury any question relating to action taken by the prison officer after Mr Lewis was found hanging in his cell. Neither did he refer to the topic in his report to prevent similar fatalities under Rule 43 of the then applicable Coroners' Rules 1984 (now Regulation 28 of the Coroners (Investigations) Regulations 2013). There was no evidence that any action taken by the prison officer after Mr Lewis was found hanging probably contributed to death, only that, as put by counsel, it *could* have. The submission was that in those circumstances a verdict was an essential or desirable foundation for any possible Rule 43 report. There was otherwise no reason to canvass evidence relating to the post hanging events. In response it was submitted that the inquest process could be wide at its opening, but could narrow so as to exclude those factors which were not probable causes of death from the eventual verdict.

52 Sedley LJ, with whose judgment Rimer LJ agreed, said (paragraphs 27-9):

> "*27…I see no reason to doubt the propriety of the ruling…of the City of London coroner…that 'the jury may, in addition to finding the direct or indirect causes or contributions to the death, also find facts relevant to the exercise of the coroner's power under rule 43.' This is likely to be more useful- as the House of Lords suggested in Middleton…where the facts are disputed or uncertain. Indeed it may be in such cases that a finding by verdict is a desirable or even necessary foundation of any rule 43 report…*
>
> *28 But [counsel's] case goes beyond a power to leave possibly but not probably causative matters to the jury: he contends for a duty to do so irrespective of whether the relevant facts are unclear or in dispute. I see the force of his foundational proposition that the circumstances of death are not limited to its probable causes: they extend as a matter of plain English to surrounding facts; while it is not contended for the present that this allows the jury to pronounce on facts, however close in time, that can have no bearing at all on the death, it can intelligibly be said that, in a jurisdiction not concerned with the allocation of blame, potentially causative circumstances can be just as relevant as actually causative ones.*
>
> *29…All of this speaks strongly in favour of a power to take the jury's verdict on such questions. But I am unable to find a reason of principle for making it a duty. It would be quite different if rule 43 were not there, backed as it*

always is by the supervisory power of the High Court to ensure that it is properly operated. There would then be significant failure…to implement the investigative requirement of article 2."

53 While agreeing in the result, Etherton LJ took a narrower approach. He did not agree that section 11(5) of the Coroners Act 1988 (replaced by section 5 of the 2009 Act) encompassed possible causes of death. As he put it (paragraphs 40 and 41):

"*Returning then, to the central issue of the proper scope and meaning of section 11(5)…[that section] is more naturally confined to actual, that is to say, probable causes of death rather than all possible causes, even if less than probable. That also fits naturally into a scheme in which limited issues are left to the jury, but a wider power is given to the coroner, a professional adjudicator, to report [under rule 43] on systemic failures…Strasbourg jurisprudence does not require a different conclusion.*

Moreover, such domestic authority as bears on this issue does not assist the claimant's case. In that connection, Sedley LJ has referred to the very different language of section 6(1) of the Fatal Accidents and Sudden Deaths Inquiry (Scotland) Act [paragraph 46 above]. As he pointed out, Lord Bingham…in Middleton's case,…giving "how" in section 11(5)(b)(ii)…a more extensive meaning than it had previously been thought to bear, appears deliberately to have omitted from the matters which might be left to the jury those in section 6(1)(c) of the 1976 Act. The Appellate Committee would seem therefore to have anticipated precisely the approach for which the claimant contends on this appeal and not adopted it."

54 *Lewis* was considered by a Divisional Court consisting of Owen J and the Chief Coroner in *The Queen (on the application of Donna LePage) v HM Assistant Deputy Coroner for Inner South London and another* [2012] EWHC 1485. The coroner's refusal to investigate a highly speculative theory about the death was upheld. The submission that she had the duty to do so because there was no rule 43 report was roundly rejected. In his judgment, with which Owen J agreed, the Chief Coroner referred to *Lewis* in the following terms (paragraphs 45 and 48):

"*In Lewis the Court of Appeal held that the coroner has a power but not a duty to leave to the jury in a Middleton inquest circumstances which were possible but not probable causes of death…*

…The ratio of Lewis is clear. Like many coroner cases Lewis was fact-specific. But the point of principle was clearly stated, identifying a power but

not a duty. On the specific facts of Lewis the Rule 43 report was important because the coroner had decided to make one. But is no part of the decision in Lewis that in the absence of a Rule 43 report the power becomes a duty. The claimant's proposition runs contrary to the decision in Lewis. It also runs contrary to established coroner law on the coroner's broad discretion."

The Chief Coroner's Guidance Note 17

55 The Note deals with short-form and narrative conclusions. At paragraph 50 it states:

"*A narrative conclusion may (but does not have to) include factual findings on matters which are possible but not probable causes of death where those findings will assist a coroner in a Report to Prevent Future Deaths: Lewis. Otherwise, a narrative verdict must only include matters which are 'causative in terms of the death' or 'relevant in terms of causation of death' or 'part of the chain of causation that led to death.*'"

Argument

56 As will become apparent, in the final analysis, and in the light of the decision in *Lewis*, the disagreement between Ms Richards QC on behalf of SYMAS and Mr Hough was a narrow one.

57 Ms Richards' argument can be shortly summarised. Subject to Schedule 5 paragraph 7, section 5(3) of the Coroners Act 2009 prohibits (here) the jury from expressing any opinion on any matter other than those specifically mentioned. It is common for the jury to hear evidence upon which in the event it will not express an opinion. It cannot do so on matters which do not cause death. In deciding that, the civil burden of proof will generally apply. Ms Richards emphasised Lord Bingham's reference in paragraph 37 of *Middleton* (paragraph 55 above) to "*directly (my emphasis) relating to the circumstances of death.* "

58 Ms Richards made two fundamental points about the majority's decision in *Lewis*. First, the issue before the court was whether there was a duty to leave non-probable causes. The observations of Sedley LJ in paragraphs 28 and 29 (paragraph 52 above) were therefore not necessary for the decision. Second, the power Sedley LJ referred to was linked (in paragraph 29) to the rule 43 exercise. Paragraphs 27 to 29 had to be read together.

59 Ms Richards submitted that the comments made by Etherton LJ, in particular those in paragraph 40 (paragraph 53 above) highlighted the contrast between the narrower statutory requirement in terms of the questions to be answered and the wider scheme in relation to rule 43 (now Regulation 28). (That too was referred to, as she submitted, by Lord Hope of Craighead DPSC in his speech (paragraph 95) in *R (Smith) v Oxfordshire Assistant Deputy Coroner* [2011] AC 1).

60 In the result, submitted Ms Richards, the Chief Coroner's guidance correctly sets out the position. It reflects the judgments in *Middleton* and *Lewis* and the terms of the 2009 Act.

61 Mr Hough submitted, first, that the reasoning of the majority in *Lewis* was straightforward. Sedley LJ was addressing a submission by counsel of general application. He accepted the proposition that the circumstances of death could include factors which may have been causative. There was the power to elicit the jury's conclusions about such matters. The duty to answer the "how" question might not make it necessary to do so. No member of the court suggested the power was limited to cases where the answers might assist in a rule 43 report.

62 Second, the power exists as part of the general discretion described in *Middleton* as to the means of eliciting conclusions on key issues. It would not be consistent with that broad discretion for coroners to be confined only to exercising that discretion in a certain type of case.

63 Third, if the power is limited in the way suggested, the principles would be difficult to apply in practice and sometimes be arbitrary. It may be very difficult to say in what circumstances a conclusion on a particular matter would assist in writing a report. That could be particularly so before all the jury's conclusions have been given. It is moreover, difficult to see why the scope of the "how" question should be different depending on whether a report is contemplated.

My conclusion

64 As is apparent from my summary of the argument, no-one suggests I do not have the power in this article 2 inquest to elicit the jury's conclusions on matters which plainly may have caused death, but cannot be shown probably to have done so. Ms Richards is constrained to accept that in the light of the decision in *Lewis*. The issue is whether I can only exercise it to assist in producing a Regulation 28 report.

65 No-one suggests the jury should be asked to reach decisions on matters which have no bearing on the deaths. No-one suggests that speculative theories or matters which could not safely be left to the jury should be.

66 Such power as I have derives from the provisions of Section 5. Section 5(2) does not define the meaning of the ordinary English words "*in what circumstances*." Neither does it speak of probable causes.

67 The case of *Middleton* emphasises the width of the coroner's discretion to elicit factual conclusions. I do not take the reference in paragraph 37 ("*directly relating to the circumstances of the death*") to mean more than there must be a sufficient connection between the conclusion sought and the death. A possible cause of death could suffice.

68 There is nothing in paragraphs 27-9 in *Lewis* to justify confining the power only where a (now) Regulation 28 report is contemplated. It is not surprising Sedley LJ referred to rule 43 in the way he did. As Mr Hough pointed out, the reference was made to make the point that it might be a duty if the jurisdiction under rule 43 did not exist.

69 No-one in *Lewis* suggested that the power was confined in the way suggested by Ms Richards. As Mr Hough pointed out, to confine the power in that way would quickly lead to absurdity. The same simple phrase, "*in what circumstances a death occurred*," would mean in one instance, what events and circumstances *probably* caused death, in another, what other events and circumstances *may* have caused death, the recording of which would assist in a report. That would be an extra-ordinary exercise of statutory construction.

70 Different standards of proof might apply in the same case to the same set of facts depending on whether a Regulation 28 report might or might not be written. In the same case on the same facts a report might be appropriate in respect of one state agent and not another (because for example, the shortcomings had been corrected). Which statutory interpretation applied might be arbitrary, as this case could illustrate. In 1990 a rule 43 report might have been appropriate in respect of, for example, SYMAS. Given the passage of time, it seems unlikely that could now sensibly arise. In 1990, on Ms Richards' analysis, the jury's decision on *possible* causes of death could have been be elicited. In 2015, on exactly the same facts, it could not.

71 Before any conclusions were reached by the jury, the coroner would have to decide whether a Regulation 28 report was appropriate. The standard of proof which the jury was to apply would depend on it. Yet such a decision could only sensibly be reached after the jury had decided the facts. As Mr Hough submitted, the statutory interpretation argued for would put the cart before the horse.

72 It follows that for the reasons I have given it does seem to me the Chief Coroner's guidance is too restricted. I should emphasise however that the circumstances in which possible causes of death are left for the jury's consideration are likely to be limited. No question could arise of leaving speculative matters for their consideration. The coroner has a wide discretion about what to leave. The jury would have to be able safely to conclude on the basis of the evidence left to them for their consideration that death might have been caused or contributed to in the way posited.

73 Those are the reasons for the ruling I gave.

Narrative conclusions: conduct of parties other than state agents

74 Although possibly academic on the facts of this case, the fundamental issue raised is whether an extended narrative conclusion could lawfully be returned in an Article 2 inquest in respect of those IPs who are not state agents. On the one hand Mr Hough submitted that once Article 2 was engaged the expanded narrative verdict of the jury may make judgmental and critical comments regarding state and non-state bodies equally. On the other hand, Mr Beer QC on behalf of Sheffield Wednesday Football Club (SWFC), in an ingenious argument, submitted that such a verdict cannot lawfully be returned in respect of SWFC (and by analogy other non-state agents) unless it is necessary to do so in order fairly and properly to judge the conduct of the state agent.

75 I ruled that determinations in respect of SWFC (or any other non-state IP) were not constrained as suggested by Mr Beer.

The statutory provisions

76 Although set out above, it may be helpful to repeat them.

77 Section 5 of the Coroners and Justice Act 2009 deals with the "*Matters to be ascertained*" in an inquest. Subsection (1) provides:

> "*The purpose of an investigation under this Part into a person's death is to ascertain-*

…(b) how, when and where the deceased came by his or her death…

…(2) Where necessary in order to avoid a breach of any Convention rights…the purpose mentioned in subsection (1)(b) is to be read as including the purpose of ascertaining in what circumstances the deceased came by his or her death.

(3) Neither the senior coroner conducting an investigation under this Part into a person's death nor the jury (if there is one) may express any opinion on any matter other than-

(a) the questions mentioned in subsection (1)…(b) (read with subsection (2) where applicable)…

This is subject to paragraph 7 of Schedule 5 [the power of the coroner to make a report to prevent future deaths]."

78 Section 10 deals with "*Determinations and findings to be made*." Section 10(1) provides:

"*After hearing the evidence at an inquest into a death, the senior coroner (if there is no jury) or the jury (if there is one) must-*

(b) make a determination as to the questions mentioned in section 5(1)…(read with section 5(2) where applicable)…"

Mr Beer's argument

79 Mr Beer submitted that the jurisdiction to return an extended determination under section 10(1)(a), when read with section 5(2) of the 2009 Act, (where "*how*" means "*in what circumstances*") depended on such a determination being "*necessary*" to avoid a breach of a Convention right. The court had to identify which Convention right was engaged, what conduct by which person or organisation would breach that right and, accordingly, the necessity of making an extended determination in relation to that person or organisation and that conduct. The Act does not distinguish between Article 2 and non-Article 2 inquests. It distinguishes between the types of determination which may be returned. The court may therefore properly investigate the actions of state and non-state bodies. That is within the coroner's discretion. However, the distinction remains legally critical at the point of determinations and conclusions.

80 In support of that submission Mr Beer drew my attention to several cases in which that distinction was made clear: see for example *R v Inner West London Coroner, ex parte Dallaglio* [1994] 4 All ER 139 at 155b; *R (Hurst) v London and Northern*

District Coroner [2007] 2 AC 189, paragraphs 7, 35, 51, 52 and 72. More recently, in *R (Smith) v Oxfordshire Assistant Deputy Coroner* [2011] 1, Lord Phillips (at paragraph 78) said:

> "*It seems to me the only difference the decision of the House in Middleton's case would have made to the Jamieson [non-Article 2 inquest] or the Middleton inquest would have been to the form of verdict…I question whether there is in truth any difference in practice between a Jamieson and a Middleton inquest, other than the verdict.*"

81 In *The Queen on the application of Sreedharan v HM Coroner for the County of Greater Manchester and others* [2013] EWCA Civ 181, the Court of Appeal considered an appeal on the question of scope in an Article 2 inquest in which the IPs included state and non-state agents. Hallett LJ, with whose judgment the Master of the Rolls and Kay LJ agreed, said (paragraph 23) that:

> "*…I [would reject counsel's] …attempt to classify this inquest as what she called a "hybrid", namely an inquest in which the procedural duty under Article 2 is only triggered by the involvement of state agents (here the emergency services personnel) but other non-state agents are swept up in the inquiry…it cannot be right to suggest…that once a coroner has embarked on an Article 2 compliant inquest there should be less intensive scrutiny of the conduct of the non-state agent than of the conduct of the state agent. It is only by examining the roles of each fully and fairly that the role of state agent can be put into its proper perspective and the truth ascertained.*
>
> *24 Here the role of the non-state party was crucial to the investigation…"*

82 Mr Beer submitted those comments supported his contentions. Hallett LJ was dealing with scope. She was not dealing with verdict. She was saying no more than scope was not constrained. Her reference to "*hybrid*" maintained the distinction between the two sorts of inquests. While it would be practically impossible to conduct an investigation by reference to different standards depending on whether the actor under investigation was a state or non-state agent, especially where their activities overlap, it does not follow that determinations cannot be "hybridised" in such a way.

83 Mr Beer made several points about the wording of the statutory provisions. Section 10(1) did not indicate the form any determination should take. "Hybridisation" of determinations is not therefore excluded. The determination must relate to the

questions posed in section 5(1), read, where applicable, with section 5(2). Section 5(3) prevents the court making any further determinations beyond seeking answers to those questions. An extended determination can only be made when it is necessary to avoid a breach of a Convention right. There is nothing to suggest the court has some residual power to do so otherwise. Nothing in *Middleton* advances the argument. *Middleton* only applied to avoid a breach of a Convention right.

84 As to the practical application of Mr Beer's analysis, he accepted it might produce complexity. That is the consequence of a proper application of the legal principles. As I understand him, Mr Beer was saying that if the jury had to make a specific decision about a state agent which on its particular facts overlapped with or directly involved a non-state agent, then the criterion of necessity would be made out. If there was no such overlap or direct involvement, it was not.

My conclusion

85 I could not accept Mr Beer's submissions.

86 I accept that in terms of determination, a distinction between Article 2 and non-Article 2 compliant inquests remains. In this case, I have decided, it is necessary to hold Article 2 compliant inquests.

87 The statutory provisions, as I think was accepted, were intended to give force to the decision in the case of *Middleton*. There is nothing in *Middleton* or in the statutory provisions to suggest that once it is necessary for Article 2 to be engaged, it is to be engaged in a limited or hybrid manner.

88 Section 5(2) does no more than acknowledge that there are some inquests in which it is necessary to engage Article 2. This, as I have said, is such an inquest. To vindicate those Article 2 rights requires the broader approach to be taken.

89 While I am prepared to accept that in *Sreedharan* Hallett LJ primarily appears to have had scope in mind, it seems to me Mr Hough was right when he submitted that her reasoning applies equally to determinations. If in a given inquest it is necessary to examine the roles of the non-state and state agents fully and fairly in order to ascertain the truth, the verdicts and determinations which express that truth should follow the same approach. If it is wrong to have an unbalanced inquiry, it is wrong to have an unbalanced verdict.

90 The consequences of Mr Beer's statutory interpretation would produce a regime which is bizarrely complex and arbitrary in practice, as Mr Hough submitted. The question of how the deceased came by his or her death would bear different meanings in the same inquest depending on the subject matter, as well as the organisation in question. When considering the conduct of a non-state agent, there would first need to be a decision as to whether that conduct overlapped with or directly involved a non-state agent. If the jury was satisfied it did, it could return an extended determination. Otherwise it could not. It would lead to conclusions with respect to SWFC on some issues and not others and be impossible to follow, as Mr Weatherby pointed out.

91. Finally, as it seems to me, if in the context of a death, both the state and non-state agents have made relevant mistakes, a fair and proper assessment of the role of the state agent will almost inevitably require an assessment and recording of the role of the non-state agent. On the facts of the present case that is almost certain to be the case. As Mr Simblet pointed out, it is almost impossible to think of an issue where the conduct of SWFC stands entirely independent of that of a public authority.

Events outside Leppings Lane

92. It is agreed that the evidence about the behaviour of fans outside Leppings Lane which led to Gate C being opened should be summed up. The fundamental issues are whether there is sufficient evidence safely to leave a question to the jury about that behaviour; if so, its form. It is a topic about which, for very understandable reasons, the families feel strongly.

The evidence relied on by the police IPs

93. Those representing the match commanders and former Assistant Chief Constable Jackson have set out in copious schedules, evidence going to the behaviour of fans outside Leppings Lane. They submit, put shortly, that the jury could conclude that a large number of fans who had no tickets were in the area of the turnstiles, making more difficult the task of organisation outside Leppings Lane: a significant proportion arrived relatively close to the kick-off, were affected by alcohol and were non-compliant with police directions. A convenient summary giving a flavour of some aspects of the sort of evidence relied upon is set out in the written submissions of the Police Federation.

94. Former PC Huckstepp, who was one of the police officers outside the turnstiles, said:

> "*[The crowd] became greater and greater, until a point around about 2.30, when it just seemed…as if someone had opened a door and a really large number of fans all arrived at the same time, and I ended up pushed back towards the turnstile wall…[T]he crush was coming from somewhere, so somebody was pushing the crowd; clearly not the people at the front…And if someone is pushing, that is not helping the situation. So whether that is bad behaviour or not, that is what was happening…Outside…it's the police lost control, but the fans were pushing at the back. There was a significant minority of fans pushing at the back, so there is a degree of culpability.*

95. The CCTV footage showed former Superintendent Marshall, the officer in charge outside the turnstiles, gesticulating to fans to move back. He said he was shouting to the fans to do so. He said there was a lot of pushing going on. The following interchange took place:

> "*What you have repeatedly [said] over the years is that some fans seemed determined to get into the ground at that time regardless? Yes…[It] was a significant minority which made life- contributed to the problems…*
> *Was…a problem…that a large number of fans seemed, for whatever reason to attend at the same time? Yes.*
> *…that time was close to the kickoff, or fairly close? Yes.*
> *So that fans appeared…to feel a strong drive to get into the ground so as not to miss the kick-off? Yes.*
> *Is it your position that the fact that some had drink on board meant they didn't exercise the judgment that you would have expected and listened to warnings? That's right…*"

96. Inspector Ellis was outside the turnstiles. For some of the time he was on the roof of a police Land Rover with a megaphone seeking verbally to restrain people. He said:

> "*[Fans] were frantic…to get into the ground because it was approaching 3 o'clock…it was unbelievable behaviour to me. I just couldn't understand it. It's mania, madness I would have called it. I saw people running under horses…My concerns were that somebody was going to get killed or seriously injured if something was not done soon…*

[Did you] get the impression…that the exhortations which you were delivering from the top of [the Land Rover] were making no difference? No difference at all.

…[F]ans were determined to get into the ground whatever? I don't know…how to put this…but it was like it's like fun. It's just simple crowd behaviour where it's a challenge, and that's how they were behaving…I remember people…screaming at the mounted [police] because they were stopping them gaining entry…I was wasting my breath."

97. There was evidence that the outer perimeter gates were forced at some stage.

98. PC Lomas was one among a number of witnesses who spoke of substantial drinking by fans. He said he had never seen so much alcohol drunk before a match and had not since.

99. Mr Rawlinson, a fan, spoke of fans pushing and shoving from behind and the side.

100. The submission of the police IPs can be put shortly. There is sufficient evidence from which the jury could safely infer that the behaviour of the fans was a cause of the disaster. The jury should consider it, whether or not the police ought to have foreseen it. I anticipated as much when in my opening to the jury I said:

"*As you listen to the evidence, you may want to bear in mind a number of topics. They are by no means exhaustive. They are merely intended to reflect some of the issues which I anticipate may arise…(6) What was the conduct of the fans or some of them (excluding those who died)? Did that play any part in the disaster? I phrase it in that way because I do not believe that anyone will suggest that the conduct of those who died in any way contributed to their deaths.*"

The submissions on behalf of the families

101. I shall not refer to all the written submissions and schedules. I have reminded myself of their contents.

102. In essence Mr Wilcock QC, on behalf of 75 of the families, submitted that factors such as alcohol consumption, ticketless supporters and non-compliance are inherently vague, subjective and variable. The issue is whether any of those things

affected police behaviour on the day. The evidence of the police officers present has to be considered with care. No officer outside could see everything that was happening. Each was a member of a force which was traumatised and on the defensive. The procedures for evidence gathering were flawed. The CCTV material is the best evidence available. There is nothing in it suggesting negative behaviour by fans. There were no arrests or any other evidence suggesting such behaviour. There is evidence from other officers, fans and residents, which contradicts that of the officers relied on. Everything that happened was predictable and should have been planned for. Mr Hopkins, the expert, said as much. If there was sufficient evidence of a lack of co-operation by fans it is impossible to ascribe it to more than the product of being in the middle of a crowd.

103. Mr Weatherby on behalf of 22 families submitted that there is no evidence that the behaviour of supporters contributed to the disaster. He accepted there was some evidence going to a lack of tickets, lateness and alcohol intake, but submitted it is insufficient safely to leave to the jury.

104. Mr Weatherby accepted there was evidence of fans without tickets. It went both ways as to whether there was more 'ticketlessness' on the day than could reasonably have been anticipated. He emphasised that Mr Cutlack (the expert witness dealing with stadium safety) said there was no evidence to suggest large numbers of fans came in without tickets. Mr Hopkins, the police expert witness, said it was, or should have been, known that Liverpool travelled with more fans without tickets than any other club. Any problem should have been anticipated. Mr Weatherby submitted, in short, the jury could not safely conclude that fans without tickets contributed to the disaster or that what happened in that respect was in any way out of the ordinary and not foreseeable.

105. Mr Weatherby referred to the evidence of, as he put it, the well-known phenomenon of supporters at Hillsborough arriving shortly before kick-off. He rightly referred to evidence which supported such a contention. It came, as he observed, from a wide variety of sources and in several forms. He submitted that on the basis of that evidence it would be difficult for the jury safely to conclude that the fans could be said to have arrived unusually or unforeseeably late. In short, he accepted there was some evidence of later arrival, but not that it was or could safely be considered to have been a contributory factor.

106. As to drink, Mr Weatherby agreed with Mr Wilcock's comments. There was nothing on the CCTV evidence to support any suggestion that drink played any, or any unusual part in the events. Moreover, some drink was foreseeable at any football match in 1989. In that regard he referred to former Chief Superintendent Marshall's comments to the effect had the disaster not occurred, he would not have thought twice about the issue of alcohol on the day.

My conclusion

107. To be left as an issue for the jury, the behaviour of fans outside Leppings Lane must be relevant. It could only conceivably be relevant if it could be said to have contributed to the disaster. If the jury can safely conclude that on the evidence the loss of police control outside the turnstiles, and the dangerous crush which developed there leading to the need to open Gate C, was exacerbated by the behaviour of a proportion of the fans, that behaviour had on its face relevance. It was a part of the chain of events which led to the disaster.

108. The issue of relevance does not stop there however. The task of the jury is to explain what caused, or may have caused, the disaster; in other words, as Mr Hough put it, what went wrong. If the behaviour of the fans was not out of the ordinary and was predictable for a football semi-final in 1989, the essential feature was not the behaviour, but the failure to take account of it in planning for and managing the match. That is what, in such a scenario, went wrong. That therefore should be part of any question. For to seek the answer to a question which simply asked about fan behaviour, as is suggested by those representing different police officers, cannot elicit a response which is meaningful as far as the inquests are concerned. Not only could such a response serve no meaningful purpose, it could be taken to deflect responsibility from where it should lie.

109. It therefore comes to this. Is there sufficient evidence for the jury safely to conclude there was any unusual or unforeseeable behaviour by some fans which contributed to the dangerous situation at the Leppings Lane turnstiles?

110. I start with some general points.

111. As is apparent from my very short summary above, the evidence relating to the events outside Leppings Lane has been copious. Although in these submissions different components of behaviour have rightly been isolated, that may, to a degree in

some instances, be somewhat artificial. For example, a jury could infer that behaviour may say something about drink.

112. The conduct of the police officers in seeking to deal with the events in Leppings Lane has been the subject of sustained criticism. I make no criticism of that. However, it cannot be for me to assess the reliability of their response to questioning. That is classically for the jury. I see no reason why they cannot safely do so.

113. Parts of the evidence can be taken to support the contentions of one side, while parts support those of the other side. Provided it may safely do so, it is for the jury not me to resolve the resulting disputes of fact. Indeed, it seems to me there is every reason for a jury finally to put these issues to rest.

114. I now briefly refer to some specific aspects of the evidence.

115. As to the number of fans without tickets, I would simply say this. There is evidence from a significant group of senior police officers of an unusually large number of what they believed to be such fans outside, whatever may have been the number inside. It is for the jury to decide, having made some assessment of their number, whether, as Mr Hopkins suggested, that should have been anticipated. The evidence is that the presence of an unusually large number of fans would make it difficult to organise the orderly entry of fans.

116. As to the time of arrival of the fans, there is evidence (a very small part of which I have referred to above) from which the jury could infer an unusually large proportion of fans arrived unusually late. A comparison between arrivals in 1988 and 1989, the jury could infer, suggests as much. Mr Weatherby pointed out the substantial countervailing evidence. It is for the jury to assess.

117. As to drink, there is evidence (again, a very small proportion of which I have referred to above), that fans were unusually affected by drink. While again, as Mr Weatherby pointed out, there is countervailing evidence, this in my judgment is a matter for the jury.

118. As to the behaviour of the crowd, I have summarised above a small proportion of evidence from which, as it seems to me, the jury could infer a significant minority were unusually non-compliant. In this regard the jury may consider the CCTV material significant countervailing evidence (as they may as far as drink is concerned). However, that is a matter for them. As Mr Hough pointed out,

they could consider that the CCTV evidence is limited. Moreover, it seems to me the jury would be entitled as a matter of common sense to infer that Gate C was opened to save those outside from being crushed: that the risk of crushing would not have arisen had there not been pushing to a significant extent to get in by kick-off.

119. In short, I have concluded the jury should be asked a question in the sort of terms indicated in paragraph 109 above.

120. I should finally say this. I am very conscious of the sensitivity of this issue. Nothing I have said indicates any view by me. However, as I have previously said when dealing with this topic, I have fairly to apply the law. It would be no kindness to the families to prevent the jury dealing with an issue when, as it seems to me, the law plainly requires that they should. Moreover, as I have touched upon above, it does seem to me there is much to be said for the jury finally putting these matters to rest. I have no doubt they can be trusted fairly to do so.

Questions/conclusions concerning SWFC

121. As I understand it, this is a topic which will first be discussed. If in due course any ruling is needed, we can return to it.

The opening of Gate C

122. The present Chief Constable of South Yorkshire Police (alone) submitted that a specific and freestanding question to the following effect be submitted to the jury:

> "*When Gate C was opened at 14.52 who was physically involved in opening the gate, at what stage of the gate opening process and what caused that person or persons to act as they did?*"

123. I ruled that on the evidence as it presently stands, no such question should be asked.

Ms Barton's submission

124. Ms Barton QC, on behalf of the Chief Constable, suggested the evidence on the topic was not entirely straightforward. It justified a discrete question. I will try and summarise her submissions as I understand them.

125. The jury could safely conclude on the evidence that Ian Marsh, an SWFC steward working at Gate C, of his own volition, and without seeking prior police authority to do so, opened Gate C to let a fan out. That was something he was entitled to do. Mr Marsh's action, not Mr Duckenfield's order may therefore have led to Gate C being opened. Because they were expecting an imminent order to do so, one or more police officers then pushed open Gate C more widely to let the crowd in. The disaster ensued. For some 26 years Mr Marsh consistently claimed a police officer in a flat cap ordered him to open Gate C. As he was forced to admit in evidence, the CCTV material contradicted that. There was no officer in a flat hat. There was no officer near him. In some recent accounts, Mr Marsh accepted he may initially have opened the gate to let a fan out.

126. There is no evidence from any officer that Mr Duckenfield's order was communicated to him or her or that Gate C was opened in consequence.

127. Inspector Purdy was in Leppings Lane. His evidence was that Superintendent Marshall had instructed the gates be opened. Mr Marshall said nothing about obtaining prior permission from Mr Duckenfield. Mr Purdy did not in fact give any instruction to open the gate. The one or more officers who opened the gate seconds after Mr Marsh's initial opening could have done so in the expectation there would be such an instruction. They are likely to have heard Superintendent Marshall's urgent request to Mr Duckenfield seeking permission to do so.

128. There was a delay of about 1 minute 30 seconds between Sergeant Goddard putting out Mr Duckenfield's order on the radio and the actual opening of the gate.

Had the order been successfully communicated there would not have been as long a delay. That suggests the opening of Gate C may have been unconnected with Mr Duckenfield's order.

129. On that analysis, submitted Ms Barton, Gate C may have been opened by a combination of circumstances which had nothing to do with Mr Duckenfield's order. These are matters which the jury should specifically consider.

Why in my view the question should not be asked

130. Mr Beggs, on behalf of Mr Duckenfield, did not lend himself to Ms Barton's submissions. Neither did any other IP. Those representing the families and the Police Federation submitted no such question should be asked. So did Mr Hough as counsel to the inquests. Having heard the submissions, the following seemed to me to be the position.

131. It was overwhelmingly likely that Mr Marsh opened Gate C as a consequence of Mr Duckenfield's order. The order was given. The gate was opened shortly thereafter. It would be a remarkable coincidence if there were no connection between the two. It seems to me inherently unlikely Mr Marsh would have opened the gate of his own volition. Little or no reliance could safely be placed on more recent accounts from Mr Marsh, whether during very lengthy questioning by Operation Resolve or to Ms Barton when giving evidence. The events happened some 26 years ago. Mr Marsh's accounts were inconsistent. Significantly, as he said when he began giving evidence, Mr Marsh suffers from a medical condition which affects his long term memory. As he gave evidence it became apparent he was a strikingly suggestible witness.

132. Mr Marsh acting on his own initiative to let a fan out would not explain the mass entry of fans. Some 50 or 100 people might have managed to get in. The gate would then have quickly been closed by the police. That is precisely what happened shortly before when the gate was opened to let someone out. On this occasion, seconds after Mr Marsh began opening the gate, police officers came to open it more widely, plainly to let fans in. It seems to me inconceivable they would have done that without specific orders to do so. To open an exit gate to let people in was unprecedented. Moreover, officers outside Gate C were directing fans to come in through Gate C. It all amounts to compelling evidence that what was done was done as part of a police plan.

133. Police officers in the vicinity and other club staff, perceived the opening of the gate to be at the direction of the police. I shall merely refer to the evidence of PC Long, which it seems to me does provide a direct link between the Duckenfield order and the opening of the gate. PC Long said:

> "*I turned to an inspector who was stood beside the turnstiles listening intently to radio transmissions being passed via his personal radio…I was then instructed, after several moments, to open the gates*"

134. The officers in the police control box perceived the opening of the gate to be a response to Mr Duckenfield's order. They caused the CCTV cameras to zoom in on Gate C just when it was about to be opened.

135. In short, I could see no sensible basis to leave this topic for the jury on the basis of what at present seems to me Ms Barton's speculative analysis. Furthermore, as Ms Williams observed, the jury is bound in any event to have to consider causation when considering the question of Mr Duckenfield and unlawful killing.

136. In the result, it did not seem to me it was necessary or appropriate for the jury to be asked the proposed freestanding question.

John Goldring
2 September 2015