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## Abstract

**Elliott, Dominic Paul**

### **Organisational Learning From Crisis: An examination of the UK Football Industry 1946 - 97**

This thesis examines organisational learning within the UK Football Industry during and after a series of crisis incidents. In particular, Turner's (1976, 1978) model of Cultural Readjustment is critically examined. In the thesis, it is argued that Turner's model is deficient in its treatment of organisational learning following public inquiries. In the case of the UK Football Industry, it is argued that there was little change to operating norms and procedures following each of the Bolton (1946), Ibrox (1971) and the Bradford and Heysel Disasters (1985). The thesis, drawing upon the relevant management literature, examines the roles played by organisational culture, structure and communication as barriers to effective learning. Effective organisational learning, it is argued, depends not only upon the development of explicit knowledge but also upon the organisational elements that influence the transfer of knowledge into changed behaviour.

In the period since 1989, the research indicates that some cultural change has occurred. However, it is argued that those elements that thwarted learning in the earlier period have impeded cultural readjustment. Further, the thesis provides an analysis of the regulatory regime pertaining throughout the period, drawing in particular upon Gouldner's (1954) 'Patterns in Industrial Bureaucracy'. It is argued that the limited cultural change can, in part, be explained by the nature of the regulatory system operated by different local authorities. In the analysis of the post 1989 period extensive use is made of Pauchant & Mitroff's Onion Model of Crisis Management; an evaluation of which forms a part of this section.

The thesis concludes by making a number of recommendations for the various bodies involved in the process for ensuring and promoting the safety of crowds inside sports stadia.

**Organisational Learning From Crisis: An examination of  
the UK Football Industry 1946 - 97**

**Dominic Paul Elliott  
University of Durham**

**May 1998**

**A thesis submitted to the University of Durham for the  
Degree of Doctor of Philosophy**

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The research was conducted in Durham University Business School

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## Declaration

No portion of the work referred to in this thesis has been submitted in support of an application for another degree or qualification of this or any other institution of learning

Dominic Elliott

Dominic Elliott obtained BA (Honours) and MBA degrees at the University of Warwick and Leicester Polytechnic (CNAA) respectively before carrying out research for the degree of Ph.D. at the University of Durham.

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It only remains for me to say that any errors or omissions are my responsibility.

## **Glossary**

<b>'F'</b>	<b>First Division Club (Respondents)</b>
<b>FA</b>	<b>Football Association</b>
<b>FL</b>	<b>Football League</b>
<b>FLA</b>	<b>Football Licensing Authority</b>
<b>Green Guide</b>	<b>Guide to Safety at Sports Grounds</b>
<b>LA</b>	<b>Local Authority (Respondents)</b>
<b>'P'</b>	<b>Premiership Club (Respondents)</b>
<b>PFA</b>	<b>Professional Footballers Association</b>
<b>'S'</b>	<b>Second Division Club (Respondents)</b>
<b>SC</b>	<b>Scottish Club (Respondents)</b>
<b>SAG</b>	<b>Safety Advisory Group</b>
<b>SFA</b>	<b>Scottish Football Association</b>
<b>SFL</b>	<b>Scottish Football League</b>
<b>'T'</b>	<b>Third Division Club (Respondents)</b>

## **Chapter 1**

# **Crisis Management, Cultural Readjustment and Perspectives on the Stadia Crises of the UK Football Industry**

## 1.0 Stimulus for Research and Objectives of Study

UK football stadia have been the scene of at least forty-five incidents involving multiple casualties or fatalities since 1945 (see table 1.1). Four of these incidents, Bolton 1946, Ibrox 1971, Bradford 1985 and Hillsborough 1989 involved more than fifty fatalities each. The scale and occurrence of these incidents suggest a particular problem for the safe management of crowds in UK football stadia.

The initial stimulus for this study arose from a personal observation that a number of measures recommended by Popplewell in 1985 were only implemented in the aftermath of the 1989 Taylor Report. Further investigation revealed that many of the recommendations put forward by Popplewell and Taylor had been advocated in previous reports. This raised questions about the translation of knowledge into action. Can organisations learn from disasters? If so, how does such learning occur? Why did the football clubs not act sooner? How can we be sure that the redevelopment of stadia following the Hillsborough Disaster incorporates the lessons identified by the various public inquiries? This study represents an attempt to examine, scientifically, these broad questions. A review of the relevant literature suggested that effective learning can be impeded by a number of organisational factors including culture and structure which forms the basis of Chapter 2 (see for example, Garvin, 1993; Smith, 1995).

Implicit in previous studies of learning from disasters, (see for example, Turner 1976, 1978, Toft & Reynolds 1992), is the hypothesis that crisis incidents will provoke a cultural readjustment in the form of a challenge to accepted beliefs about the world and its hazards. Hypothetically, this readjustment manifests itself in changes to operating norms and procedures (i.e. changes to behaviour). Although Turner (1978) alludes to the potential limitations of a full cultural readjustment, given the focus of his analysis upon the incubation of disasters, this is an issue that remains underdeveloped.<sup>1</sup> The first objective of this study was to

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<sup>1</sup> "this cultural readjustment is limited by the amount of disagreement which prevails among groups about the effectiveness of any new precautions adopted" (Turner, 1978, p92) The discussion contained within Chapters 1 and 2 puts forward a framework by which this can be assessed.

assess the extent to which a full cultural readjustment occurred within the football industry. As it is argued that no full readjustment took place, the second objective was to explore and examine why there was little learning from the various crisis incidents.

The remainder of Chapter 1 deals with a number of issues. First, it deals with the social or organisational dimension of crisis incidents and suggests that human activity may influence the potential for a systems failure. The Chapter proceeds to the identification of a series of stadium incidents providing the basis for cross national and sport comparisons. Three perspectives regarding causality of the UK's stadia accidents are examined. The Chapter concludes with a consideration of three stages of crisis and assesses the potential contribution of learning at each stage.

### **1.1 Definition of Terms**

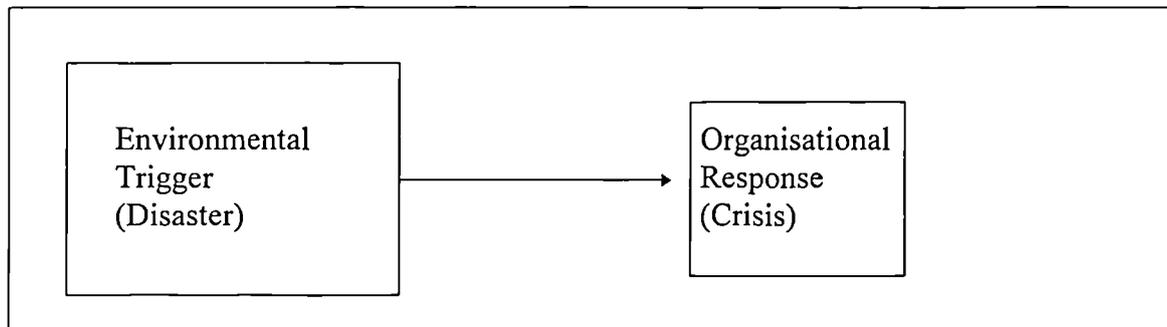
The study of organisationally based crises and disasters, many authors use the terms interchangeably, has received increasing attention in recent years (Pauchant & Douville 1993). Although used interchangeably, each term may imply a particular view of the nature of crises or disasters. Broadly two general approaches exist which we have termed here the 'Disaster' and 'Crisis' Management Schools. A limitation of any review of such a diverse literature is that it will fail to do justice to the complexity of writing within a particular field. Of course individual researchers rarely fit neatly into one view or another and of course, writers may change their views over time. With these limitations in mind attention is drawn to the main differences between these two Schools.

## 1.2 Crisis and Disaster Management Theory

This section introduces and defines the key terms that are used throughout this thesis. A thorough review of this literature is beyond the scope of this thesis and a number of such reviews have been undertaken (See for example, Lagadec 1993; Quarantelli 1988; Pauchant & Douville 1993 ). Some authors have suggested that overuse has stripped the term 'crisis' of scholarly meaning (see for example, Robinson 1971, Morin 1976, Eberwein 1978 and Pauchant 1993). A brief review of the evolution of research in the field of disaster and crisis management sets the context for the use of the terms crisis and disaster within this thesis.

The Disaster Management School has since the 1960s focused primarily on the response of organisations, particularly the emergency services, to natural disasters. The term 'crisis management' in this context has been equated with 'emergency managing' only (see for example, Quarantelli 1988). That is, particular attention is given to understanding the processes by which post disaster communications and co-ordination are achieved. The underlying causality of crises has not been considered in detail by the 'Disaster School', reflecting its primary concern with 'naturally occurring disasters'. No human intervention could prevent an earthquake or tornado, for example. Although it would be unfair to suggest that researchers from this field hold a simplistic view of the underlying causes of crises, it is evident that its emphasis upon the post incident phase has been to the detriment of the study of the pre incident phase (See for example, Dynes & Aguirre 1971, Quarantelli 1988). As Horlick-Jones (1990), Toft & Reynolds (1992) have argued, the cause of such crisis incidents are often explained as 'acts of God,' highlighting a potential danger of this approach; that organisations and/or communities are treated

as separate from their environment. In Figure 1.1 the relationship between the environmental trigger (disaster) and organisational response (crisis management) is shown, as seen from a 'disaster management' perspective.



*Figure 1.1 : Disaster & Organisational Response*

A key limitation of focusing upon the post crisis incident phase was identified by Hardin (1971) who examined the deaths of some 500,000 people following a cyclone in East Bengal. Hardin (1971) criticised the view that the cyclone was the cause of death as too simplistic, instead suggesting that the underlying cause was systemic, including a combination of inadequate infrastructure, overpopulation and the decision to locate people in a hazardous area. Although Hardin (1971) made no use of the term 'trigger' it is clear from his analysis that human activity can create the potential for disaster of which the cyclone was merely the trigger.

Alternatively, the Crisis Management School, uses the term 'crisis management' to refer to organisational activity before, during and after a specific crisis incident as shown in figure 1.2. As Shrivastava (1987a), Pauchant & Mitroff (1988) and Smith (1990a) have argued, the activities and inactivities of managers may, and often do, play a key role in the promulgation of crisis incidents, as well as influence the immediate organisational response and subsequent recovery. Although figure 1.2 is shown as a linear model it should be seen as circular with the post crisis stage feeding back into the pre crisis stage of a subsequent crisis

incident. Learning from crisis is an important means by which this ‘vicious circle’ can be broken (see for example, Smith, 1995). The research interests of the ‘crisis management’ school, therefore, are not only with the crisis incident and immediate

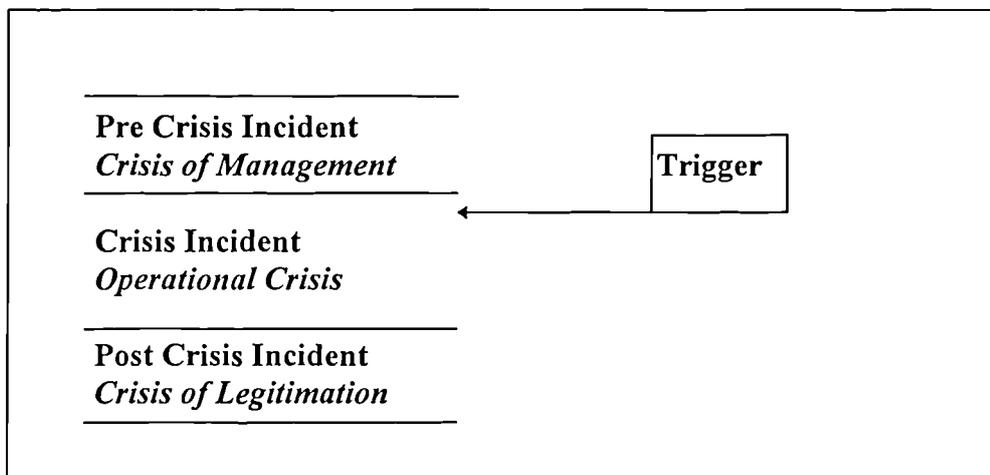


Figure 1.2: Three Stages of Crisis  
Source: Smith (1990a)

response but also focuses attention on the organisational causes of crises. The crisis management approach, which underpins this thesis, rests on the assumption that organisations themselves influence their propensity to crisis, a point which is discussed in more detail later in this Chapter. However, despite the distinction drawn between a crisis and disaster management approach, identified above, these two terms are used interchangeably throughout this thesis except where specified. The next section draws further distinctions between the term crisis, accident and incident. Additionally, the next section examines the concept of cultural readjustment, which refers to the process by which organisational learning from crisis is translated into new precautionary norms and operating procedures that break the ‘vicious circle’ of crisis. However, where the term ‘crisis incident’ is used in this thesis it refers to the second stage of the model shown in figure 1.2.

### 1.3 Distinguishing between Crises and Accidents: Cultural Significance

Learning from crisis has received relatively scant attention within a literature that has focused upon understanding both the causes of socio-technical crises and the immediate recovery from crisis incidents (see for example, Quarantelli 1988, for a review of the Disaster Management literature). However, some recent studies (most notably Toft & Reynolds 1992, Smith & Sipika 1993, Smith 1995, Fortune & Peters 1995) have dealt with the issues associated with organisational learning from crisis incidents.

Central to the learning process is the role of culture, defined for the present as a set of assumptions and practices, which permits beliefs about issues such as risk and safety to be constructed. Toft & Reynolds (1992) argued that:

“A culture is created and recreated as members of it repeatedly behave in ways which seem to them to be the natural, obvious and unquestionable way of acting.”(p3).

The link between beliefs and behaviour is central to this definition of culture and is discussed more fully in Chapter 2. Turner’s (1976, 1978) analysis suggested that following a ‘major man-made disaster’ full cultural readjustment may take place:

“when the immediate effects [of a disaster] have subsided, it becomes possible to move toward something like a full cultural readjustment.... of beliefs, norms and precautions, making them compatible with the newly gained understanding of the world.”(Turner, 1976, p382).

Turner’s analysis was primarily concerned with the incubation of crises and identifying “organizational patterns that precede ... disasters”(Turner 1976, p380).

This thesis challenges the hypothesis, implicit within Turner’s (1976, 1978) analysis, arguing that in the case of the football industry, which was subject to incidents investigated by four public inquiries in the period 1946-89, no such full cultural readjustment occurred. The commissioning of a public inquiry is used by

Turner (1976, 1978) and Toft & Reynolds (1992) as a proxy measure for the cultural significance of a particular incident. As Turner (1976) argues:

“there is little need for a re-evaluation of culturally accepted devices when accidents, even on a large scale, occur in situations recognized as hazardous. When a trawler is lost in Arctic fishing grounds, or when a wall collapses onto a firefighting team, there is much less comment than when an accident kills passengers on a suburban commuter train.” (p380).

For a number of authors it is the cultural significance of an event that distinguishes a crisis from a simple accident. Turner (1978) refuting arguments that defined disasters by scale (see for a recent example, Keller et al 1990) suggested that for an accident to be described as a disaster:

“it will probably need to be an unusually large-scale accident, an unusually costly accident, an unusually public accident, an unusually unexpected accident or have some combination of these properties.” (Turner, 1978, p26).

Pauchant & Mitroff (1992a) suggested a typology of crisis, based on the work of Perrow (1984) and Habermas (1973), that restricted use of the term ‘crisis’ to those

		Systems Area	
		Subsystem	Whole System
Systems Level	Physical	Incident	Accident
	Symbolic	Conflict	Crisis

Figure 1.3: Definition of Terms in Crisis Management  
 Source: Pauchant & Mitroff (1992a) p13

‘happenings’ that physically affect an entire system and challenge basic assumptions of members of that system to the point at which they are forced to acknowledge the faulty basis of these assumptions or develop defence mechanisms to protect these assumptions. The term ‘accident’ is used to describe a disruption that affects a whole system physically but not symbolically. This typology is shown

in figure 1.3. Turner's (1976) Arctic trawler might thus be described as an accident because it does not trigger a cultural re-evaluation.

Pauchant & Mitroff (1992a) used the example of Bhopal which they modelled both as an accident and as a crisis (see appendices 1.1 and 1.2 respectively). The accident model focused upon the detail of what went wrong (technically and organisationally) whilst the crisis model, encompassing all this detail, also emphasised the symbolic importance of the disaster with reference to operating norms and procedures within Union Carbide, the World Wide Chemical Industry, and the operations of Multi National Companies in developing countries. This view is linked closely with Turner's (1976) view of cultural readjustment. A crisis incident, as defined by Pauchant & Mitroff (1992a), has a symbolic importance that leads managers and other personnel to question critically existing methods of operation and thus leads to the development of new operating norms:

“To some extent this is what distinguishes *crisis management*, where both the physical and symbolic dimensions of a crisis are addressed before and after a crisis, from *security management* which is limited to the technical side of safety, and *crash management* which is limited to reactive actions.” (Pauchant & Mitroff 1992a, p18).

These qualities of a crisis share much with Turner's (1978) definition of disaster:

“an event, concentrated in time and space, which threatens society or a relatively self-sufficient subdivision of a society with major unwanted consequences as a result of the collapse of precautions which had hitherto been culturally acceptable as adequate.” (pp83-4).

Turner's (1976) notion of full cultural readjustment is clearly referring to the symbolic dimension identified by Pauchant & Mitroff (1992a). Previous studies have also drawn a distinction between the structural and psychological aspects of crisis. For example, Billings et al (1980) critiqued Hermann's (1971) 'classical'

model that had identified three dimensions to crisis, 'degree of threat, surprise and limited time for decision making':

"Two actors may be in precisely the same situation, yet one may feel uncertainty, time pressure etc. and define the situation as crisis, while the other may see it as a routine decision-making situation. Crisis resides in the person as well as in the situation." (Billings et al. 1980, p.306).

Eberwein (1978) distinguished between structural and psychological approaches to crisis:

"structural concepts of crisis stress the objective aspect of the phenomenon that is a specific state of affairs independent from the fact of being perceived or not ... while psychological concepts are those defining the subjective or perceptual aspect of a specific state of affairs ... irrespective of the fact whether such a state of affairs exists or not outside... perception." (p126).

It follows from this discussion that two identical events may be perceived of in different ways, one as a crisis, the other as an accident, to use Pauchant & Mitroff's (1992a) terminology. That is, one possesses a symbolic importance and leads to a challenge of the core organisational assumptions which acts as the first step towards full cultural readjustment; alternatively, the other (an accident) is treated as a 'structural' failure only; hence Smith's (1995) observation that the biggest hurdle to learning from disasters concerns the focus of managers upon the technical elements only of a system's failure.

The perceived importance by individual decision makers of a particular incident sets an important dimension to the context in which organisational learning occurs. Only the physical or technical elements of an incident will be examined where it is perceived to be an 'accident'. Smith (1995) argued that the greatest barrier to learning is that managers search for technocratic solutions to socio-technical problems reflecting their inability to see the importance of cultural, human and social factors.

“The dilemma is that if we focus only on the technocratic group of elements then we will, by definition, leave the dangerous human elements free and active within the system.” (Smith, 1995, p20).

This reflects the importance of symbolism to Pauchant & Mitroff’s (1992a) definition of crisis; it suggests that examination goes beyond the technical issues to include a questioning of the social and organisational dimension of crisis.

In summary, the terms crisis and disaster are used interchangeably throughout this thesis. They refer to ‘culturally significant’ events, indicated by the commissioning of a public inquiry. Cultural readjustment combines the re-evaluation of ‘beliefs and precautionary norms’ and their translation into new operating procedures. That is, the challenge to previously held assumptions leads to changed behaviour, based on the newly acquired understanding through the public inquiry process. The commissioning of four public inquiries, in addition to other official reports, indicates the symbolic importance of the major football stadia disasters. Thus, each might have been expected to trigger a full cultural readjustment. The principal hypothesis to be examined is that:

**“a full cultural readjustment did not occur following each of the stadium disasters.”**

A full explanation of how this hypothesis was examined is provided in Chapter 3.

#### **1.4 Learning from Disaster: Full Cultural Readjustment?**

In their study of learning from disasters, Toft & Reynolds (1992) concluded that single loop learning is the most common response to disasters leading to what they defined as a failure of hindsight. Single loop learning (Argyris 1994), which may be defined as ‘within paradigm learning,’ focuses upon the structural elements only. Turner (1976, 1978) had earlier referred to failures of foresight in which the warning signals of disaster potential were misunderstood or ignored. Toft &

Reynold's (1992) analysis went a step further by suggesting that following a disaster, failures of hindsight occurred because an inability to learn from major system failures leads to the recurrence of 'like incidents'. Single loop learning forms the explicit basis for two of the three 'pure' types of learning identified by Toft & Reynolds (1992); *organisation specific learning* (where each organisation involved in a disaster draws its own lessons from the incident); *iconic learning* (where organisations are informed of an event). Within the third type double loop learning is implicit; *isomorphic learning* (where 'universally applicable lessons' from an incident are learned). Toft & Reynolds (1992) were particularly concerned with isomorphic learning and the transfer of knowledge between superficially different systems. For example, understanding the behaviour of people when threatened by a fire can be of value regardless of whether the potential fire location is a theatre, hotel, football ground or underground station.

As discussed in section 1.2, crises differ from accidents in the symbolic significance attributed to them. Figure 1.4, developed in part from Turner's (1976) 6 stage model, identifies the process by which cultural readjustment and organisational learning may take place. Turner's (1976, 1978) model is shown at the right hand of figure 1.4, alongside the relevant stage in the organisational learning from crisis process model. The concern of Turner with the pre crisis incident stages can be seen clearly. The pivotal role of the public inquiry is identified, although, it is suggested in this thesis that actual learning is more complex than simply receiving the results of such inquiries. This is the key omission in the works of Turner (1976, 1978) and Toft & Reynolds (1992),

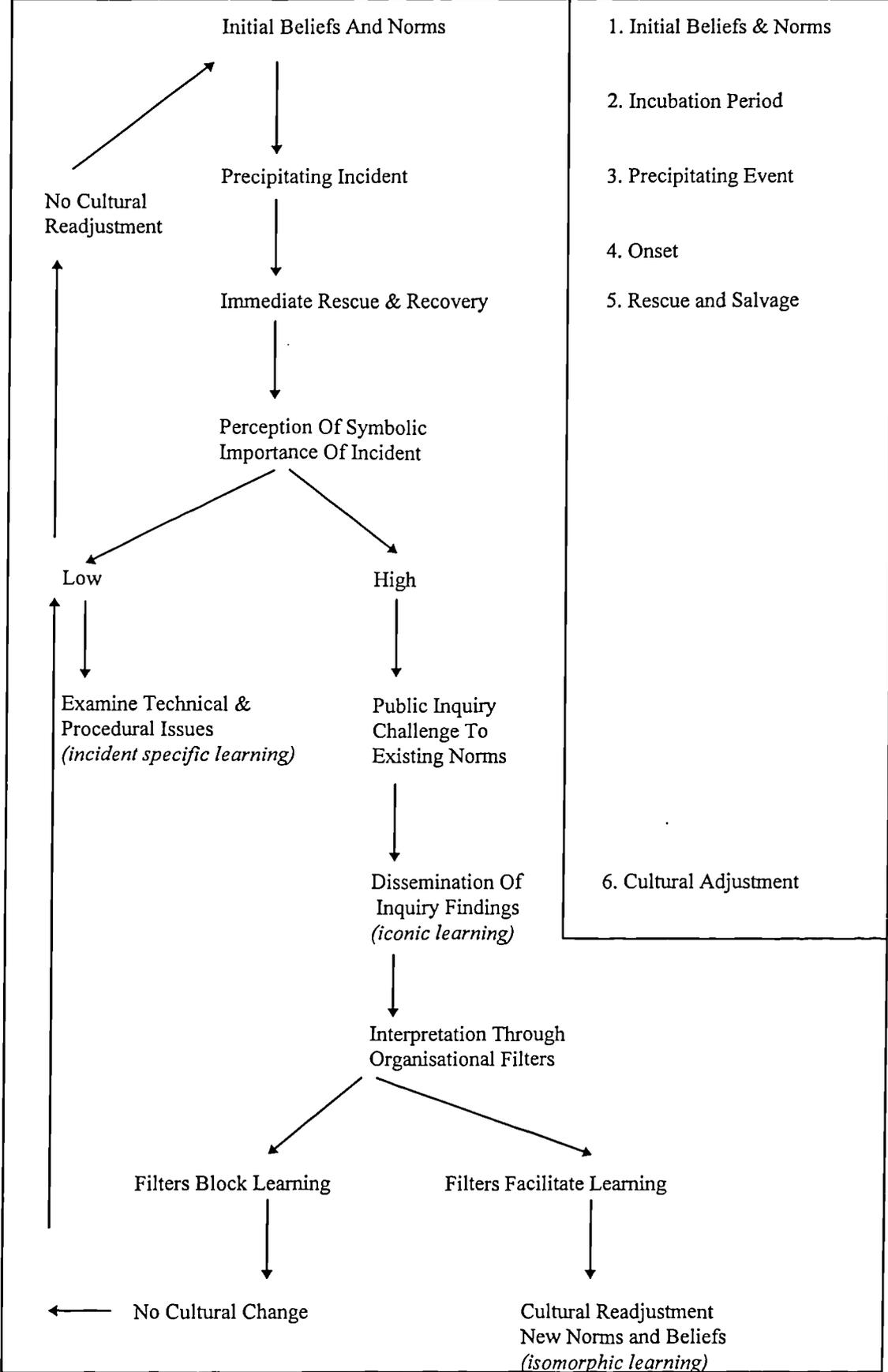


Figure 1.4 : The Organisational Learning From Crisis Process

although it should be noted that their concerns were with distinct incidents rather than the series of disasters within one industry that are the focus of this study. As figure 1.4 highlights, information from the public inquiry process will be examined and interpreted through a number of organisational and individual filters. This is the key contribution to the models suggested by Turner (1976, 1978) and Toft & Reynolds (1992) who failed to develop any critical examination of how organisations might learn and how they might filter information. The nature of these filters forms the basis for much of the discussion in Chapter 2 and it is hypothesised that these filters have a powerful influence on the quality of learning that occurs.

Figure 1.4 also identifies Toft & Reynolds' (1992) three types of learning (shown in italics) and places them within the context of an overall learning process. It differs from the models put forward by Turner (1976) and Toft & Reynolds (1992) by the inclusion of a stage of interpretation which, it is argued in this thesis, is the key to understanding how the knowledge acquired is translated into active learning. Turner (1976) fails to explore how the definition of new, well-structured problems and appropriate precautions through the inquiry process, is translated into new norms and operating procedures. This process, it is argued, is more complex than either Turner (1976, 1978) or Toft & Reynolds (1992) suggested. A main objective of this thesis is to develop insights into this process with reference to the UK football industry..

The next section presents a brief background to the series of crises experienced by the UK Football Industry. Comparisons are made with other countries and other sports suggesting that the UK football industry had a particular problem over a period of forty years. As discussed earlier, despite recent interest in organisational

learning from system failures there has been no attempt to systematically examine an industry which has experienced a series of disasters. The experiences of the Football Industry up to and including early 1997 offer an opportunity for such an examination.

### 1.5 The UK Football Industry: A Series of System Failures

On April 15th 1989 ninety-five people died in the Hillsborough Stadium, a ninety sixth victim died some three years later, never having recovered consciousness.

“After eight previous reports and three editions of the Green Guide<sup>2</sup> it seemed astounding that 95 people could die from overcrowding before the very eyes of those controlling the event.”(Taylor ,1989 p4)

As Taylor’s statement indicates, the Hillsborough tragedy was not seen as a freak accident, technical failure or simple Act of God, a usual explanation for such catastrophes (Horlick-Jones 1990, Toft & Reynolds 1992), but as a failure of those responsible for ensuring crowd safety inside sports stadia.

Before Hillsborough, eight Government sponsored reports had led to a myriad of recommendations, the introduction of a legislative and advisory framework, and the development of a stadium licensing system. Between 1945 and the 1989 Hillsborough tragedy, over two hundred and fifty spectators died inside British Football Stadia, and, many more had been injured (see Table 1.1). Taylor (1989) noted ‘that many of the deficiencies .. *had* been envisaged’ suggesting that the problem of managing crowds inside stadia had been treated with some complacency.

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<sup>2</sup> Green Guide to Safety in Sports Grounds, first published in 1973 and subsequently revised in 1986, 1990, 1997. The Green Guide is the main source of guidance for football clubs and regulatory agencies regarding the technical requirements for stadia and more recently, advice on safety management.

There are two key arguments of this thesis. The first is that the tragedies, of which Hillsborough was only the most recent (others include Ibrox 1971, Bradford 1985), were the result not simply of the technical and organisational failures on the day of the disasters, but of a longer process influenced by the norms and values of individuals and organisations associated with the football industry. That is, failure to learn by the various agencies within the industry contributed to each disaster. The second main argument is that despite the major redevelopment of football grounds since 1989, these norms and values have changed only superficially.

### **1.5.1 Stadium Disasters in the UK and World-wide**

Stadium disasters are not a problem restricted to the UK. For comparative purposes a summary of world wide stadia disasters is shown in Table 1.2. A number of observations can be made about the data included within the two tables.

(i) Fatal accidents have occurred inside football stadia since the creation of the Football League (1888).

(ii) There has been an apparent increase in the number of incidents in the period since 1960. Although table 1.1 suggests that the incidence of 'stadium accidents' may have increased since 1960 the lack of detailed evidence for the preceding period prevents a proper analysis from being undertaken.

(iii) Accidents are not restricted to larger football stadia but have also occurred in those owned by clubs with smaller stadium capacities.

(iv) Although extensive efforts were made to collect data from developed countries, particularly from the UK's immediate European neighbours where football is similarly popular, most of the examples included in Table 1.2 would be

Venue	Year	Fatalities	Injuries	Disaster Type
Valley Parade (Bradford)	1888	1	3	Railings collapse
Blackburn	1896		5	Stand Collapse
Ibrox (Glasgow)	1902	26	500	Collapsed temporary stand
Brentford	1907		25	Fence Collapse
Leicester	1907		25	Barrier Collapse
Hillsborough (Sheffield)	1914		80	Wall collapse
Charlton	1923		24	Crowd Crush
Wembley	1923		1000	Crowd Crush
Burnley	1924	1	50	Crowd Crush
Manchester (City)	1926		25	Crowd Crush
Huddersfield	1932		100	Crowd Crush
Huddersfield	1937		4	Crowd Crush
Watford	1937		<10	Crowd Crush
Fulham	1938		<25	Crowd Crush
Rochdale Athletic Ground	1939	1	17	Roof Collapse
Burnden Park (Bolton)	1946	33	400	Crowd Crush
Shawfield (Clyde)	1957	1	50	Barrier Collapsed
Ibrox (Glasgow)	1961	2		Crowd Crush on Stairway 13
Oldham	1962		15	Barriers Collapse
Arsenal	1963		100	Crushing
Port Vale (Stoke on Trent)	1964		2	Fall/Crushing
Roker Park (Sunderland)	1964		80	Crowd Crush
Anfield (Liverpool)	1966		31	Crowd Crush
Leeds	1967		32	Crowd Crush
Ibrox (Glasgow)	1967		8	Crowd Crush on Stairway 13
Dunfermline	1968	1	49	Crowd Crush
Ibrox (Glasgow)	1969		24	Crowd Crush on Stairway 13
Ibrox (Glasgow)	1971	66	<100	Crowd Crush on Stairway 13
Carlisle	1971		5	Barrier Collapse
Oxford	1971		25	Wall Collapse
Stoke	1971		46	Crowd Crush
Wolverhampton	1972		80	Barrier Collapse
Arsenal	1972		42	Crowd Crush
Lincoln	1975		5	Wall Collapse
Leyton Orient	1978		30	Barrier/Wall Collapse
Hillsborough (Sheffield)	1981		38	Crowd Crush
Middlesborough	1981	2	<20	Gate collapses,
Walsall	1984		20	Wall Collapsed
Bradford	1985	56		Fire
Birmingham	1985	1	200	Wall Collapsed/Hooliganism
Heysel (Brussels)	1985	39		Wall Collapsed. Hooliganism
Easter Road Edinburgh	1987		150	Crushing
Hillsborough (Sheffield)	1989	95	400	Crowd Crush
Middlesborough	1989		19	Crowd Crush
Stockport	1991		3	Crowd Crush

Table 1.1: Stadium Disasters in the UK:

Sources: Elliott, D (1996), Inglis, S (1996), McGibbon, E (1996) FSDAC Bibliography (1993)

Venue	Year	Fatalities	Fatalities	Disaster Type
Lima (Peru)	1964	300		Crowd Riot
Turkey	1967	41		Crush
Buenos Aires (Argentina)	1977	71		Crush
Cairo (Egypt)	1974	48		Crush
Piraeus (Greece)	1981	24		Crush/Stampede
Ibague (Colombia)	1981	18		Crush
Cali (Colombia)	1982	24	250	Crushing/Stampede
Algiers (Algeria)	1982	10		Roof Collapse
Moscow Spartak (Soviet Union)	1982	340		Crowd Crush
Mexico City (Mexico)	1985	10	29	Crushing
Tripoli (Libya)	1987	20		Crush
Katmandu (Nepal)	1988	70		Stampede during Hailstorm
Lagos (Nigeria)	1989	12		Crush
Orkney (South Africa)	1991	40	50	Riot/Stampede
Bastia (Corsica)	1992	17		Crush
Lusaka (Zambia)	1996	9	52	Crowd Crush, exit from ground
Guatemala	1996	80	150	Crowd Crush

Table 1.2 : Stadium Disasters World-wide

Sources: Elliott 1996, Inglis 1996, McGibbon 1996, Daily Telegraph 1996

considered as developing nations. For example, the United Kingdom is the only G7 nation to have been the scene of more than one stadium disaster. Few of the incidents reported in table 1.2 received the media coverage given to the UK tragedies, making it highly probable that this list is incomplete. For example, the recent Zambian disaster was reported in only one British Newspaper and received coverage of less than one column inch (Daily Telegraph, 25/06/96).

(v) A number of the disasters listed in table 1.2 were triggered either by adverse weather conditions or by political violence, neither of which has been identified as triggers for UK Stadia Disasters.

(vi) The absence of examples of stadia accidents in Italy, Germany and The Netherlands is surprising given the popularity of football in these countries and the large attendances that matches attract. A table of some 80 European stadia that have been used as 'big match venues' is included at appendix 1.2 to demonstrate that stadia are of equal size to those in the UK . The regular concentration of large

crowds into stadia is not peculiar to Great Britain. The average age of stadia (in 1994) ranged from 41 years (Germany), 45 years (Italy, Holland), 53 Years (Spain), 54 years (France) and 91 years (Great Britain). It should be noted that the age has been calculated on the basis of when a stadium was first established on a particular site. Difficulties in assessing the extent of any subsequent refurbishment prohibited the use of rebuild as a measure of age. The significance of age, apart from the implications for the design of stadia and its possible condition, concerns the geographical location of stadia given that transport to and from such constructions was very different in the early twentieth century from that now (Bale 1993). Another observation is that in the cases of Italy and Germany, and to some extent Spain and France, municipal authorities have been frequently involved in the development of new stadia with a multi purpose use anticipated (e.g. with running tracks surrounding the pitch). In the cases of Germany and Italy, new build appears to have occurred in two main phases with government investment. The first during the post First World War period in which grand stadia may be linked to the rise of nationalism. The second phase when preparations for hosting major international events were made; the Olympics (Germany 1972) and Football World Cup (Italy 1990). A final observation is that the reduction in stadia capacities has not been restricted to Great Britain (see appendices 1.2 and 1.4) and as the figures for Germany, Italy and Spain illustrate, official capacities have been exceeded in the past and current capacities are much lower than some twenty years ago. This evidence supports the view that the concentration of large numbers inside sports stadia is not unique to Great Britain, neither is the reduction in capacities. Key

differences lie however, in the forms of ownership of stadia and in the time elapsed since the decision to first build a stadium on a particular site was made.

(vii) A comparison with Rugby League, the second most popular spectator sport in the UK, if measured by the average attendances at first division matches (see Appendix 1.3), indicates a large difference in attendances. In the ten year period 1986 to 1995 some seventy two instances of crowds in excess of twenty thousand are recorded (excluding cup finals). Of these exactly half took place at either Wembley or a League football club's ground. Notably, the first recorded death in a crowd related incident at a British stadium took place at a Rugby League match in 1888 (Inglis 1996). For comparison, on an average Saturday in 1997 there are some fifteen football crowds in excess of twenty thousand.

(viii) Although Hillsborough was the last 'tragedy' to date, other 'incidents' have occurred in and around sports stadia since 1989. Two are identified in table 1.1. Another, that cannot be identified because of assurances from the author regarding anonymity, concerned a crushing incident as crowds sought to re-enter a ground.

The UK appears to have a particular problem concerning crowd safety inside sports stadia. It is clear that the concentration of large crowds inside stadia is not peculiar to the UK but the use of stadia appears to be a riskier activity for British football spectators than for their Rugby League or Continental European peers. Within the relevant literature three basic explanations of the Stadia disasters can be identified.

## **1.6 Explanation One: The Hooligan Trigger**

The first view, and one that has received some popular currency (See Giulianotti et al 1994 for a discussion of media coverage), suggests that the

tragedies were caused largely by one factor, hooliganism, either directly by the hooligans themselves or indirectly by the ways in which measures were introduced to deal with this problem. Reflecting the former view, Sir Bernard Ingham (1996), Chief Press Officer (1980-90) for Prime Minister Thatcher, stated:

“that the Hillsborough soccer disaster was caused by tanked up yobs who arrived late, determined to force their way into the ground. (Daily Mail 20/06/96, p11).

Ian Taylor (1989) putting forward a similar view, albeit from an alternative political perspective, discussed the ‘over-determination’ of the issue of crowd safety during the 1980s, setting it against a national context of poor investment in infrastructure and the desire of Government to deal with the problems of hooliganism by increasing police powers rather than to search for its underlying causes:

“The determining cause, if this is the appropriate word, of the Hillsborough tragedy was, indeed, the way in which the Leppings Lane terrace, like so many of the ‘popular ends’ at English soccer grounds had been reconstructed over the years as a caged in ‘pen’ from which there was no means of escape at a predictable moment of crisis of mass spectator excitement and anxiety. It is vital to understand that this process of caging in a section of the soccer audience, identifiable with that portion of the underclass seen to be generally and universally capable of violent behaviour, is a social process - prioritising ‘secure containment’ - and a product or expression of a particular historical and *political moment* deriving from the late 1960s and 1970s.”(Ian Taylor, 1989, p95).

The coincidence of the Bradford fire in 1985 with incidents of football hooliganism in Britain and the Heysel stadium tragedy in Brussels meant that the upsurge in political interest in Britain, including the involvement of Prime Minister Thatcher, was concerned primarily with the issue of hooliganism. Hogwood (1987), Taylor (1989), and Giulianotti (1994) argued that such a view suited the dominant view of the “state” and allowed for the development of technocratic solutions in the form of more rigid police control of spectators and the building of more fences to

contain football supporters. At Heysel, thirty-nine spectators were crushed to death following a charge of English supporters. Although subsequent inquiries highlighted that the Heysel Stadium contained structural flaws and that inadequate communications had existed between the various police agencies overseeing the event (t'Hart & Pinjenburg, 1989), hooligans clearly played a key role in triggering the incident. Popplewell's Interim Report (1985) dealt largely with the Bradford Fire and the events at Birmingham, on the same day, that saw the death of one spectator following a confrontation between rival fans inside the stadium. The Final Popplewell Report (1986) focused upon the Heysel Tragedy, devoting the majority of its content to the issues of crowd control and hooliganism. Concluding the Final Report Popplewell (1986) stated:

“I do not pretend that my Report can be all embracing or provide a simple solution to a complex problem. There is no panacea. There is no one solution to violence.” (p61).

thus illustrating that the issue of football violence was perceived to be at the core of the problem - despite his own findings that violence played no part in the events of the Bradford Fire and that there were a number of organisational and technical failures<sup>3</sup> associated with the Heysel Stadium disaster. The Government of the day did not wait for Popplewell to complete his report, but announced several measures within a week of the Heysel tragedy (Giulianotti 1994). This indicated a desire to be seen to act quickly, even without possession of the full facts. The influence of this particular view will be discussed in greater detail in Chapter 4. However, it is argued that the focus upon hooliganism as the football industry's primary problem was an important factor that helped to limit the effectiveness of learning.

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<sup>3</sup> A discussion and analysis of the various football disasters, including Bradford and Heysel is included in Chapter 5

## 1.7 Explanation Two: Simple Causes

A second explanation (a non-systemic approach) suggests that every disaster or crisis is unique, a view which Toft & Reynolds (1992) criticise for constraining learning to incident specific issues. For advocates of this perspective, that four major tragedies occurred within a thirty year time frame represented an unfortunate coincidence; but each should be treated on its own merits and not linked into any search for a common pattern.

Such an explanation rejects a systemic view, focusing solely upon the incident in question. Criticising such views Toft & Reynolds (1992) cite von Bertalanffy

“It did not matter whether a particular system was biological, sociological or mechanical in origin, it would display the same (or essentially similar) properties, if it was in fact the same basic kind of system.”(p3).

From this Toft & Reynolds (1992) deduct two further inferences, for which they provide extensive supporting evidence.

“First, that any failure that occurs in one system will have a propensity to recur in another like system for similar reasons. Second, although two particular systems may appear to be completely different, if they possess the same or similar underlying component parts or processes, then they will both be open to common modes of failure.”(pp4-5).

Recent comprehensive reviews of research in the fields of Man-made Disasters (Horlick-Jones 1990) and Crisis Management (Pauchant & Douville 1993) reported the growing agreement amongst researchers that crises (disasters) are system failures, resulting from complex interrelationships among many factors. Toft & Reynolds (1992) argued that the limited focus of learning from disaster incidents (i.e. incident specific rather than isomorphic or systemic) had been an important contributory factor to the recurrence of such incidents. Public Inquiries (the principal tool used to examine the various football stadia disasters), reported Toft &

Reynolds (1992), describe the events leading up to an incident, an analysis of these events and a series of recommendations that deal with technical issues aimed at preventing the recurrence of similar incidents. They fail to examine the systemic causes of crisis incidents, that is, the social and technical aspects together, thereby losing an opportunity to transfer learning to other socio-technical systems that share similar properties.

An example from the Football Industry concerns the Public Inquiry into the causes of the Ibrox tragedy, undertaken by Lord Wheatley. Following Wheatley's Report (1972) the Safety in Sports Grounds Act (1975) was introduced with supporting guidance in the form of the so called 'Green Guide'. The aim of the Green Guide was to provide guidelines for the design and management of sports stadia. Canter et al (1989) have argued that the Safety at Sports Ground Act (1975) and Green Guide put forward untested, technical solutions to the problems of managing crowds within stadia. The engineering simplicity of these technical fixes did not bear up to psychological examination; for example, people moving along a corridor or through an exit do not flow like liquid through a tube (Canter et al, 1989). Indeed technical advice contained within the Green Guide was in at least one case based upon incomplete and preliminary research. This guidance, reported Canter et al (1989), was treated as established fact. The ways in which technical approaches have been implemented suggests a widely held view that problems of crowd control and safety can be dealt with once and for all through the implementation of design standards that are created in response to specific incidents. Prior to the Hillsborough tragedy 'safety inspections' of grounds focused exclusively upon testing the strength of crush barriers. A further example, the

“Football Stadia Design Advisory Council” (FSDAC), set up following Taylor’s Reports, put forward guidelines based on people of average height. This average made no allowances for differences between men, women and children (John, 1993). No justification for this approach was made despite objections at the conference made by both the author and by a representative of the Royal Society for the Prevention of Accidents<sup>4</sup>.

A further problem is that despite the availability of guidance a number of football clubs failed to act upon advice. This failure was encouraged by Wheatley’s (1972) decision not to press for the introduction of a statutory Code of Regulations, but to opt for “a more flexible system under which the requirements of each stadium might be considered”. This “flexibility” was in spite of one of his concluding remarks concerning the failure of some clubs to implement the recommendations of the earlier Lang (1969) Report. As will be shown in Chapter 4, there is extensive evidence that many clubs failed to follow the guidance set down in the Green Guide and that an ineffective regulatory system ensured that these failures were rarely identified.

Whilst an overemphasis upon the failure of technical elements is most notable within the history of the football industry other examples do exist. Lord Justice Stuart-Smith, appointed by the Labour Government to determine whether there are grounds for re-opening the Hillsborough public inquiry, ‘joked’ when first meeting the Hillsborough Families Support Group, asking if “other families were going to turn up late like Liverpool fans” thus suggesting a simplistic interpretation of the causes of the Hillsborough disaster (Guardian, October 3rd) 1997 .

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<sup>4</sup> The Conference was held at the Home Office Training College at Easingwold, Yorkshire. It sought to bring together a number of experts in the field of crowd and sporting venue management.

The similarities between the first and second explanations of the various tragedies concern their focus on simple causes. In the first case, the hooligan problem is identified as the key trigger, in the second, technical failures or bad luck conspired to cause accidents. As de Quidt (1997a)<sup>5</sup> noted, the immediate response to the Hillsborough tragedy has been the redevelopment of football stadia (i.e. an emphasis upon technical solutions). The role of the Football Licensing Authority, de Quidt identifies, is to build upon these improvements and to facilitate the development of a real 'safety culture'. de Quidt's (1997a) view, and the evidence of recent near misses, lead to a research question that flows from the first hypothesis. Why didn't effective or active organisational learning occur? The focus upon technical issues appears to have formed a powerful mindset. This raises questions about the nature of the learning process and the organisational filters through which knowledge is processed and translated into actions. The underlying theoretical basis for the third explanation provides an alternative way of looking at the stadium disasters and an approach for exploring the issues of organisational learning from crisis.

### **1.8 Explanation Three: A Systemic View of Football Stadia Crises**

A third explanation, based upon a systemic view of crises, emphasises a common pattern of inadequate management practices, behaviour and attitudes within the industry that lies behind each of the crisis incidents (see for example t'Hart & Pinjenburg 1989, Elliott & Smith 1993a). Extensive supporting evidence for this view is included in Chapters 5 and 6 which contain a detailed analysis of each of the main crisis incidents.

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<sup>5</sup> Chairman of the Football Licensing Authority

An underlying assumption of this thesis (following for example, Turner 1976, 1978; Perrow 1984; Shrivastava 1987a; Smith 1990a; Pauchant & Mitroff 1992a; Toft & Reynolds 1992) is that the stadium disasters were socio-technical system failures. In a review of the crisis management literature, Pauchant & Douville (1993) criticised the approach of many researchers who focused upon only a few variables arguing that:

“Crises do not happen in a vacuum; they are the results of complex systemic interrelationships among many different variables.”(p51).

A systems approach seeks to avoid the flaw of over emphasising a particular causal factor by seeking to deal with the interplay between various system elements. As Checkland (1981) has identified, the central concept of systems thinking may be described as:

“the idea of a set of elements connected together which form a whole, this showing properties which are properties of the whole, rather than properties of its component parts.” (Checkland 1981, p3).

Using Checkland’s (1981) classification, a football stadium may be described as sharing the properties of a ‘designed physical system’ (the technical infrastructure) and a ‘human activity system’ (comprised of the people using a stadium, its management and the various agencies associated with crowd safety). The label ‘socio-technical system’ recognises this combination of physical and human components throughout this thesis. Checkland (1981) argued that each system type possesses its own idiosyncrasies. This view, it will be argued, has been ignored by many of the public inquiries regarding the stadia disasters, the results of which make the assumption that human behaviour can be regulated in the same way as liquids and gases in test tubes and pipes (see for example Sime 1985, Canter et al 1989). It can be hypothesised that ‘the response to the football stadia tragedies has

concentrated upon the technical system elements to the detriment of social components’.

It is argued that the stadium incidents were not the consequence of technical factors alone, instead they represented failures of complex systems, triggered by the individuals working within them.. Within this tradition this thesis argues that the various stadia tragedies 1971-89 were not unique but that they represented manifestations of a wider ‘crisis of management’ (Smith 1990a, Elliott & Smith 1993a) within the UK Football Industry. The remainder of this Chapter provides an overview of a crisis management approach. Figure 1.5 highlights the influence of each of these explanations upon the learning process. The high profile given to hooliganism and emphasis upon technical solutions operated throughout the learning process through the public inquiry to the implementation of recommendations. For individual clubs, it is argued, culture, structure and communications acted as filters through which learning was translated into new norms and operating procedures.

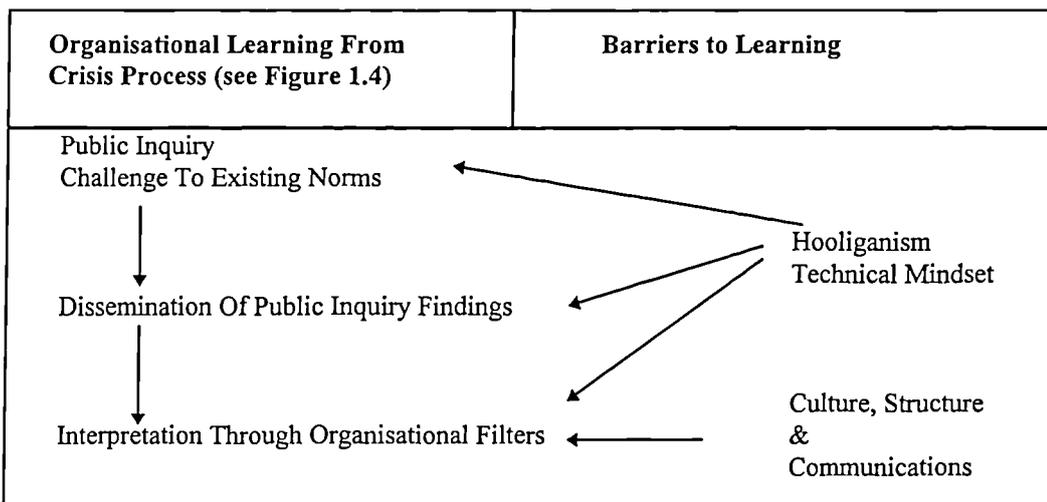


Figure 1.5: Barriers to Learning from Crisis

## 1.9 Stages of Crisis and The Organisational Incubation of Crises

The study of industrial and commercial crises is a relatively new and evolving discipline. It is important to recognise the distinction between those who are concerned with a largely reactive model of crisis management and those who advocate a more strategic approach. The contingency based approach to disaster management of the former group is exemplified by studies of media response (Scanlon 1992), organisational dynamics (Dynes & Aguirre, 1979, Quarantelli 1988) and medical response (Wallace et al., 1994). The latter group (see for example, Turner 1976, 1978, Shrivastava 1987a, Smith 1990a, Pauchant & Mitroff 1992a) are concerned with issues of prevention, change and learning rather than simply with response. A number of the key studies reflecting this latter view are summarised in table 1.3 which indicate the key developments. A common characteristic is the identification of a number of stages through which a crisis proceeds. As table 1.3 indicates researchers have identified a different number of stages. However, there is agreement upon three basic stages, pre crisis, crisis incident and post crisis recovery and turnaround.

From a theoretical perspective the opportunity to intervene early in system failures was lost to early researchers because the models did not include a pre-crisis stage. That is, they advocated reactive rather than proactive strategies (see for example, Fink et al. 1971).

Turner's (1976, 1978) seminal work was amongst the first to identify the role played by organisational culture and faulty assumptions in creating the preconditions for crisis:

“Common causal features are rigidities in institutional beliefs, distracting decoy phenomena, neglect of outside complaints, multiple information handling

difficulties, exacerbation of the hazards by strangers, failure to comply with regulations and a tendency to minimise emergent danger.” (Turner 1976, p378).

Turner (1976, 1978) argues that this combination of factors leads to a ‘failure of foresight’ as organisational personnel and systems are unable to identify potential risks. Toft & Reynolds (1992) developed this argument into the notion of

	Fink et al (1971)	Turner (1976)	Slatter (1984)	Fink (1986b)	Smith (1990a) (1995)	Shrivastava et al 1991	Pauchant & Mitroff (1992a)
<b>Pre Crisis Incident</b>		Stage 1 Starting beliefs about the world	Crisis Susceptibility	Stage 1 Prodromal Crisis	Stage 1 Crisis of Management	Stage 1 Environmental Munificence Firm: Optimism & expansion	Stage 1 Signal Detection
		Stage 2 Incubation period				Stage 2 Crunch Economic slowdown Firm: Cutbacks	Stage 2 Preparation and Prevention
						Stage 3 Uncertainty	
<b>Crisis Incident</b>	Stage 1 Shock	Stage 3 Precipitating Event	Stage 1 Crisis Denial	Stage 2 Acute Crisis	Stage 2 Operational Crisis	Stage 4 Triggering Event	Focal Crisis Incident
		Stage 4 Onset of crisis	Stage 2 Hidden Crisis	Stage 3 Chronic Crisis			
		Stage 5	Stage 3 Disintegration of organisation				Stage 3 Containment /Damage limitation
<b>Post Crisis Incident</b>		Rescue & Salvage	Stage 4 Collapse		Stage 3 Crisis of Legitimation		
	Stage 2 Defensive Retreat				(i) Defensive phase		
	Stage 3 Acknowledgement			Stage 4 Crisis Resolution	(ii) Consolidation phase		Stage 4 Recovery
	Stage 4 Adaptation & Change	Stage 6 Full cultural Readjustment	Stage 5 Recovery or Failure		(iii) Offensive Phase Learning		Stage 5 Learning Learning Feedback

Table 1.3 : Models of Crisis

‘failures of hindsight’ where organisations failed to learn effectively from crisis events leading to the recurrence of similar crisis incidents. Even with the benefit of hindsight, these rigidities of belief, information handling difficulties etc. act to prevent effective learning.

Turner (1976) also introduced the concept of a trigger event, the effect of which is dependent upon an organisation's 'susceptibility' to crisis. This argument is central to the contribution of later authors including Shrivastava (1987a) Pauchant & Mitroff (1988, 1992a), and Smith (1990a) who, whilst not dismissing the relevance of environmental factors, argued that crises can often be better explained in terms of internal (i.e. organisational) factors than external ones. That is, the propensity to crisis resides within organisations. The external factors may influence the internal ones and external elements may provide a trigger, but the inherent vulnerability is internal. This is not to say that the crisis resilient organisation will be able to deal with every 'external trigger' but that it will be better placed to do so. For example, a study of the effects of the bombing of the City of London upon resident banks found that:

"The particular organisational crises triggered by the City of London bombings were largely determined by internal factors- the degree of centralisation, hardware and software backup routines and out of hours staff communications. A gas explosion or earthquake might have had similar effects. Following the City's Bishopsgate bombing, the Nat West's data transfer routines were cited as a key factor in its ability to maintain operations. Conversely, the routines of the Hong Kong and Shanghai Bank Corporation did not facilitate a quick return to normality." (Swartz et al 1995, p19).

Increasingly the focus of research in the field of crisis management has shifted towards developing a greater understanding of how the preconditions for crisis arise as indicated in table 1.3. The notion that organisations possess crisis prone and crisis resistant properties has received much attention from a number of authors (See for example Slatter 1984; Schwartz 1987; Pauchant & Mitroff 1988, 1992a; D'aveni 1990b; Miller 1990). Others including Roberts (1990a & b, 1993a & b), Weick (1988,1993), La Porte 1996, deal with similar issues from the alternative perspective of 'high reliability organisations.' The basic philosophy

underlying this extensive research is that organisations influence their exposure to crisis and that greater effectiveness requires co-ordinated changes to plans and structures through fundamental changes in organisational beliefs and individual assumptions. For High Reliability Organisations (HRO), these authors focus on those organisations that have largely avoided crisis incidents despite operating in hazardous industries. However, HRO's are very narrowly defined against a set of specific criteria and there is thus a problem in using their arguments in other organisational settings. Despite this shift in emphasis within the academic literature, the 'professional' literature is still largely concerned with crisis response (see for example Regester 1987). Smith (1990a) has argued that this is indicative of 'the threat that such changes bring with them.'(p12). In other words, it is easier to justify resources for developing and resourcing contingency plans than it is to secure backing for the fundamental changes that a full crisis prevention process might require. Thus management inactivity may contribute to the incubation of crises.

'Incubation' is the term used by Turner (1976), Smith (1990a) and Toft & Reynolds (1992) to refer to the organisational process(es) by which the potential for crisis is created or enhanced. For example Smith (1990a) stated:

“the actions or inactions of management can promulgate the development of an organisational climate and culture within which a relatively minor triggering event can rapidly escalate up through the system and result in catastrophic failure.” (p271).

Toft & Reynolds (1992), recognising that crises frequently concern many organisations argued that:

“The socio-technical system operates, possibly suffering from inherent latent system failures which build up until some event occurs that precipitates or triggers an incident, accident or disaster.” (p9)

Within the Football Industry, the many 'incidents' or 'accidents' (to use Pauchant & Mitroff's typology) suggest many warnings of latent system faults which were generally ignored. This thesis now moves on to a consideration of those factors that have been identified as influencing the propensity of organisations to crisis.

#### **1.10 Factors that Influence the Propensity to Crisis**

Recent studies have identified the importance of "human" factors such as culture, structure, communications and history and "technical" factors such as systems' coupling and complexity, control, contingency planning and cost that cause some organisations to be more prone to crisis than others (see for example, Smith 1990a, 1993 Pauchant & Mitroff 1992a). Smith (1990a, 1992, 1995) for example, identified a number of critical elements within crisis causation, described as the 7 C's of crisis management. Two groups were identified in Smith's 7 element model, shown in figure 1.6, which may be seen as a critique of the search for excellence 7 S framework. Smith (1995) argued that the excellence characteristics embedded within the 7 S framework (Waterman et al 1980, Pascale & Athos 1981) represent one end of a continuum and that the 7 Cs represent the move into crisis incubation. Using the typology of Waterman et al (1980) and Athos & Pascale (1981), Smith (1995) grouped the 7Cs into technical (cold) and socio-politico (warm) categories. The 'cold square' elements of 'contingency planning', 'control', 'coupling and complexity' and 'cost' represent the technocratic aspects of crisis management, whereas the 'warm triangle' elements of 'culture', 'communications' and 'configuration' represent the organic aspects of the process. Smith (1990a) argued that the 7C's can be seen to operate in each of the different phases of crisis management (see figure 1.6).

Identifying causal factors is however, extremely difficult and the search for single or simple causes may be misleading, as Turner (1976, 1978) and more recently, Smith (1990a, 1992) noted. The interdependence of multiple factors is generally accepted within the literature (for example, Perrow 1984, Thain & Goldthorpe 1989a, 1989b, 1990; Smith 1990a; Pauchant & Mitroff 1992a; Shrivastava et al. 1991). No hierarchy is implied as it is the relationships between the various factors that are important. That is, a systems approach is used. Other research has sought to identify common patterns to identify organisational types.

Smith (1995) drawing on D’aveni’s (1990b) work on organisations and financial crises, suggested that this incubation phase may be up to ten years. From

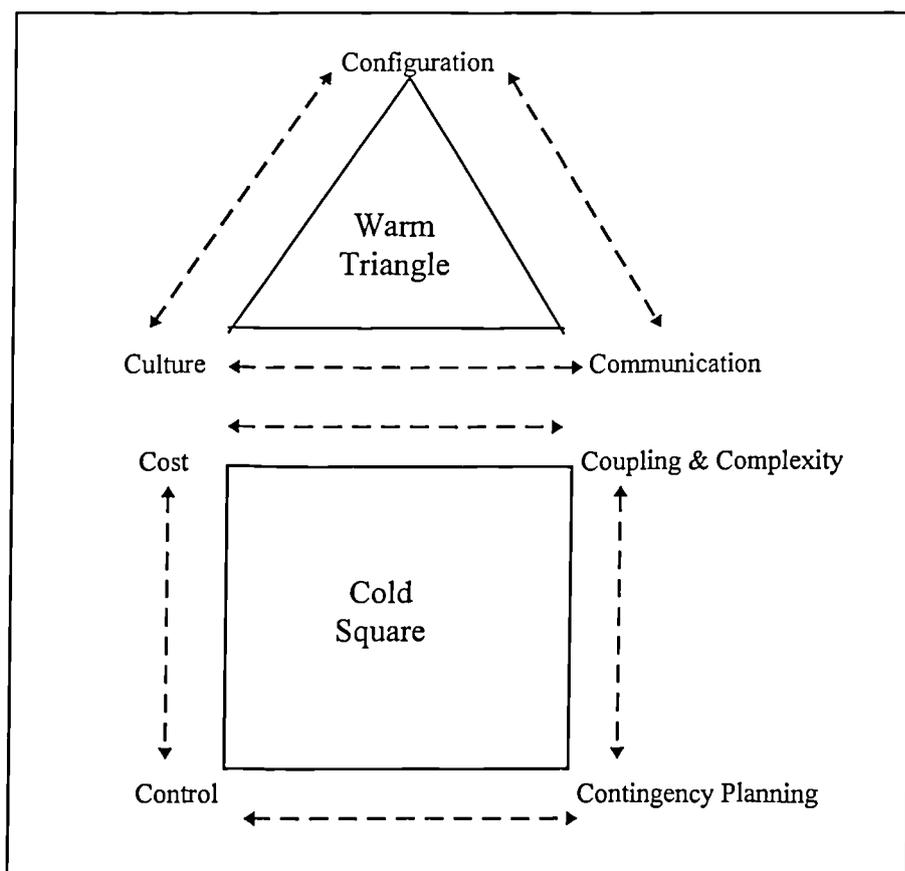


Figure 1.6: 7 Cs of Crisis Management  
 Source: adapted from Smith (1995)

a previous analysis of the football industry (see Elliott & Smith 1993a; 1997), and drawing on Turner's (1976) analysis this may be extended to encompass far longer periods.

The importance of core assumptions and beliefs about the world and potential hazards (identified by Turner (1976) Shrivastava (1987a) and Mitroff & Pauchant (1988)) indicate the influence of years rather than days or months. The influence of these core beliefs and assumptions is that events at variance with them are ignored or their importance is devalued (Turner 1976). Fink (1986b) described these as prodromes or warnings that are either not seen, or disregarded or the organisation fails to respond effectively to them. Fink (1986b) suggested that the prodromal stage began at least "13 months prior" to the Three Mile Island leak. With reference to the Football Industry, Stairway 13 in the Ibrox Stadium was the scene of three serious crowd incidents in the 10 years preceding the 1971 tragedy.

In summary the image of organisation formed by these writers is of a system in precarious balance, constantly adjusting and readjusting.

"It is clear, then, that what is important for the concept of crisis is not so much the external disruption which in certain cases effectively triggers a crisis process. Rather it is the internal disruption from processes apparently not disruptive.... and the internal disruption, triggered by overloading or double bind, will manifest itself as failure in the regulation or the decay of an homeostasis."(Morin 1976, p14).

In general terms the "trigger event" had become synonymous with the crisis itself. It is now seen by many authors as one phase ,or part of a phase, of the crisis process, which includes pre-trigger crisis conditions as well as a post trigger crisis incident.

### **1.11 Crisis Management Approach: The Operational Crisis**

At this stage the potential for crisis is translated into a system wide incident. This stage has received significant attention from researchers. As previously identified the Disaster Planning School starts from the assumption that a “catastrophe” has occurred. Typical subject matter includes studies of crisis communications and the examination of organisation structure and crisis response (see for example Dynes 1970, Dynes & Aguirre 1971, Hage et al. 1971, Quarantelli 1988). For Dynes (1970) crisis situations provided “a natural laboratory for testing hypotheses about organisational and group behaviour under realistic conditions of severe strain and stress”(p4). The interests of this group have usually concerned community based disasters reflecting the sociological origins of this approach. Quarantelli’s (1988) summary of this school’s research findings argues that the greatest improvement to “disaster crisis management” will be achieved from improving the behaviour of emergency organisations. This focus upon the emergency service distinguishes this literature from that of the management science field, although both schools of thought share an interest in the problems of information, communications and decision making (see Smart & Vertinsky 1977 for example).

Other researchers have examined the reactions of victims and rescuers alike (see for example James 1988, Hodgkinson & Stewart 1989, Elliott & Smith 1993b). The aim of research has been focused upon understanding how groups, individuals and organisations deal with the effects of the pressures generated by a crisis situation.

### 1.12 Crisis Management Approach: Crisis of Legitimation

Smith & Sipika (1993) have identified three distinct phases of crisis response shown in figure 1.7. The third phase shares some features of Turner's (1976, 1978) model. Smith & Sipika (1993), suggest that the removal of 'scapegoats' provides a basis for a restructuring and the 'cultural change process that is the embodiment of this final phase'. Smith & Sipika (1993) drawing upon the case of Union Carbide following the Bhopal disaster, argued that the removal of senior decision makers

<b>Crisis Incident</b>	
<b>Post Crisis</b>	
<i>Defensive Phase</i>	Immediate crisis response, attempt to limit the impact of crisis incident upon the organisation.
<i>Consolidation Phase</i>	Organisation seeks to provide a firm base on which to develop a strategy for repair and recovery.
<i>Offensive Phase</i>	Scapegoating and removal of a number of senior decision makers - Organisation adapts its culture and configuration to facilitate growth

Figure 1.7: Three Phases of Post Crisis Stage:  
Source Adapted from Smith & Sipika 1993

(scapegoats) provided a platform for cultural adjustment and reconfiguration. This may occur in some cases but not in all. A review of safety systems at the Bradford Football Stadium some eight years following the fire indicated the continuance of the lax safety culture that predated the disaster (Laybrun 1995), despite the removal of those held to be at fault.

Smith (1995), developing this model further, suggested that the issue of organisational learning from such events is often overlooked. The extent and type of such learning may prove to be a key factor in determining the future proneness of an organisation to crisis. That is, the crisis of legitimation feeds back directly into the crisis of management. Where one ends and the other starts is difficult if not impossible to determine. Understanding organisational learning and those factors

which influence the process, is key to understanding whether or not core individual beliefs and assumptions have changed. This process is discussed in greater detail in the next chapter.

### **1.13 Summary**

This thesis is concerned with two distinct but related issues. The first is to examine the hypothesis that “no full cultural readjustment followed the various stadium disasters”. Chapters 5 and 6 provide a detailed analysis of the football industry in the 1946-97 period which provides extensive evidence in support of the principal hypothesis.

The second issue concerns the reasons why no full cultural readjustment occurred. A hypothetical model of the ‘Organisational Learning from Crisis Process’ was identified in figure 1.4 and contrasted with that put forward by Turner (1976, 1978). This new model emphasises the role played by organisational filters as determinants of the extent of learning from crisis. That is, the public inquiry process through to the dissemination of its findings represents only one part of the cultural readjustment process. This raises a number of research questions which flow from the preceding discussion. First, what are these organisational filters and what are their characteristics? Chapter 2 identifies the theoretical justification for selecting culture, structure and communications as filters and provides frameworks by which these factors can be examined with reference to the UK football industry. Second, how did these organisational filters influence learning within the UK football industry? In particular how did these filters influence the interpretation of public inquiry findings and their translation into new operating norms and procedures? Cultural readjustment, as Chapter 1 has argued, refers to a process in

which knowledge is translated into changed behaviour. It is hypothesised that culture, structure and communications acted together to restrict organisational learning and cultural readjustment. With regard to culture, which is examined in detail in Chapter 2, it is argued that beliefs and assumptions about the role of hooliganism (directly and indirectly) and technical failures acted as powerful influences not only upon organisational learning but upon the entire public inquiry process. These arguments flow directly from the crisis management approach, discussed above, that suggests that organisations and managers themselves promulgate the conditions for crisis incidents. Each public inquiry represented an opportunity for the UK football industry to break the 'vicious circle' of crisis.

Finally, although the period since 1989 has witnessed the extensive redevelopment of stadia, the core beliefs and assumptions of managers within the industry have, it is argued, largely remained unchanged and that such superficial changes are unlikely to prevent future incidents. In other words, the football clubs and related agencies have not learned effectively from past incidents and the potential for future tragedy is high. The purpose of this thesis may be summarised as the testing of the first hypothesis concerning the extent of cultural adjustment and a supplementary exploration of organisational learning from crisis with reference to the football industry.

Chapter 2 introduces the analytical framework on which this thesis is based. It explores the key dimensions that influence organisational behaviour and argues that effective change to behaviour requires challenging deep-seated beliefs and assumptions. An analytical framework, based upon the crisis management literature is put forward as a model for examining the football industry. Chapter 3

describes the principal methods used during the research with an analysis of their advantages and disadvantages. The methodology made use of a mixed methods approach, one suited to the complexity of the subject under investigation. Chapter 4 provides background information to the industry; considers the contribution of the hooliganism debate to an understanding of stadia disasters; and outlines the organisational characteristics of the key agencies involved within the football industry. Chapter 5 examines the various stadium tragedies and analyses the response of football clubs to regulations in the period since 1946. In particular, this thesis is concerned with exploring the nature of organisational learning in the period between the Bolton (1946) and Hillsborough (1989) tragedies. Chapter 6 deals with the football industry in the post Hillsborough period and examines the extent of the cultural readjustment that has occurred within the football clubs and regulatory agencies. Chapter 7 includes the conclusions and recommendations for further research.

The main contribution of this research is that it represents the first attempt, from the literature reviewed, to examine organisational learning within an industry that has experienced a series of system failures. The final Chapter concludes with a series of recommendations regarding both directions for future research and practical measures for developing learning within the industry.

## **Chapter 2**

# **Crisis Management Theory and Organisational Learning**

## 2.1 Introduction

In Chapter 1 it was argued that the scale and occurrence of stadia disasters indicated a particular problem for the UK football industry. The commissioning of four public inquiries in a forty year period indicated the high symbolic importance attributed to these crisis events. Despite their high profile the recurrence of a series of accidents and crises suggests that no full cultural readjustment occurred raising questions of the ability of organisations and individuals working within the football industry to learn.

This Chapter concentrates upon organisational learning and identifies and examines those factors which may influence the learning process. It begins with an evaluation of the public inquiry process, given its prominence as a mechanism for learning, based upon previous studies. The Chapter introduces the guiding analytical framework which pulls together the key organisational characteristics that influence learning with the three stage crisis model (shown in figure 2.1).

Culture, configuration and communications have emerged from the literature as key factors. Each of these is critically examined in the subsequent parts of this Chapter. In particular, Pauchant & Mitroff's (1988, 1992a) Onion Model of Crisis Management is used to provide a framework for the identification of individual and social barriers to organisational learning (i.e. defence mechanisms, fatalism, inner orientation). Organisational structure and communications are examined with reference to Mintzberg's (1983) model of configuration which argues that there is a

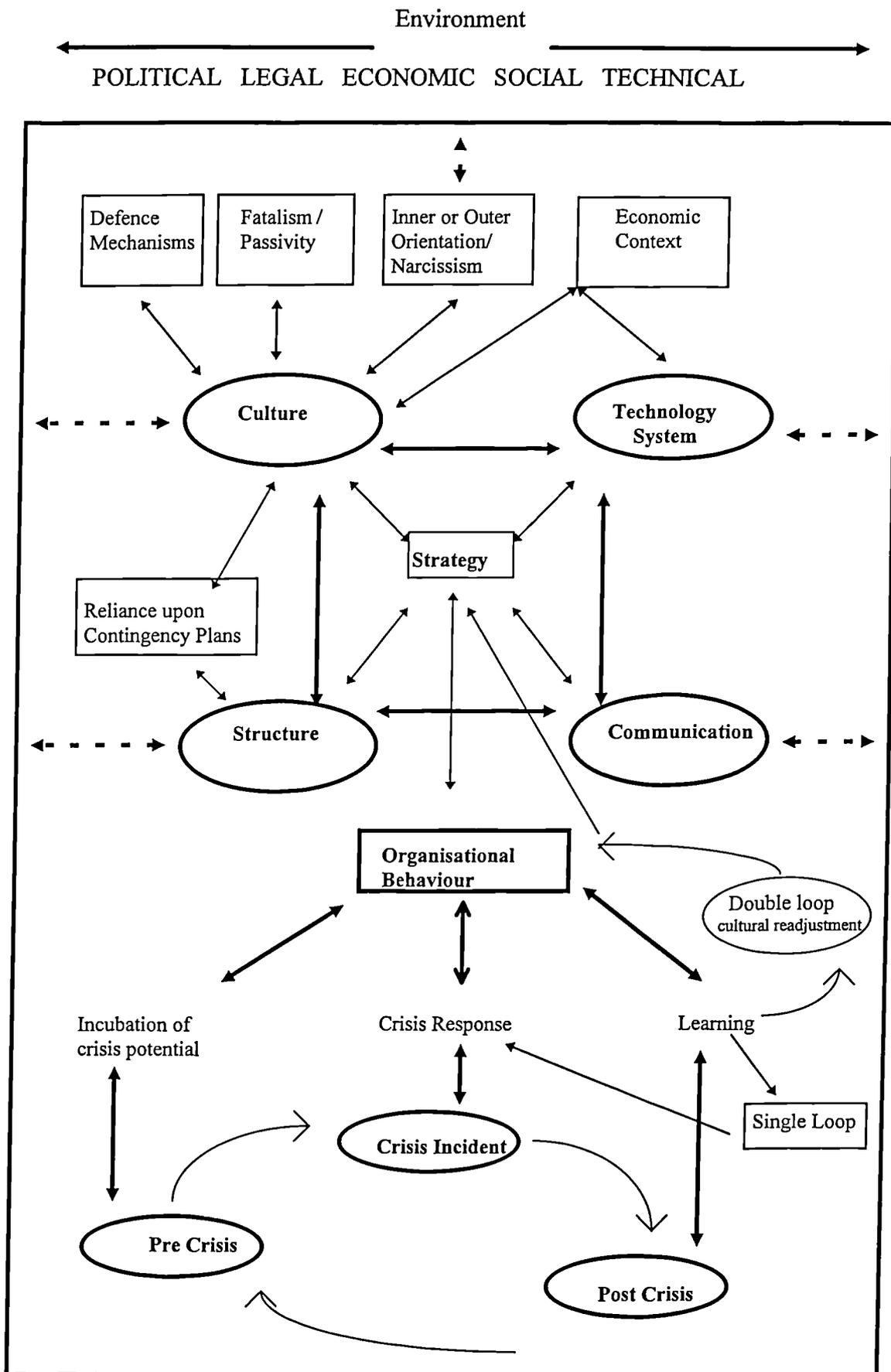


Figure 2.1: Analytical Framework

close relationship between an organisation's size, age and environment.

In figure 2.1 the three filters, culture, structure and communications are shown interlinked with the fourth system element of technology. Together, these form the context in which a strategy emerges, leading ultimately, to organisational behaviour. The analysis in this chapter examines each of these four elements and introduces frameworks to be used in the examination of the football industry. Although each may have an influence upon learning this is shown as closely linked to behaviour with both single and double loop learning identified. This is significant given the focus of this study upon learning from crises and the public inquiry process.

## **2.2 The Public Inquiry Process**

The public inquiry is the mechanism by which events of a special significance are investigated. The purpose of the public inquiry, it has been argued, is frequently to apportion blame (see for example Toft & Reynolds 1992, Fortune & Peters 1993). The collection and analysis of evidence usually takes place within a particular paradigm, the basis of which is rarely examined. Often the public inquiry concentrates upon one focal incident, thereby discouraging learning which may arise from the consideration of similar failures. Reference to other incidents may be made, but these are rarely re-evaluated in the light of new evidence.

Figure 2.2 illustrates the major incidents that have occurred since 1946. The occurrence of a number of large scale accidents that were subsequently investigated through the public inquiry process offers an opportunity to examine organisational learning over a period of nearly half a century. Within Figure 2.2 each circle

represents the three stages of crisis for each incident, with the final stage feeding directly into the pre crisis stage of the successive incident.

Following each incident the Government of the day instigated a public inquiry into the causes of the tragedies. A number of criticisms have been made of the public inquiry process:

- i) Political considerations and context. A view expressed that issues other than evidence are taken into consideration for political reasons (Toft & Reynolds 1992). For example, the UK Government acted before Popplewell (1985, 1986) had published his findings regarding the causes of the Bradford Fire and Heysel Stadium Tragedy.
- ii) Limited or biased terms of reference. Setting the scope and scale of the inquiry from the outset can have a major impact upon its findings (Toft & Reynolds 1992). The terms of reference reflect the dominant paradigms re. causality and a non-systemic view as identified by Canter et al (1989) with regard to the public inquiry into the Ibrox Disaster. From this study it emerged that the public inquiry focuses upon explicit knowledge and frequently deals with technical issues. That is, recommendations are made that seek to prevent the exact re-occurrence of a particular set of conditions by the imposition of specific, technical, recommendations. Little attention is given to the social system elements that are, as identified in Chapter 1, key to understanding the behaviour of modern organisations. Organisational learning is restricted in such cases to the pursuit of technical excellence through the implementation of specific recommendations.
- iii) Quasi-legal structure. It has been suggested that rather than seeking the truth, inquiries have an implicit goal of apportioning blame (Toft & Reynolds 1992).

Smith (1992) identified the tendency for post crisis reviews to apportion blame. Perrow (1984) and Senge (1990) argue that systems may cause their own behaviour making the search for individual scapegoats nonsensical.

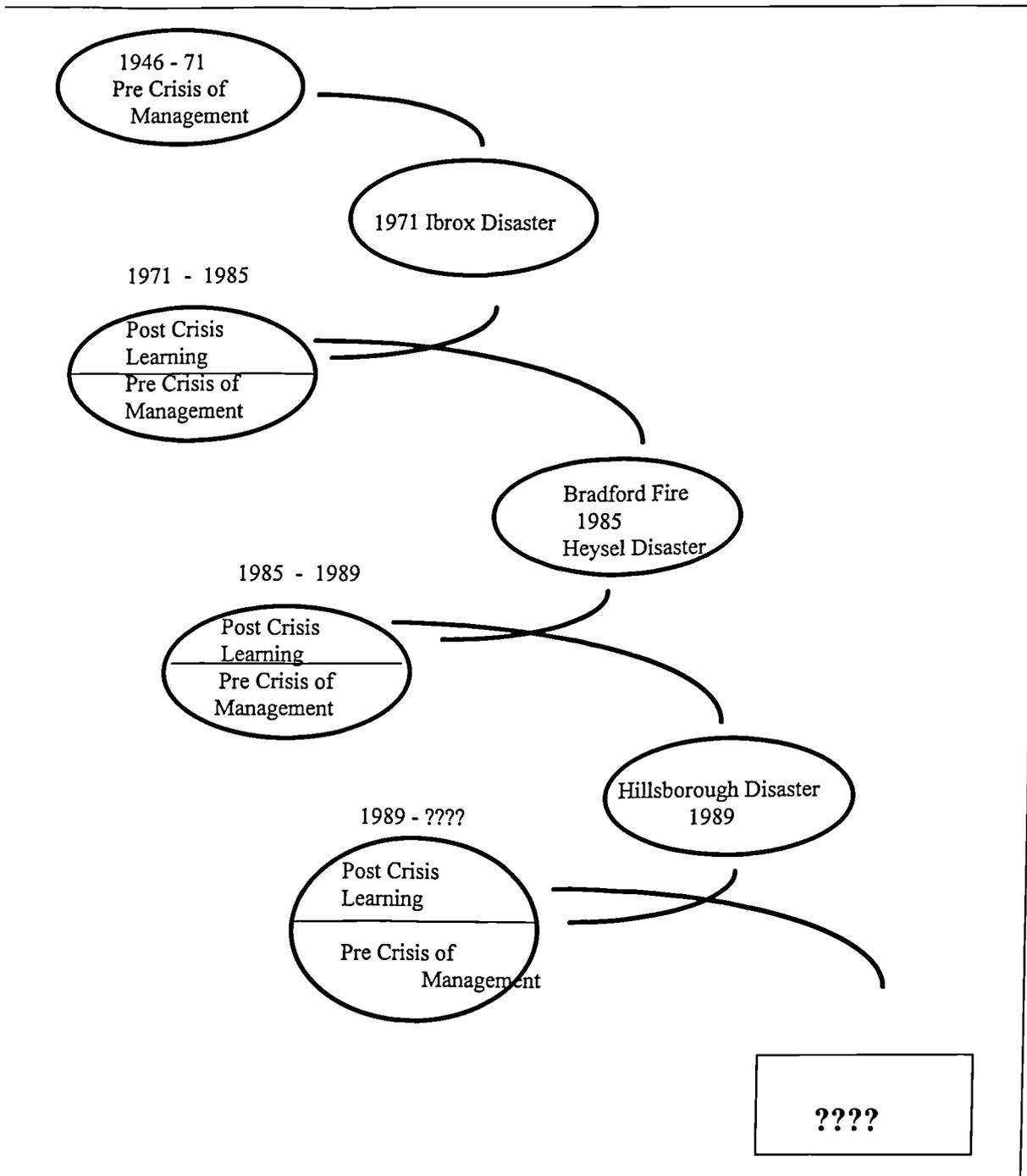


Figure 2.2: Stadium Crises in the Football Industry 1946 - 96

iv) Time consuming (Fortune & Peters 1995). The length of time between the commissioning of an inquiry and publication of its final recommendations may encourage government or others to act prematurely as may have been the case with the government response to the Bradford and Heysel disasters.

v) There is no requirement to act on their findings. (Fortune & Peters 1995). The public inquiry process does not necessarily have the full force of law. Identification is only the first step in the process of changing behaviour. As already indicated the public inquiries concerning stadia accidents had made a number of recommendations that, if implemented could have averted the Hillsborough tragedy. (For example, Moelwyn-Hughes' (1946) recommendation regarding the counting and control of spectators into stadium enclosures). A second, and equally important step, is translating knowledge into action via changes to operating norms and procedures. This raises questions about the communication of the findings of public inquiries and the mechanisms by which organisations implement them.

vi) Perrow (1984) argued that many investigations into accidents are 'left censored' in that they examine only failures and not systems with the same characteristics that have not failed.

In summary, the commissioning of a public inquiry may act as an indicator of the perceived symbolic importance of an incident. However, its adversarial nature, limiting terms of reference and political context may combine to limit, rather than enhance, their usefulness as a tool for learning. Further, those that most need to learn are the subjects rather than participants in the inquiry process. This distinction raises questions of how involvement in the public inquiry process may influence the acquisition and interpretation of knowledge.

### 2.3 Knowledge, Organisational Learning and Cultural Readjustment

Recent debate in organisational theory has focused much attention upon learning, yet as Garvin (1993) notes, “a clear definition of learning has proved to be elusive”[p79]. It is clearly an important construct as Nonaka & Takeuchi (1995) have argued:

“In an economy where the only certainty is uncertainty, the one source of competitive advantage is knowledge.” (p99).

Knowledge, whether gained from mental models, experience, mistakes or shared insights, is the consistent element of many definitions of learning (see for example; Levitt & March 1988; Argyris, 1991, 1994; Toft & Reynolds, 1992; Garvin 1993;). Implicit in all these definitions is the translation of knowledge into changed behaviour. Nonaka (1991) distinguished between tacit and explicit forms of knowledge. Tacit knowledge is personal and difficult to formalise while explicit knowledge is formal and available in a form that is easily communicated. Nonaka (1991) used the example of a craftsman to highlight the nature of tacit knowledge. Knowledge and skill develop during a long apprenticeship served working alongside a master craftsman. Such knowledge can not be made explicit easily. That is, it can not be readily transferred to others in the way that the logic of a computer programme might be demonstrated. Senge (1990) made a similar distinction when he argued that the term learning had lost its central meaning stating that it had become synonymous with absorbing facts. Learning, argues Senge, should also involve ‘a fundamental shift or movement of mind’. Nonaka (1991) stated that tacit knowledge lies in the mental models, beliefs and perspectives that influence the way in which people perceive their world and act in it. Tacit learning, it follows, may incorporate a questioning of these mental models,

a form of learning which has been described as double loop. (see for example, Argyris 1991, Stacey 1993).

Within organisations, Stacey (1993) argued that learning may take place within a cultural framework or it may seek to question existing norms and practices. In the case of the former, learning takes the form of single, negative, feedback loops in which organisations review and learn from actions that they or others have taken. Such learning takes place within a given paradigm. Double loop learning takes further steps in that it questions not only the objective facts, but asks questions about those facts, their context, the reasons and motives that surround them and their presentation. Argyris (1994) defined the two approaches with reference to the simple example of the thermostat:

“Single loop learning asks one dimensional questions to elicit a one dimensional answer. For example, a thermostat which measures ambient temperature against a standard setting and turns the heat source on or off accordingly. Double loop learning takes an additional step, or more often than not, several additional steps. It turns the question back on the questioner.... In the case of the thermostat for example, double loop learning would wonder whether the current setting was actually the most effective temperature at which to keep the room and, if so, whether the present heat source was the most effective means of achieving it. A double loop process might also ask why the current setting was chosen in the first place.” (Argyris 1994 pp78-79).

Double loop and tacit learning question underlying assumptions, and in their most extreme forms take nothing for granted. In explaining the development of science, Kuhn (1970) argued that a paradigm was more than just a set of rules or procedures but that it constituted, at a sub-conscious level, a whole way of thinking that conditioned how science was carried out. A scientific revolution occurred when more and more anomalies came to light, challenging the basis of the existing dominant paradigm. Kuhn's (1970) theory of the development of science mirrors

the 'cultural readjustment' hypothesised by Turner (1976). Cultural readjustment occurred, argued Turner (1976) when:

“disaster provoking events tend to accumulate because they have been overlooked or misinterpreted as a result of false assumptions, poor communications, cultural lag, and misplaced optimism.”(p395).

Major incidents, argued Turner (1976, 1978), challenge these false assumptions leading to new mental models and beliefs. The importance of symbolism to Pauchant & Mitroff's (1992a) definition of crisis reiterates this point. Toft & Reynolds (1992) suggested that major incidents provoke active, as distinct from passive, learning, which results in 'fundamental' remedial action to correct errors. The emphasis of Toft & Reynolds analysis, as illustrated by the three types of learning described in Chapter 1, is upon a sophisticated form of single loop learning, improving techniques for analysing incidents and accidents with a view to improving organisational learning. Such an approach is akin to TQM with its emphasis upon continuous improvement - the question of replacement is never considered. Toft & Reynolds (1992) failed to examine the organisational factors that influence the type, scope and scale of learning, nor did they make reference to single and double loop learning.

It is clear from the foregoing discussion that learning may occur in a variety of ways and at different levels. The cultural readjustment identified by Turner (1976) and later by Toft & Reynolds (1992) is clearly concerned with the development of tacit knowledge, based upon double loop learning. Given that learning implies the translation of knowledge into action, the analysis in Chapters 5 and 6 examines the extent to which stadium and crowd management changed in the period 1946-97.

As identified in Chapter 1, a number of authors have identified a pre-crisis incident stage in which occur a series of incidents which are at odds with accepted beliefs about hazards and the means of avoiding them (see for example, Turner 1976, Fink 1986a, Smith 1990a, Toft & Reynolds 1992). Such incidents mirror the build up of anomalies described by Kuhn (1970) in the development of a science. A crisis, to use Pauchant & Mitroff's (1992a) definition, occurs when these anomalies can no longer be ignored and a particular incident acts as a watershed in the development of a new paradigm. However, Kuhn's (1970) notion of scientific revolution suggests too clear cut a development or transition from one paradigm to another. In the case of organisations, some may undergo a cultural transformation whilst others remain wedded to existing norms and practices. A key area of interest therefore, concerns the question, what factors influence the nature and extent of organisational learning?

#### **2.4 Factors That Influence Organisational Learning**

Pedler et al (1991), Rochlin (1993), Garvin (1993), and Argyris (1994), amongst others, have observed that learning processes reflect the culture, communications, structures and reward systems of organisations. Smith (1995) identified culture, communications and configuration as the three main drivers of the learning process. An alternative way of expressing this view is to describe these factors as filters through which information is collected, examined and translated into behaviour, procedures and mental models. These three factors (i.e. culture, communications and configuration) correspond to the "warm triangle" or 'human' elements of a system that has failed (Smith 1995). Citing Reason (1987), Smith (1995) has argued that these human-centred elements may act as Reason's 'resident

pathogens', which can lie dormant for periods of time before triggering crisis events. For most of the time such pathogens are:

“either tolerated or kept in check by protective measures. But every now and again a set of circumstances occurs which permits these ‘resident pathogens’ to thwart the defences, thus making the system vulnerable to threats that could have otherwise been withstood.”(Reason, 1987, p465).

A danger is that by focusing solely upon technical elements, the human elements are ignored and left free and active within a system. Smith (1990a) has previously argued that these three ‘human’ factors together with the technical system elements (control, cost, contingency planning, and coupling and complexity) interact as the drivers of an incubating crisis and that the organisational climate of human factors may act as barriers to learning. A remedy, argued Smith (1995), is for organisations to ‘generate turbulence’ by a constant challenging of the underlying paradigm of core beliefs, assumptions and shared values. Such controlled turbulence provides an environment in which double loop learning is both encouraged and supported (Smith’s 1995 model is shown at appendix 2.1). Organisational learning is divided between single loop with fixed standards and double loop with reassessed standards. The relationship between the cold square and warm triangle is key. Smith (1995) describes this process as:

“turning the overall learning process on its head and, rather than immediately focus on the technocratic elements of the supposed solution, we begin to question the basis of technocratic rationality in organisations.”(p21).

Smith’s (1995) ideal learning organisation is one in which reassessed standards of decision making are in a state of constant flux and open to criticism from those outside of the decision body. Ideal learning may be conceived of as active in the sense that the learner is not simply the passive recipient of explicit knowledge. Instead active learning involves the ongoing questioning of new knowledge and the

mindsets that created it. This is of particular relevance to the development of technical specifications that are clearly forms of explicit knowledge. Fischer (1991) has argued that the culture of technocracy is important in luring organisations into a false sense of security concerning their decision making. Organisational learning in this broad sense encompasses both explicit and tacit learning. It refers not simply to the ongoing monitoring of the responses to one dimensional answers but seeks to question the filters through which new knowledge is acquired.

In the analytical framework (see figure 2.1), organisational strategy and behaviour are shown as the outcome of the interaction of the various socio-technical elements of the system (culture, structure, communications and technology) which are each shown as open to the environment. That is, open to influences outside the focal system itself. Double loop learning feeds directly back into the organisational system, alternatively single loop learning acts as positive or negative feedback into organisational behaviour. There is clearly a need for both. Single loop learning enables operational control, double loop ensures the ongoing evaluation of standards. They are complementary rather than contradictory.

Missing from the framework are two categories, no learning and passive learning. No learning occurs where an organisation fails to collect any information regarding possible systems failures. The failure to collect information may reflect a culture of denial within an organisation, one of the defence mechanisms discussed in the following section. Passive learning is where a threat is identified but ignored, again suggesting the presence of cultural defence mechanisms. Just as active learning is facilitated by organisational characteristics, so too are passive and no learning.

In addition to culture the other organisational characteristics are identified as configuration, communications and technical elements. It is argued that these four characteristics interact with one another to produce an organisations strategy and ultimately organisational behaviour at each stage of the crisis cycle.

The defence mechanisms, degree of fatalism and inner/outer focus of decision makers shown in figure 2.1 represent dimensions of culture or the individual and collective mediators of learning. The addition of 'economic context' feeding into both culture and technology systems recognises that decisions are rarely free of commercial considerations. Configuration and communication are both linked to the ways in which organisations co-ordinate work practices and information flows. The lower end of figure 2.1 illustrates the three stage cycle of crisis, as described by Smith (1990a), emphasising that the framework as a whole represents only a snapshot and that it should be conceived of as a fluid system, with the organisation's characteristics influencing its capabilities within each phase of the crisis process. Implicit within the model is that organisational learning should also be an ongoing process rather than a periodic review or response to crisis. This Chapter now turns to consider each of these factors and their influence upon organisational learning.

## **2.5 Defining Culture**

Culture, stated Hofstede (1990), has acquired a status similar to strategy and structure within the management literature, identifying the acceptance by both theorists and practitioners of its importance. Defining culture however, is not straightforward. Mitroff et al (1989) offered a simple definition when they suggested that culture is to the organisation as personality is to the individual. A

more comprehensive definition, also offered by Mitroff et al (1989), drawing extensively upon the work of Schein (1985) stated that:

“The culture of an organisation may be defined as the set of rarely articulated, largely unconscious beliefs, values, norms and fundamental assumptions that the organisation makes about itself, the nature of people in general and its environment. In effect, culture is the set of “unwritten rules” that govern “acceptable behaviour” within and outside the organisation.” (Mitroff et al 1989, p271).

Schein’s (1985) definition concluded that culture represents:

“the accumulated shared learning of a given group covering behavioural, emotional and cognitive elements of the group members’ total psychological functioning... a pattern of shared basic assumptions that the group learned.” (pp 10-12).

This view of culture as a stable phenomenon, consisting of shared values, norms and fundamental assumptions has been widely accepted (see also Turner 1976, Williams et al 1989, Hofstede 1990, Hampden-Turner & Trompenaars 1994). There is also much agreement that a useful framework for examining culture incorporates a number of levels, the innermost of which are hidden or obscure (see table 2.1). Turner (1976) in an analysis of three disasters (Aberfan, Hixon and Summerland)<sup>1</sup> argued that all organisations develop a continuous culture closely related to their tasks and environment which carried the risk of a ‘collective blindness’ to important issues:

“This is the danger, that some vital factors have been left outside the framework of bounded rationality. When a pervasive and long established set of beliefs exists within an organisation, these beliefs influence the attitudes of men and women inside the organisation. They affect decision making procedures and mould organisational arrangements and provisions so that there is the possibility of a vicious self reinforcing circle growing up.”[p388].

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<sup>1</sup> Aberfan (1966), A mudslide in a Welsh village slipped killing 144 people; Hixon (1968) in which a slow moving lorry was hit by a train on a newly automated level crossing killing 11 people; Summerland (1974), A fire in a leisure complex on the Isle of Man killing 50 people.

	Schein (1985)	Mitroff & Pauchant (1988)	Williams et al 1989	Hofstede (1990)	Trompenaars (1993)	Hampden Turner (1994)
Description	Multi layered	Onion	Lily Pond	Onion	Onion	Circle/Spirals cites Schein (1985)
Key level 1 Observable/Visible	Level 1 artefacts, creations Visible organisational structures and processes	Level 1 Organisational plans	Level 1 Behaviours	Level 1 Symbols	Level 1 Explicit Culture (observable reality in language etc.)	
		Level 2 Organisational Structure		Level 2 Heroes		
				Level 3 Rituals		
Key level 2 Reportable, greater level of awareness	Level 2 Espoused values strategies, goals, philosophies	Level 3 Assumptions and Beliefs	Level 2 Attitudes and Values (Reportable)	Level 4 Values	Level 2 Norms and values	
Key level 3 Unconscious, invisible	Level 3 Basic underlying assumptions	Level 4 Individual Beliefs	Level 3 Beliefs (Unconscious)		Level 3 Core assumptions about existence	

Table 2.1: Alternative Models of Organisational Culture

Levitt & March (1988) argued that organisational learning occurs within a ‘structure of meaning’ that is broadly shared. They suggested that such structures are sufficiently flexible to permit some change in operational procedures but that:

“participants collude in support of interpretations that sustain the [organisational] myths. As a result stories, paradigms and beliefs are conserved in the face of considerable disconfirmation and what is learned appears to be influenced less by history than by the frames applied to that history”[p324]

A similar phenomenon was observed by Starbuck et al (1978) who observed that organisations seek to ‘routinise’ the means by which they have been successful and in so doing become internally focused and concerned with driving efficiency. From this evidence it is clear that culture can and does act as a powerful force upon the process of organisational learning.

Developing this view, Pauchant & Mitroff (1988) argued that all organisations could be placed upon a continuum ranging from those with a crisis prone culture to

those with a crisis resistant one. The characteristics of crisis prone organisations included an 'inward orientation' and rigid, inflexible structures and belief systems. Their resulting "Onion Model" (see figure 2.3) emphasised the inter-relatedness of individual beliefs, shared organisational values, structure and processes and ultimately organisational behaviour. In particular the Onion Model provided the basis for the cultural element of the analytical framework shown in figure 2.1.

Pauchant & Mitroff (1988, 1992a) argued that in crisis prone organisations, managers may use a variety of defence mechanisms in relation to crisis. Drawing from a psychoanalysis literature they argued that managers use these mechanisms to avoid having to deal with complex, potentially threatening situations. For example, managers might avoid a systems approach to a problem because of its complexity, preferring in its place to deal with the system components individually, a defence mechanism they label splitting. Support for this view comes from Argyris & Schon (1996) who described a similar phenomenon within organisations, namely 'defensive routines'. Threats are dealt with by defensive reasoning which inhibits an effective response to disturbing stimuli. Argyris (1994) defined defensive reasoning as consisting of :

"all policies, practices and actions that prevent human beings from having to experience embarrassment or threat and, at the same time, prevent them from examining the nature and causes of that embarrassment or threat."(p78).

People and groups within organisations employ a range of strategies to resist change, even when events highlight inadequacies in systems, procedures and beliefs. Organisational culture acts as a key influence upon the effectiveness of learning. Mitroff et al (1989) suggested that there is:

"extreme overlap and interpenetration between the various factors that compose the levels such that it is extremely difficult to say at times which circles are true subsets of which."(p273).

At the surface layer are the most observable factors (described by Schein 1985, as artefacts) such as plans and actual behaviour. These are the tangible elements that reflect the beliefs, values and assumptions of the core. The analytical framework (figure 2.1) draws out the intangible elements of culture, structure and

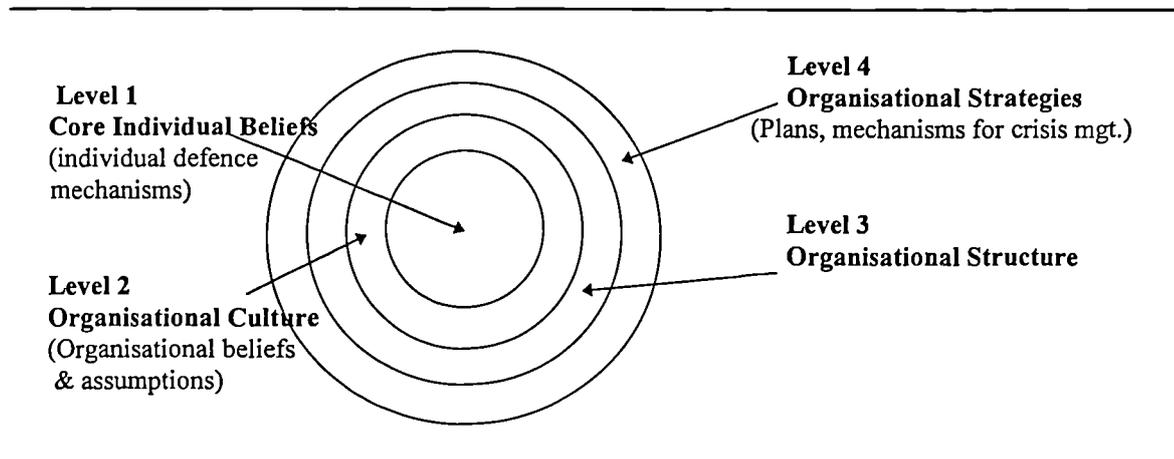


Figure 2.3: The Onion Model of Crisis Management  
Source: Pauchant & Mitroff 1988

communications and illustrates how they interact with the technical elements and drive organisational behaviour. Single loop learning operates at a superficial level, restricted to the outer layer of the onion model. Double loop learning, at its most effective, penetrates to the core of the onion model. Effective learning requires going beyond the outer layers to develop a firm understanding of the nature of the core and its influence upon behaviour. This means developing an understanding of the factors that make up the inner two layers. For example, the use of defence mechanisms or a high degree of inner orientation will be reflected in rigid structures and a lack of crisis preparedness.

## 2.6 Level 1 of the Onion Model : Individual Core Beliefs

At the core of the Onion Model three key factors were identified by Pauchant & Mitroff (1988, 1992a) as providing a basis for measuring the extent of crisis proneness for an organisation. Suggesting that each should be thought of as existing

on a continuum, Pauchant & Mitroff (1988, 1992a) identify the degree of self centredness, the nature of defence mechanisms and the degree of fatalism.

### **2.6.1 Inner or Outer Orientation: Layer 1 of the Onion Model**

Drawing on the work of Kohut (1977), Pauchant & Mitroff (1992a) identified, from an interview survey of 410 firms, that crisis-prepared organisations displayed a positive self regard for key stakeholders such as employees and their communities. Contrastingly, unhealthy or crisis prone organisations had a narrow view of stakeholders. When a crisis occurred, it happened to them alone. For the prepared organisation, crises occurred to customers, community and employees as well as to the company.

The 'orientation' of organisations has been identified as being closely related to their ability to consider a range of points of view. For example, Shrivastava's (1987a) analysis of the Bhopal tragedy offers three models of the crisis based upon three distinct stakeholder groups. Each model has validity, but Shrivastava (1987a) argues that organisations need to look at themselves, their activities and even crises through the eyes of different groups. Echoing Smith's (1995) 'self generated turbulence', Shrivastava argued that in so doing they may see themselves from a new perspective and gain fresh insight. At Bhopal :

'the stakeholders worked independently to achieve their own goals. While their actions each made sense from an individual point of view, when they interacted with each other they created a series of secondary effects that only served to deepen the crisis.' (p71).

A stakeholder perspective is akin to a system's perspective. It acknowledges the importance of other groups and provides the basis for understanding how these might impact upon organisations. A number of authors, including Pauchant & Mitroff 1988, and Shrivastava 1987a, argue that those organisations with better

crisis preparations are outer directed and take a broader stakeholder view. This outer orientation may be expressed in terms of seeing beyond traditional organisational boundaries and thereby facilitating a greater understanding of the environment. Writing about organisational learning in general Garvin (1993) recommends the removal of organisational boundaries as an essential step in promoting the development of an effective learning climate within organisations.

As Allison (1971) has demonstrated, in an analysis of the Cuban missile crisis, by looking at issues from different perspectives new insights may be gained. Not only will potential or real problems be identified but “empathising” may encourage reflection on the appropriateness of existing organisational frameworks.

“Multiple perspective analysis involves understanding and describing events from the perspective of all key stakeholder groups. This is done by acknowledging that social events are subject to multiple, conflicting and disparate interests, assumptions, values, and interpretations, and then using those interests, values, and interpretations as a basis for building an understanding of events.”(p72).

A high degree of inner orientation or narcissism would suggest that no multiple perspective view had been developed. Smith (1995) identifies external verification as one process for encouraging double loop learning. Exposure to contrary viewpoints is one source of such verification as it encourages reflection on the assumptions that lie behind operating norms and practices.

An inner orientation acts as a major block to the infusion of new ideas and perspectives. Other barriers to learning arise from the perceived control that executives have over their organisations.

### **2.6.2 The Degree Of Fatalism/Passivity: Layer 1**

Fatalism, observed Mitroff et al (1989), reduces guilt and responsibility and acts as a justification for doing nothing. At its most basic, the view that the

disasters are freak accidents, acts of God or caused by some other external agency reduces the perceived control that any organisation or executive has over them. Such a view will have a strong influence on the amount of time and resources that are invested in crisis prevention and preparation.

Fatalism acts as a barrier to learning because it assumes that there is nothing to be done. Pauchant & Mitroff (1992a) cite the President of Exxon who insisted that the Valdez accident was an “act of God that could not have been prevented.(p97)”. Pauchant & Mitroff (1992a) point out that the president did not acknowledge twenty nine previous oil spills that shared many similarities. Given the absence, other than in theory, of no risk or total safety, fatalism is a question of degree. High degrees of fatalism block learning because it assumes that nothing can be done by organisations to prevent failures.

### **2.6.3 The Nature Of Defensive Mechanisms: Layers 1**

Defence mechanisms, argued Pauchant & Mitroff (1992a), are employed to ‘distort external reality’ to such an extent that individuals can avoid having to deal with complicated, potentially threatening situations. Drawing upon a psycho-analytic literature, eight basic devices were identified by Pauchant & Mitroff (1992a). A brief explanation of each is included in table 2.2. These devices range from simply denying the existence of a threat to isolating different elements so that the whole does not have to be dealt with. That is, it creates the appearance of reducing the threat by identifying fragments which are dealt with but leaving the rest virtually untouched. Pauchant & Mitroff (1988) found that crisis prone organisations were approximately seven times as likely to use these devices as crisis prepared ones. Pauchant & Mitroff (1992a) argued that intellectualisation is the

most commonly used in organisations and leads directly to the faulty rationalisations and assumptions that they argue characterise the second layer of their Onion Model.

Level 1: Mechanisms	Defence	Explanation
Denial		Expressed refusal to acknowledge a threatening reality or realities
Disavowal		Acknowledge a threatening reality but downplay its importance
Fixation		Rigid commitment to a particular course of action or attitude in dealing with a threatening situation
Grandiosity		The feeling of omnipotence. "We're so big and powerful that nothing bad can happen to us"[Mitroff & Pauchant 1990]
Idealisation		Ascribing omnipotence to another person
Intellectualisation		The elaboration of an action or thought. Pauchant & Mitroff (1992a) argue that intellectualisations frequently involve distorted schemes of reasoning to justify a particular course of action.
Projection		Attributing unacceptable actions or thoughts to others.
Splitting		The extreme isolation of different elements, extreme dichotomisation or fragmentation.

Table 2.2: Defence Mechanisms

Source Adapted from Pauchant & Mitroff (1988)

Fixation, the unquestioning pursuit of a particular course of action represents an almost complete absence of double loop learning. The ubiquity of technical solutions to socio-technical problems identified in the opening Chapter provides a powerful example of fixation. Similarly denial and disavowal provide some justification for executives doing nothing. Grandiosity and idealisation reflect a view that some one (us or another agency) will be sufficiently powerful to deal with all eventualities. Individually and together, the presence of these defence mechanisms provides a strong indication of the effectiveness of organisational learning.

Following a similar argument, Argyris & Schon (1996) suggested that when individuals are threatened or potentially embarrassed they employ a defence

mechanism that inhibits double loop learning. Referring to internal communications they cited, for example, the case of an organisation:

“For example, concern and caring come to mean : “Act diplomatically; say things that people want to hear”-meanings that lead to action strategies such as easing in, covering-up and telling white lies.” (p96).

Information becomes distorted and manipulated as individuals acting in groups make use of vagueness, ambiguity, inconsistency and withholding data to obscure errors and make them uncorrectable. Hirokawa’s (1988) analysis of the Challenger disaster described how defence mechanisms acted as powerful blockers to the collection, analysis, discussion and exchange of information between engineers employed by the designers of the Space Shuttle and NASA representatives.

In summary, defence mechanisms act as powerful barriers to organisational learning. At their most extreme (denial) they block out any attempt to collect information. More subtly, they permit the distortion and misinterpretation of information and reduce the effectiveness of learning. In developing their argument Pauchant & Mitroff (1992a) suggested that these defence mechanisms play an important role in determining corporate views and assumptions regarding the four key issues, which form the second level of their Onion Model.

Although Chapter 3 deals with research issues, it is important to point out that the choice of semi-structured interviews within a grounded theory methodology represented a deliberate attempt to deal with the complex issues surrounding individual beliefs. This data was subsequently complemented by a questionnaire adapted from Pauchant & Mitroff’s (1992a) culture measurement tool.

## 2.7 Organisational Assumptions and Rationalisations:

Where level one reflects individual beliefs, level two refers to collective or group assumptions. Key words in definitions of culture emphasise shared values, stable beliefs and rigidity in thinking. Earlier the persistence of faulty assumptions in the light of contradictory evidence was identified (see for example Turner 1976, 1978). From a crisis management perspective Pauchant & Mitroff (1988, 1992a) group such assumptions into four issues:

1. Assumptions about the properties of the organisation.
2. Assumptions about the properties of the environment.
3. Assumptions regarding the properties of crisis.
4. Assumptions regarding the properties of prior crisis management preparations.

These groups of assumptions are closely related to the three 'level 1' factors discussed above. Indeed, argue Pauchant & Mitroff (1992a), these assumptions represent the manifestations of particular defence mechanisms. Grandiosity, for example may lead an organisation to assume that it has the properties to deal with any crisis incident. The interaction or overlap between elements from levels one and two raises questions about the validity of Pauchant & Mitroff's (1988, 1992a) Onion Model. The delineation between the levels formed a part of the analysis in Chapter 6.

Denial and disavowal may be employed by organisations to ignore potential environmental threats. Pauchant & Mitroff (1992a) argue that inner oriented organisations were more likely to ignore external threats. More significantly their lack of environmental awareness was reflected structurally and procedurally in the lack of any mechanisms for scanning the environment. This may raise the probability that warning signals are not interpreted accurately and this inner

orientation may also act as a barrier to learning from the experience of other organisations. That is a failure of foresight. ( Toft & Reynolds 1992).

The third group concerns the properties of crises themselves. A deeply held assumption, supported by the response of some of those agencies charged with responsibility for stadia safety is that crises have technical solutions. However, technology is not used in a vacuum but within a system designed and operated by people. The introduction of all seater stadia may increase safety but the Bradford Stand that caught fire was all seater, the Ibrox tragedy occurred as spectators were leaving the ground. As was argued in Chapter 1 and is argued in Chapter 5 these incidents were the result of the complex interaction between a variety of human, organisational and technical elements. The technical components form an important part of the system, but only a part (see for example Canter et al 1989, Reason 1987, Toft & Reynolds 1992) and technical guidelines quickly take on the attributes of 'sacred writing'. As Chapter 5 identifies, the 'Green Guide' was used by many clubs and Local Authority Safety Committees in a rigid and technical way. This assumption, 'that crises are technical in nature', means that only one group of system components (as identified in figure 2.1) is dealt with.

A second assumption regarding crises is that they occur by chance or fate. Fate can be employed as a device to justify doing nothing. Such a view is contrary to the evidence that suggests that organisations themselves create the pre-conditions for crisis.

A third assumption relates closely to the defence mechanism of splitting. The public inquiry approach that seeks to identify a single point of failure (the pilot at Kegworth or police at Hillsborough) encourages a very partial view of a socio-

technical system failure. It lends credence to the view that crises are simple events and that simple, technical solutions will suffice.

From a learning perspective, assumptions regarding these four issues will create not only ideological barriers to learning, but will also influence the transfer of knowledge into action by determining the allocation of resources in the form of time and money devoted to a particular area. Thus, assumptions about the nature of the organisation will play an important role in determining the importance given to issues such as safety management. An organisation that believes itself 'omnipotent' will not devote time or money to safety management. Learning may be blocked through lack of time to consider the relevant issues and through the lowly status of support service executives. Organisations may also focus upon a narrow range of high profile activities to the detriment of support activities. Within the Finance Sector, for example, the dealers who trade in stocks and shares attract large remuneration packages. Support services such as Information Technology and Business Continuity Planners receive less attention and fewer resources, although without these services the dealers could not function either efficiently or effectively (See for example, Elliott et al 1997).

An inward looking organisation may become efficient at performing certain tasks but it may also lose touch with its environment, a phenomenon described by Miller (1990) in the 'Icarus Paradox'. An inner orientation offers few opportunities for double loop learning given that it is associated with an absence of external verification. Alternative mindsets are not just rejected, they are simply never considered.

Assumptions regarding the properties of crises may act as barriers to learning by setting constraints to the collection and analysis of data. For example, an extreme fatalist view will lead to no consideration of crisis prevention strategies - there is little point in seeking to prevent an Act of God. The focus upon technical issues identified previously and in Chapter 1 will similarly constrain learning to a single loop reconsideration of technological improvements.

There is a close link between assumptions regarding the properties of crises and prior crisis management efforts. For the fatalist, to do nothing may appear a reasonable strategy. Where there is a focus upon technical issues then basic contingency plans may suffice. In this way the individual beliefs and core organisational assumptions may be seen to interact and create a climate of decision making which determines, in large part, the behaviour of an organisation. These factors will influence the nature of organisational learning at each stage of crisis. These rationalisations also manifest themselves in the forms of structure and communications employed by organisations to co-ordinate their activities. It is to these two components that this thesis now turns.

## **2.8 Structure and Communication**

The discussion of configuration and communication builds upon the previous sections that dealt with culture. Structure may be defined as the means by which an organisation co-ordinates the activities of its staff. It is the most tangible form of the operating norms and procedures. Communication is discussed with structure because the two are inextricably linked. Organisations with formal hierarchies and stable operating procedures place great emphasis upon formal communication, including for example, written memos and job descriptions. In discussing the

relationship between structure and strategy Mintzberg (1983) dismissed Chandler's (1962) 'structure follows strategy' assertion by arguing that the one follows the other no more than the left foot follows the right when walking. Widely accepted models (see for example Waterman et al 1980, Galbraith 1983, Pauchant & Mitroff 1992a) emphasise the importance of a consistency between a number of organisational characteristics. Mintzberg (1983) identified distinct clusters of organisational characteristics which he labelled configuration. Configuration enabled an organisation:

“to achieve an internal consistency or harmony, as well as a basic consistency with the organisation's situation - its size, age, the kind of environment in which it functions, the technical systems it uses and so on.” (Mintzberg 1983, p3).

Figure 2.4 identifies five of these configurational types and indicates the characteristics of environment with which they are consistent. A description of each is shown in table 2.3. These five configurations result from the interaction of the key parts of the organisation (namely, the strategic apex, middle line, operating core, technostructure and support staff) with the demands placed upon it from its environment (these environmental characteristics are shown on the two axes in figure 2.4).

Within the football industry a number of these configurations were evident. The Football Association itself might be described as a small machine bureaucracy. It is governed by a 93 member council representing professional, amateur, military, regional and gender organisations. Its essential role is to oversee the regulation of football in England. The Football Leagues of England and Wales and Scotland are managed in similar ways. A weakness of these configurations is their emphasis

upon formality. Mintzberg (1983) identified that their ‘natural’ environment is stable and simple and the resulting structure reflects this. As a result they do not

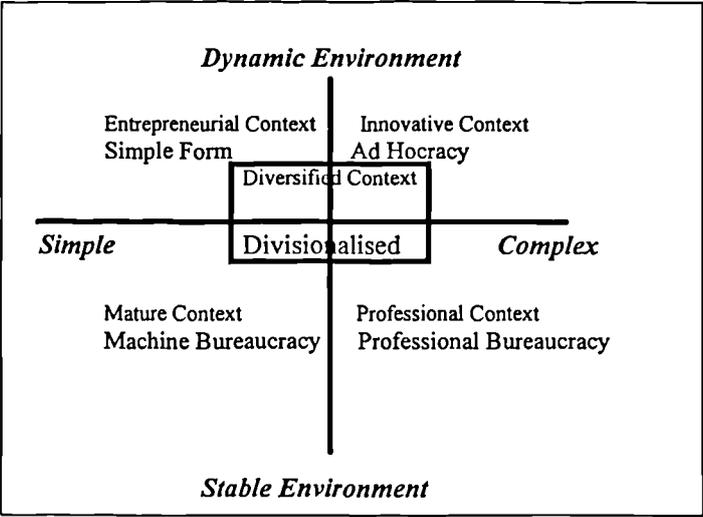


Figure 2.4: Organisational Configuration  
Source: Mintzberg 1983.

cope well with change. The earlier reference to Starbuck et al (1978) highlighted a tendency for success to lead to programming, echoing Mintzberg’s (1983) theory that organisational success and growth tend to lead towards greater formalisation. The formality and rigidity of the machine bureaucracy may act as a barrier to double loop learning and hence, cultural change. Culture, structure and communications reflect core values of stability, formalisation, adherence to rules and lengthy decision making processes, frequently through formal communications and committees. Table 2.3 highlights the key characteristics of the machine bureaucracy.

Although the larger football clubs have recently invested more resources in their administrative and commercial infrastructures, many are still run along the lines of the Simple form. Exceptions might include those that have become public

limited companies such as Manchester United and Tottenham Hotspur; a phenomenon that is increasing in 1997 as more clubs take advantage of the

Organisational Type	Description and characteristics
Simple Form	Means of Co-Ordination : Direct Supervision Environment : Simple & Dynamic “few support staffers, loose division of labour, minimal differentiation among its units, and a small managerial hierarchy. Little of its behaviour is formalised, and it makes little use of planning, training and liaison devices, it is above all organic” [p159] e.g. Small sales based firm
Machine Bureaucracy	Means of Co-Ordination : Standardisation of work processes Environment : Simple and Stable “highly specialised, routine operating tasks; very formalised procedures in the operating core; a proliferation of rules, regulations, and formalised communication throughout the organisation.....relatively centralised power for decision making; and an elaborate administrative structure with a sharp distinction between line and staff” e.g. Royal Mail, Fire Service, Chemical Plant
Professional Bureaucracy	Means of Co-Ordination : Standardisation of skills (through lengthy vocational training) Environment : Complex and Stable “operating work is stable leading to predetermined or predictable, in effect, standardised behaviour. But it is also complex and so must be controlled by the operators who do it” e.g. University, Police, Hospital
Ad Hocracy	Means of Co-Ordination : Mutual Adjustment Environment : Complex and Dynamic “highly organic structure, with little formalisation of behaviour, high horizontal job specialisation based on formal training... deploy specialists in small market based project teams to do their work. Reliance on liaison devices to encourage mutual adjustment” e.g. Research team, professional partnership in dynamic industry
Divisionalised Form	Means of Co-Ordination : Standardised outputs (e.g. via performance measures) Environment : May incorporate other types and thus exist in different environments. e.g. Conglomerate

Table 2.3: *Characteristics of Configurational Types*  
Source: Adapted from Mintzberg (1983).

economic attractiveness of Premiership football. A common response amongst League football club secretaries to questions concerning administration and business practices was that their job amounted to being a ‘jack of all trades’. The results indicated some differences between respondents which will be examined in Chapter 5. Mintzberg’s (1983) identified possible weaknesses of the simple form:

“The chief executive can get so enmeshed in operating problems that he loses sight of strategic considerations. Alternatively he may get so excited about

strategic opportunities that the more routine operations wither for lack of attention and eventually pull down the whole organisation.” (p161).

The extreme centralisation of decision making acts as a barrier to spending money on essential but non-glamorous activities, particularly when clubs are operating on a financial shoestring. A barrier to organisational learning lies with the personality and capabilities of the figure head or chief executive. It is argued that the growing complexity of managing a professional football club requires a different form of structure than the one that has evolved. The simple structure, with its lack of formalisation and little use of training and liaison techniques, makes dealing with a wide range of tasks, difficult. Organisational learning may be effectively blocked by the resources of the Chief Executive .

### **2.8.1 Crisis of Management: Structure and Communication**

Each of the structures identified by Mintzberg may be conceived of as solutions to particular problems. The machine bureaucracy organisation, for example, is the solution to the problem of how to carry out operations in the most efficient manner. Starbuck et al (1978) identified a tendency for organisations to move towards a bureaucratic solution in their search for success:

“Programming often facilitates success and success always fosters programming.” (p786).

The inner orientation that follows from this standardisation (e.g. desire to maximise efficiency of programmes and emphasis upon scientific management approaches such as work study) causes the organisation to be less able to perceive what is happening within its environment. Miller (1990), in ‘The Icarus Paradox’, argued that this flaw was widespread in US industry:

“American firms have become complacent, careless and out of touch. They pursue short term, bottom line targets and bury themselves in technical or

financial intricacies, while they neglect the substance - the products and the customers - of their business.”(p1).

The insularity of the machine bureaucracy, reinforced by time consuming procedures, the filtering and aggregation of information and reliance upon standard programmes prevents it from effectively monitoring the harmony between the various internal and external elements. This tendency has not been restricted to twentieth century corporations as Toynbee’s (1972) study of world civilisations illustrates. The essence of Toynbee’s argument is that the decline of many civilisations came from a cultural and structural stagnation borne of internal rigidity, complacency and oppression.

Mintzberg (1983) argued that each configuration possesses a unique set of strengths and weaknesses. The machine bureaucracy has already been discussed. The versatility of the simple structure is balanced by its reliance upon the whim, skill and health of one individual. For the professional bureaucracy, the benefits of the efficient provision of complex operations may be undermined by the length of time required to change the practices of highly trained individual operators; a vital problem for the police involved in the management of crowds inside football stadia. The current problems facing the Health Service illustrate this point. Curing sick people suits the skills and experience of many professional health care workers, prevention of ill health is less tangible, and arguably commands less prestige resulting in less attention from key operatives. This reflects a cultural bias and provides an illustration of how the very presence of structures provides a powerful barrier to change. Finally, the reliance of the ad hococracy upon much communication means that it is well suited to dynamic and complex environments that require innovation but less well suited to the stable, simple environment that

requires mass production. In the ad hococracy the regular communication and interaction between key staff provides fertile ground for double loop learning. The development of the personal computer and software reflects the strength of these structures. The Graphical User Interface (GUI)<sup>2</sup> was first developed by Xerox, a large bureaucratic organisation who failed to see its potential. Microsoft, at the time a good example of the ad hococracy was quick to refine and develop the GUI and achieve dramatic success.

For the Football Industry the growing commercialisation evident in the Premier League and development of a Safety Management infrastructure requires greater specialist input as it places a strain on the 'jack of all trades' who can not hope to become sufficiently expert in all task areas. Crisis prepared organisations will recognise this and employ specialists whether internally or externally to ensure that they have the right blend of skills required. Crisis prone organisations are more likely to seek to 'plod along' just 'getting by' on their existing resource base. If the football industry has only changed superficially it would be expected that structure would have changed little since 1989 and the publication of Taylor's (1989) Interim Report. Growing specialisation, with the employment of experts, would suggest a more fundamental change.

The incubation of crises may, therefore, occur when the harmony of internal and external elements is disrupted without any effective response, planned or emergent, from the organisation. Additionally the characteristics of each organisation may lend themselves to particular types of crisis. For example, the reliance of the simple form upon an individual leaves it vulnerable to sudden

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<sup>2</sup> The so called GUI interface forms the basis of the popular Windows computer operating environment. It was developed some twenty years before Microsoft recognised its potential and commercialised it.

changes in that person's performance. The filtering of information through the machine form will reduce its ability to monitor internal and external elements.

### **2.8.2 Operational Crisis (Incident): Structure and Communication**

Just as the organisation provides a framework in which the potential for crisis can be incubated, they also provide the arena in which crises unfold. Structure provides the mechanisms for crisis response. (See for example, Dynes & Aguirre 1971, Smith 1990a).

In an examination of the Kegworth Air Crash, Smith (1992) utilised Mintzberg's five configurational types as a framework for examining the response of those organisations involved. Of particular relevance here, was the behaviour of the Fire Service who use a drilled response to many of the routine incidents with which they deal (see Elliott & Smith 1993b). Using Mintzberg's terminology the Fire Service usually operates as a machine bureaucracy. This form is used for two key reasons. First, because the uncoordinated actions of one fire fighter might put the lives of others at risk. Second, because any delay can lead to the endangerment of life, hence the importance of an immediate, drilled response. Such a form is appropriate to the routine small fire and road traffic accidents attended by the fire service but is less appropriate for dealing with a major incident where the dynamism and complexity of a crisis incident may make contingency plans inoperable. In such cases co-ordination is achieved through feedback to a central co-ordinator. Any deviation from drill needs to be communicated to and agreed by the central co-ordinator. Where an incident is complex and dynamic, the central co-ordinator may be overloaded with requests from officers seeking to deviate from their drilled response. At Kegworth communication problems between fire fighters

and the central co-ordinator were compounded by radio failures, the presence of three brigades, eighteen fire tenders and the sheer volume of information and requests for decisions to the central co-ordinator (see Smith 1992). The machine bureaucracy is less able to adapt to a complex and dynamic environment, (the conditions frequently associated with crises), potentially resulting in a reduction in its effectiveness and placing personnel under pressure, thereby increasing the risk of error (see Elliott and Smith 1993b). The method by which the machine bureaucracy seeks to deal with such extraordinary events is through contingency planning.

Criticisms of a contingency plan based approach to crisis management focus largely upon the issue of structure. It is not enough (see for example, Smith 1990a, 1995, Elliott & Smith 1993b) to prepare a plan and expect it to be implemented. Individual behaviour is influenced not only by formal instruction but by the culture, shared value and structures with which they are familiar. Contingency plans are only one element of any changed behaviour and any strategy for ensuring effective crisis response must take account of these human issues. A further criticism is that contingency plans are 'rigid' and if they are to be implemented as written requires that the incident has to happen as expected.

### **2.8.3 Post Crisis Learning: Structure and Communication**

Turner (1976, 1978) concluded that organisations often impede the flow and utilisation of knowledge that could have been used preventively. Jasnoff (1994) argues that organisational barriers stand in the way of communicating knowledge in an appropriate form, to people who have the influence and will to take preventive action. Toft & Reynolds (1992) identified the 'failure of hindsight' to describe the

inability of organisations to learn from their own experience or that of others in related industries. Toft & Reynold's (1992) discussion of isomorphic learning may be interpreted as a call for the development of techniques that will facilitate learning from incidents that superficially have little obvious similarity. Toft & Reynolds (1992) argued that the a role for managers and analysts is to develop a systemic view that will enable them to uncover the lessons from seemingly unrelated incidents, the key lying in the ability to generalise from the appropriate level. (Thus emphasising the importance of challenging core individual beliefs).

The series of incidents within the football industry identified earlier (see table 1.1), indicates the poverty of learning within the industry. Toft & Reynolds (1992) suggested that learning can be promoted by developing a:

“cumulative, reflecting and saturating process through which all personnel within organisations learn to understand and continually reinterpret the world in which they work by means of the organisational experiences to which they are exposed.” (p7).

Such an approach requires an appropriate corporate culture that encourages the free flow of information and permits employees to challenge established practices and assumptions. Culture is however, only one element. Structure may also play an important role in facilitating or hindering the flow of communication and the involvement of all staff. The failure of the police to learn from the previous years experiences raises the important issue of post crisis incident learning.

It may be seen from Mintzberg's (1983) organisational forms that only one configuration lends itself readily to the conditions identified by Toft & Reynolds (1992) as necessary for effective learning to take place, that is the ad hocracy. The machine bureaucracy is too inflexible and restrictive of communication. The dominance of the chief executive over the simple form requires that effective

learning take place at the strategic apex or not at all. The emphasis of the professional bureaucracy on pre-employment vocational training may make the transfer of new knowledge a lengthy process, particularly given Weick's (1987) observation, based upon a study of pilots, that professionals revert to their earliest learnt processes at times of crisis.

## **2.9 Culture, Structure and Communications: A Summary**

From the above discussion it is apparent that a number of studies have identified these three elements as influential factors in determining the ability of organisations to translate knowledge into realised behaviour. The application of the concept of the trinity emphasises the close interrelationships between the three elements. It is recognised that the variables being explored are extraordinarily complex and that the use of a single measure to describe each variable adequately is impossible. This recognition led to the decision to employ a mixed methods approach with the aim of painting as rich a picture as possible of the system under investigation. As Pauchant & Mitroff (1992a) indicated, there is no clear dividing line between these three elements making the analogy with the trinity more apt. Indeed it is the interaction between these three elements that permits a multi-dimensional analysis. Notwithstanding these difficulties the research methodology sought to explore the influence of these elements upon organisational learning within the football industry. Particular attention was placed upon the following issues that emerged from the review of literature.

1. The extent to which respondent organisations indicated an inner or outer orientation. Following on from the earlier discussion, an inner orientation, as indicated by formal and informal links with other stakeholders, participation in

forums or the stated attitudes of respondents will provide an indication of the inner or outer directedness of individuals and organisations within the football industry.

2. The degree of fatalism expressed by respondents with regard to past and potential future stadium incidents. Semi-structured interviews permitted interviewer and respondent to explore perceptions regarding the causes of past disasters and the potential for future ones. This was complemented by inclusion of questions related to fatalism incorporated within the questionnaire survey of football safety officers. A high level of fatalism may be associated with decisions to do nothing or to do the bare minimum.

3. The employment of defence mechanisms with regard to past incidents and current practices. Again the use of semi-structured interviews permitted the exploration of this area with further investigation undertaken through the survey of football safety officers.

4. Given the close linkages between the layers of the Onion Model the analysis of issues 1 - 3 proved a useful basis on which to examine organisational culture and assumptions about the properties of crisis management. This study, as will be outlined in later Chapters, represents an opportunity to examine the linkages between the different levels and to determine whether distinct layers actually exist.

5. An examination of how respondents interpreted the various stadium accidents within the historical context of the football industry.

6. An examination of respondent perceptions regarding the basis for and efficacy of changes in management practices.

This Chapter now turns to a brief consideration of technology which builds upon the earlier comments about a systems approach to crisis management research.

## 2.10 Technology

A Football stadium does not have the appearance of the highly technical system that is evident in the case of either a nuclear power or industrial chemical plant. As Toft & Reynolds (1992) have argued, despite these superficial

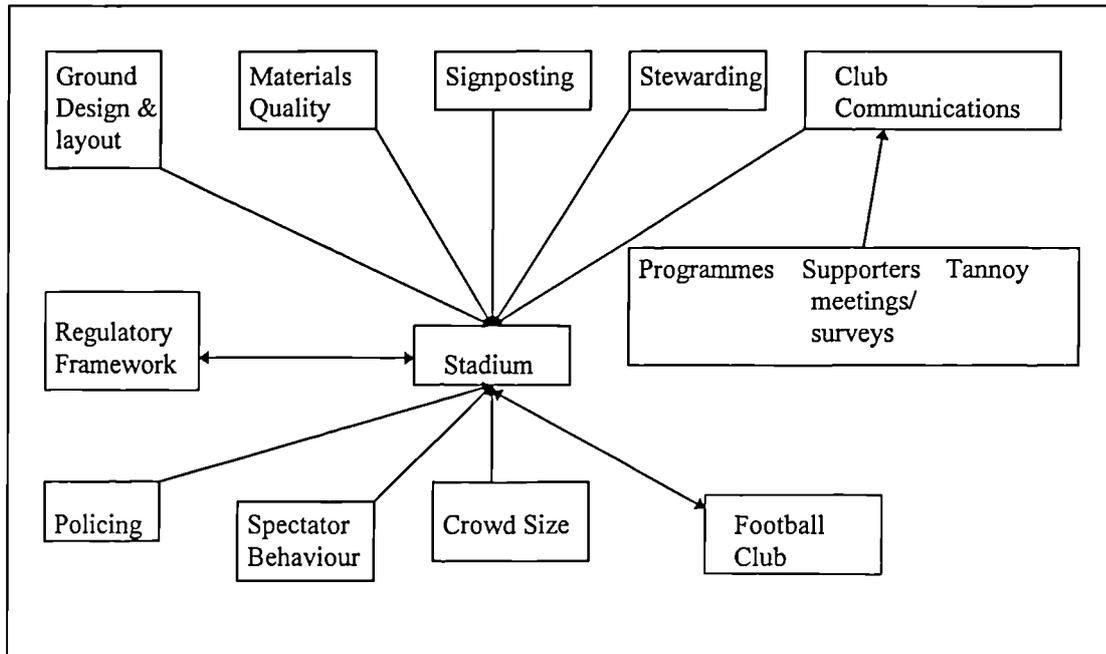


Figure 2.5: Systems map of the stadium

dissimilarities, stadia and industrial plants share many features as socio-technical systems and that concepts such as interactive complexity and tight coupling have relevance to both. This line of argument is fully developed in Chapter 5 which examines each of the stadia tragedies. Figure 2.5 illustrates a map of the stadium as a system.

These technical system aspects consist of the physical attributes of the stadium, its design and layout, materials such as crush barriers and state of repair of fixtures and fittings. The fences, gates, tunnels, exits and turnstiles all form a part of this physical system. This physical system is itself the result of compromise between the advice of regulators, architects and other specialists and the resources and priorities of the Club responsible for providing the investment to fund its

ongoing development and upkeep. When an event is held the stadium is transformed. It is the context for the gathering of large numbers of people. The physical form of the stadium influences behaviour as do semi-physical elements such as signposting (Poplewell 1985, Taylor 1989). However, the crowd itself develops its own characteristics, introducing uncertainty, (McPhail 1991, Lewis 1982, 1989, Lewis & Veneman 1987) and is itself influenced by those with responsibility for overseeing safety and control at football matches.

Despite this observation, Official Inquiries have focused on technical improvements to stadia to the detriment of developing a safety culture. de Quidt (1997a) Chairman of the Football Licensing Authority (FLA) states that a key role for the FLA in the future is to switch the emphasis from technical safety to culture safety. The introduction of all seater safety, whilst reducing the risk from specific types of crisis incidents has done little to prevent a recurrence of either the Bradford Fire or an Ibrox style accident. This emphasis upon technical issues is one important factor, it is argued, in the continuing crisis proneness of the football industry. The following section illustrates this argument with reference to Perrow (1984) and a study undertaken of two stadia tragedies.

Drawing extensively from the work of Perrow (1984), 't Hart and Pinjenburg (1988, 1992a) offered an analysis of the Heysel and Hillsborough Stadia tragedies. As such, their work is a part of the development of applying 'crisis management' models to systems that are not 'technologically' complex. The interactive complexity of such systems derives from the presence of large numbers of people in a confined space. As a consequence there is the potential for unexpected interactions similar to those encountered in high tech environments. Tight coupling

arises from the physical infrastructure that accommodates these people and the difficulty in controlling movement. In the case of sports stadia, and theatres, cinemas etc. the need to ensure that only paying customers are admitted and cannot move to more expensive parts of the structure adds further problems. Jacobs & t'Hart (1991) asserted that:

“In an almost purely social system, it is not realistic to reduce the causes of major accidents to technological flaws (or flaws in handling technology) only. Rather, one should look for the personal, organisational and inter-organisational dynamics shaping the planning, preparations and interventions that affect the operation of these systems.” (p141).

Their argument is that various parts of the system at Heysel interacted in an

“elaborate and unintended way due to the fact that system components are complex and tightly coupled; consequently chain reactions follow quite easily.”(p208).

The context in which the Heysel soccer match took place ‘contained built in flaws and errors which were conducive to disaster’. These flaws concern the variety of agencies involved, tensions between them, their different preparations and interpretations of what was required and the complexity of rules, regulations, guidelines and advice which influenced their efforts (a thorough analysis is included within Chapter 5). Given this context, the authors argue that when the ‘error inducing system’ was placed under severe pressure a chain reaction occurred during which these weaknesses emerged to contribute to the final disaster.

The political aftermath of Heysel, t'Hart & Pinjenburg (1989) argued, highlighted the difficulties associated with learning from such incidents. They reported the immediate search for culprits reflecting the simplistic assumptions of cause and effect that Perrow's model sought to counter. They note that although the tragedy shocked everyone as:

“time passed local authorities under budgetary or commercial pressures became more willing, once again, to take ‘acceptable risk’ with the lives and well being of soccer fans.”(p223).

In summary, t’Hart and colleagues offer a systems view of crises, that examines the relationships between social and technical factors, placing greatest emphasis upon inter-organisational breakdowns. They echo the argument of Shrivastava (1987a) regarding the Bhopal Accident, who identified human, organisational and technical failures.

### **2.11 Implications for this study**

A deficiency in the treatment of crisis and organisational learning so far is that previous studies have failed to explore fully the relationship between organisation characteristics and learning. Much of this deficiency may be explained by the bibliographies of the two texts dealing with learning from disasters (Toft & Reynolds 1992, Fortune & Peters 1993,) which make almost no reference to the work of the Crisis Management School (see above), reflecting a tendency of researchers to remain within discipline. Although Toft & Reynold’s (1992) analysis contains many valuable insights, the absence of a grounding in the management and organisation literature prevents a full development of their ideas. From the above discussion a number of factors have been identified that drive or hinder the organisational learning process. Chapters 5 and 6 examine data collected from the football industry with a view to determining the presence of these factors. It is intended that some of the mechanisms that have blocked learning can be identified. Given the series of crisis incidents identified it can be hypothesised that there should be extensive evidence of factors that hinder organisational learning. For

those concerned with the future safety of sports stadia, the presence of these factors in the post 1989 period may be cause for some alarm.

## **2.12 Conclusions**

This Chapter has dealt with the nature of organisational learning and its relationship with the different stages of crisis. This thesis is based upon the premise that the stadia disasters represented socio-technical failures. Figure 2.1 mapped the key elements of this approach and illustrates the relationships between system elements. Given that the focus of this study is upon learning from system failures this map should be read as a fluid diagram, with ongoing interaction between the various system components. Double loop learning feeds directly back to the organisation.

From the discussion above, a number of key issues have emerged related to the nature of knowledge, forms of learning and barriers to effective learning. These inter-related issues form the analytical basis for this thesis.

A distinction has been made between explicit and tacit knowledge. It is argued that explicit knowledge is developed within a particular paradigm. Paradigms are resilient to change and exert tremendous influence over the validity of the information collected, analysed and translated into knowledge. For organisations, these paradigms or mindsets are manifested in the cultural assumptions that are made regarding themselves, the nature of crisis, their environment and the nature of crisis management preparations. The resilience of a particular mindset creates a powerful inertia to change. From the crisis management literature, a particularly persistent mindset focuses upon the technical causes of crises to the detriment of human and organisational factors. Learning, it

is argued, has been largely constrained to explicit knowledge in the form of technological modifications. Conversely little attention has been given to the social elements of culture, structure and communications identified in figure 2.1.

The concepts of single and double loop learning have been developed to explain how organisations might develop tacit in addition to explicit learning. That is, the learning questions core assumptions. It has been argued that although there is a need for both forms of learning, that each fulfils a different task. Single loop learning might be summarised as 'within paradigm' monitoring and evaluation. It is vital for operation's management. Double loop learning questions the rules and assumptions that underlie decisions. A parallel might be drawn between these two terms and the differences between efficiency and effectiveness. The former meaning doing something well, the latter doing the right thing.

Double loop learning is closely allied to the concept of 'cultural re-adjustment' that Turner (1976) and Toft & Reynolds (1992) hypothesised would occur to an organisation following a disaster. They argued that the significance of a major disaster would lead to a fundamental questioning and change to the organisational mindset. Evidence has been offered that this is not always the case. Further, it is argued that to wait for a major incident to challenge the cultural mindset may be expensive in lives and money. A key question that arises is, why do organisations fail to learn?

From previous studies within the field of Crisis Management and within the broader field of organisational studies, a number of barriers to learning have been identified. Culture, structure and communications have been identified in a number of separate studies from two distinct fields, which lends some credence to the

findings. From the foregoing discussion a number of research questions arise. First, what evidence is there for a full cultural readjustment having taken place within the football industry? Second, if no full cultural readjustment has occurred, what factors have impeded the learning process? Specifically, do individuals and organisations within the industry demonstrate an inner or outer orientation? Is there evidence of defence mechanisms in the forms outlined above? What are the views of those operating within the industry regarding the causes of the previous stadia disasters? What is the economic context for the industry now and in the preceding fifty year period? What is the nature of the involvement of other agencies with responsibility for promoting safe stadia? Analysis of these issues forms the main part of the remainder of this thesis.

The analysis of cultural barriers to learning within this thesis, has been developed from Pauchant & Mitroff's (1988, 1992a) Onion Model of Crisis Management. Specific factors including the use of defence mechanisms by organisations, the degree of their inner orientation and a fatalistic view of the world have been identified as factors that hinder effective learning. Indeed these factors, it has been argued, frequently prevent double loop learning and thereby forestall cultural readjustment. These factors are more fully explored with reference to the football industry in chapters 5 and 6.

The two other social elements identified in figure 2.1, structure and communication, have been discussed together. It has been argued that structures may either impede or facilitate the free flow of information, determine the extent to which knowledge is shared, and set the context in which decisions are made. Structure provides the context in which learning takes place or does not take place.

Certain structures have proved more amenable to double loop learning and Mintzberg's (1983) framework is used to examine the football industry.

Finally, the Chapter introduced the concept of the stadium as a socio-technical system. Emphasis was placed upon demonstrating the interaction between the hard and soft system elements.

Chapter 3 provides a review of the available research methods and provides a rationale for and explication of the approach adopted in this study. The analysis then proceeds to an examination of the well documented football stadia tragedies Ibrox (1971) Bradford (1985), Heysel (1985) and Hillsborough (1989). It is emphasised that whilst these incidents provide a necessary entrance to the discussion, the other crisis stages should be the focus. It is intended to provide evidence that the incidents reflected a common pattern of causality that came from the industry itself. It is argued that although the first three incidents provoked considerable government and public response, the fourth (i.e. Hillsborough) and the subsequent Taylor Report was a watershed for the industry. This Chapter combines an examination of the regulation of the industry within this period. It argues that the early periods were characterised by an indulgent regulatory regime that failed to have the desired impact.

This thesis then proceeds to an examination of the post 1989 period, reporting the evidence collected in the course of this study, as a means of examining the first principal hypothesis which suggests that recent developments have done little to change the underlying cultural and structural causes of these crisis incidents.

## **Chapter 3**

### **Research Methods**

### **3.1 Introduction**

This Chapter reviews the methods used to obtain information during this research project. First, the problem area and the key research questions addressed in this thesis are discussed. Second, it explains what was done, how it was done and seeks to provide a justification for why the study was operationalised in a particular way.

### **3.2 The Nature of the Problem**

The purpose of this study was to explore the issues surrounding organisational learning from crises. A key objective was to increase understanding of how organisations learn or, conversely, why they fail to learn. The origins of the study lay in the observation that the UK football industry had experienced a series of fatal accidents, the most serious of which have been investigated by the public inquiry process. Chapter 1 indicated that the rate of accidents has been much higher in the UK than in other, comparable countries suggesting a particular problem. A key argument is that the various stadia disasters represented socio-technical failures and that they are linked together despite the superficial differences between them. This assumption, discussed in Chapter 1 underpins this thesis. Previous studies have suggested that a **full** cultural readjustment will follow a ‘disaster incident’ leading to new operating norms, beliefs and procedures (see Turner 1976, 1978; Toft & Reynolds 1992). The principal hypothesis contends that following the various stadia disasters no full cultural readjustment occurred. The emphasis upon the word ‘full’ is important, although a reading of Turner (1976, 1978) and Toft & Reynolds (1992) indicates that the notion of full cultural readjustment is an ideal one. However, the means by which cultural readjustment occurs were not discussed at length. The focus of these studies lies primarily upon learning from the public

inquiry process, rather than upon the broader process of organisational learning which is the focus of this study. Central to this thesis is the notion of active learning which, it is argued, corresponds with Turner's notion of cultural readjustment (i.e. the translation of knowledge into operating norms and practices). While it is difficult to quantify organisational learning, and more particularly to specify when 'full cultural readjustment has occurred,' it is possible to qualitatively assess changed behaviour and identify the range of factors that influence it. This is an important consideration that justifies the need for qualitative methods to provide a rich picture combined with quantitative methods to provide the population validity. A focus upon the inquiry documents alone would not give sufficiently rich insights into the responses made by the organisations to the output from those public inquiries. That is, the study of cultural change requires not only an assessment of beliefs, assumptions and values but of how such changes manifest themselves in altered behaviour.

Learning at an appropriate level, therefore, appears central to the notion of cultural readjustment. The review of the organisational learning literature identifies two broad forms that relate to 'factual' and 'cultural learning respectively. Argyris (see 1993 for example) distinguishes between single and double loop learning while Nonaka (1991) identified explicit and tacit knowledge. Whilst the two ideal forms of learning are quite distinct, in practice the distinction between them is more difficult to specify as Kolb's (1986) Learning Cycle portrays. Also as Nonaka's (1991) illustration of the baker (see chapter 2) suggests, the output reflects the skills of the craftsman as well as the ingredients used.

Any understanding of cultural readjustment it is argued, depends upon the nature of learning and those factors that influence it. The second stage of the

research project (which is discussed in greater detail below) combined a review of the relevant literature with the use of a grounded approach. A grounded approach was used primarily to avoid simply exploring the issues believed to be key at the outset of the project. In line with Strauss & Corbin's (1991) approach to grounded theory, it was employed to prevent the study simply reflecting the reading undertaken at that point and the inevitable researcher bias. In practice the whole research process is, of course, an iterative one with multiple feedback loops between the different stages, not always in keeping with what Bryman (1988) has described as the 'post constructed logic of many theses'. From this exploratory, grounded stage a number of themes emerged that could be linked to the beliefs and assumptions of those associated with the football industry and to the structures of their organisations. The role of regulators was identified as a central issue in the post 1989 period but appeared less relevant in the preceding years. Other themes that emerged included relations between clubs and external stakeholders; the roles of police and stewards; assumptions regarding the causes of preceding incidents; the different types of club structures; varying perceptions of the importance of safety management and steward training. ( a full list of the key issues covered is included at appendix 3.1). In short a number of specific propositions were identified during the grounded approach that were linked, ultimately to key issues that emerged from the review of the relevant literature. It appeared that the way in which regulations were enforced influenced the type of response of each club; the structure of many clubs appeared to impede the effective consideration of safety management; the lack of effective strategic planning also appeared connected to the failure of clubs to deal with safety management issues effectively; the relations between club and regulatory agencies appeared to be influenced by a narrow perception of the purpose

of the club and a desire to reduce expenditure on match policing. Although these themes emerged from the data, it was inevitable that prior knowledge would inform the categorisation process. It is emphasised again that the grounded approach was used deliberately to foster an open minded approach to the data, so far as that was possible. The identification of Gouldner's (1955) framework of 'patterns of industrial bureaucracy' was introduced at this stage as it appeared, from a study conducted by the author fifteen years previously, to achieve a close fit with the data from the first two stages of this project. It is possible that without the open minded approach encouraged by the use of grounded theory that this important contribution would have been overlooked.

### **3.3 Stadium Disaster Case Studies**

The first stage consisted of collection and analysis of data concerning five high profile disasters (Bolton 1946, Ibrox 1971, Bradford 1985, Heysel 1985, Hillsborough 1989). The scale of these incidents, in terms of fatalities, was such that each might have been expected to trigger a fundamental reconsidering of the paradigm for managing crowds inside stadia. Data were collected from a variety of sources including the Reports of the relevant public inquiries, media coverage of the incidents and semi structured interviews of those involved in an official capacity at the Hillsborough Disaster. This latter group of interviews was conducted with members of the Police Forces of South Yorkshire, Merseyside and West Midlands; the latter had been charged with the task of collecting evidence for Taylor's Committee. One problem that arose, concerned the different accounts given by different sources. The analysis in Chapters 5 and 6 is largely based upon the factual evidence provided in the Official Inquiry Reports. Owing to the brief coverage of the Ibrox Stadium disaster in the Wheatley Report, other sources including Burrows

(1982) were used to reconstruct the events that day. In the case of Hillsborough, interviews with the South Yorkshire Police elicited some information that had not been presented at Taylor’s Inquiry. Wherever possible, data from different sources were compared as a means of ensuring reliability.

Although some forty five incidents were identified in table 1.1 there was scant data available regarding the majority of them. There is no body charged with the central collection of data concerning such incidents. To facilitate analysis the post 1946 period was divided into periods that used the major incidents as break points, based on the hypothesis that changes in behaviour would follow a disaster (see table 3.1). The historical analysis that resulted from this first stage proved useful in two key ways. First, the detailed analysis of each major incident provided a means of assessing ‘actual learning’ from preceding disasters and inquiries and thus permitted the testing of the hypothesis. Second, analysis of the periods between

Time	Data Collection & Analysis
Bolton 1946	Systemic analysis of crisis incident
Intervening period, 1946 - 71	Search for evidence of Cultural Readjustment
Ibrox 1971	Systemic analysis of crisis incident
Intervening period 1971 - 85	Search for evidence of Cultural Readjustment
Bradford, Heysel 1985	Systemic analysis of crisis incident
Intervening period 1985 - 89	Search for evidence of Cultural Readjustment
Hillsborough 1989	Systemic analysis of crisis incident
Intervening period ? 1989 - ?	Search for evidence of Cultural Readjustment

*Table 3.1: Crisis events and intervening periods.*

crisis incidents provided valuable insights regarding the relations between regulatory agencies and the clubs.

The final analysis, (see Chapters 5 & 6 ) was arranged in chronological order. Gouldner’s (1955) classification of patterns of industrial bureaucracy was used as one framework to explore changes in patterns of behaviour with regard to active regulation from the enforcement agencies (police, fire, local authorities) and to

positive action on the part of the stadium owners. Additionally, the analysis concentrated upon the three 'barriers' to learning, (namely culture, structure and communications) identified in Chapter 2. It should be emphasised that culture and structure had also emerged as key themes from the grounded data collection, although the categories that emerged were frequently at a more specific level. A key aim of the analysis was to explore the extent to which these variables influenced organisational learning during each historical period.

### **3.4 From Desk to Field Research**

The second stage of data collection was focused upon the clubs themselves with the purpose of identifying evidence of organisational learning and cultural readjustment. Semi-structured interviews were used to ensure that key areas already identified, were covered whilst providing the flexibility to identify those areas held to be important by respondents.

To ensure access to clubs, the support of the various football authorities was requested and granted. The purpose of the research project was explained to these authorities (respective national football associations and leagues) who agreed to dispatch a letter of introduction to the Chief Executive of each club in the selected sample. A subsequent telephone call was made to arrange an appointment with the senior administrative and commercial manager (either the club secretary or chief executive).

A sample of four clubs from each division in England and Wales, and two each from the two senior Scottish divisions was selected. This disparity reflected the different sizes of the English and Scottish divisions. Football clubs were selected on the basis of three criteria (see table 3.2) which have been identified as key in previous

studies, most notably in the first and second Chester Reports (1968 and 1983 respectively).

Criteria	
1. Division of Club in 1992/3	Recommendations from the Taylor report had been targeted at different divisions, particularly in the timing by which clubs had to comply. League position also reflects different commercial opportunities and clubs in the various divisions receive differing contributions from the various leagues. Much of the moneys received by football clubs for items such as competition sponsorships and fees paid for TV rights are collected by the leagues and redistributed to all clubs on a fixed payment to each club dependent on their division. This payment amounts to a significantly higher proportion of total income for lower division clubs than for those in higher ones.
2. Average Attendance in the 1992/3 season	A club was selected from each quartile. Although there is a link between the division in which a team plays and its average attendance this is not fixed. For example teams that are relegated may see persistently high average attendance's when compared to other teams in their division. Consistently high attendances would also be reflected in grounds with larger capacities. Thus a team playing in the second division may have average crowds than a team playing in the premier division. The premier team however would be able to expect higher levels of income from sources other than gate money (e.g. sponsorship and television moneys).
3. Region	Clubs from various parts of the country were visited: Wales, South, North East, North West, Midlands and Scotland. Wheatley's (1971) Report had identified that centres of population such as London differed in regulation by virtue of the fact that expertise could be developed where local authorities had responsibility for a number of venues. Historically the football league developed largely in the north and midlands of England. Although many of these teams were no longer as successful as they had once been, if success is measured in league and cup performance, they possessed large stadia which might pose different problems to safety than clubs in the south that had risen from semi-professional status more recently and would therefore have less traditional support and smaller, more modern stadia.

*Table 3.2 Criteria for sample of UK football clubs selection.*

All interviews were conducted in the offices of respondents. To ensure anonymity respondents are identified in the analysis by a case reference (P1 for the first Premiership respondent, P2 for the second Premiership respondent, F1 for the first First division respondent, S1 for the first Second division respondent, T1 for the first Third division respondent and SC1 for the first Scottish respondent etc.). At the start of each interview it was explained that the project was not primarily concerned with the issue of hooliganism, a frequent misunderstanding.

A copy of the questionnaire outline is included in appendix 3.1. Great care was taken to ensure that the respondents were allowed to do most of the talking and the questionnaire was used as a checklist rather than as a rigid framework for the

interview. All interviews were recorded on tape and transcribed as soon as possible following each visit. Hand-written notes were also taken during all interviews, partly as a back up to the tape and partly to record interruptions and to record other non-vocal forms of communication. In some cases the Club's safety officer was invited for the latter part of the interview and in three cases was interviewed separately.

Initially the taped interviews were typed up as short summaries. However, it became clear that these incomplete transcripts failed to capture the full richness of the interviews and these early interviews were subsequently typed up in full, with notes to indicate pauses, respondent mood in terms of excitement, annoyance and perceived willingness to answer questions frankly. Interviews lasted an average of two and a quarter hours for Welsh and English clubs and forty five minutes for Scottish clubs.

The purpose of the interviews was to determine the extent of cultural readjustment and to identify factors that influenced organisational learning. The interview typically began by asking respondents to describe how their club had responded to the Bradford and Hillsborough tragedies, providing evidence of how each incident had been perceived. Other key issues discussed included the role of the board of directors and owners, the management processes used within each club (including safety management processes), the views, beliefs and assumptions of the various club executives regarding safety management post-Taylor, as well as the causes of the Hillsborough and Bradford Stadium tragedies.

When all the interviews with club executives had been completed, the procedure shown in table 3.3 was followed to sort and analyse the data (see Easterby Smith et al 1993, Strauss & Corbin 1990). Throughout this process a

number of techniques were used to make sense of the voluminous amounts of data generated in the course of the interviews, including the use of matrix sheets to facilitate analysis between clubs (Miles & Huberman 1994). Such reductionism is inevitable as analysis develops. The purpose of using a grounded theory approach, in the first instance, was to ensure that such summarising or focus emerged from the interviewees and the data itself rather than from the researcher's preconceptions .

Rigour was achieved by closely following established methods of analysis. The decision to use grounded theory in the initial stages was taken as a means of avoiding simply placing frameworks drawn from the literature to the data. The intention thus was to avoid simply fitting the data into predetermined 'holes' and to seek instead to be creative in interpreting it. That is not to say that the initial stages of this process were not informed by a good knowledge of the relevant literature, given the length of time in which this had been critically reviewed over the preceding years, but that efforts were made to prevent premature disclosure on conclusions already reached. Also experience of organisations provided some insights into aspects of the data. As Strauss & Corbin (1990) suggested, the researcher should, periodically stand back and ask 'what is going on here'? What is being communicated through these interviews? What of importance is being omitted? Why is the interviewee focusing on this particular aspect? What might this focus reveal about the organisation, its culture, its processes in addition to the perceptions of the individual? Given that the context was a discussion of safety and management following a series of disasters, it was expected that interviewees would seek to emphasise positive aspects rather than negative ones. The label

- i) **Familiarisation** with the data, re-reading and re-listening to the interviews. Re-listening to the interviews, although time consuming proved extremely useful as voice intonation or hesitations provided further clues to the meaning of interviewees.
- ii) **Reflection** on the data and emerging themes. In practice it was difficult to distinguish absolutely between these first stages and as the study progresses this difficulty became more pronounced. Familiarisation and reflection inevitably go hand in hand. Some 45 key themes emerged at this stage.
- iii) **Conceptualisation**. Again the distinction between this stage and the first two was blurred. A conscious attempt was made to avoid premature conceptualisation using existing frameworks. However, as this stage emerged in its own right a reflection upon the wider literature and frameworks was used to link the themes together.
- iv) **Cataloguing** concepts. This process was begun before stages i)-iii) were concluded. Transcripts were stored in tables on a 'Word' file. A master copy of each transcript was kept separate. Use of the cut and paste facility was made to group data under themes, sorted by club reference. Where data could be included under two or more themes it was placed in two or more tables.
- v) **Recoding** of concepts. As the analysis progressed and concepts were linked together the number of themes was reduced to eleven. Despite the temptation to hurry this process, this stage proved extremely useful in reconsidering the analysis that had already been undertaken. The use of a grounded theory approach had been made to facilitate creativity and ensure that structure emerged from the data.
- vi) **Linking** concepts. A model of the concepts was drawn up and refined many times in an attempt to highlight important relationships (See figure ?). These are discussed in greater detail below.
- vii) **Re-evaluation** of themes. Given the independent nature of the PhD this stage was used as yet another opportunity to reflect upon the process and re-read the transcripts once more. This final re-reading sought to treat each transcript holistically with a view to identifying the underlying meaning.

*Table 3.3: Stages of Grounded Theory methodology  
Source Easterby-Smith et al (1993)*

'displacement' was applied to those instances where the interviewee indicated that a certain task or area of responsibility belonged to another agency. This was added to Pauchant & Mitroff's (1988, 1992a) seven types of defence mechanism. Correspondingly a label of non-displacement was identified to facilitate collection of instances where interviewees reported that tasks were their own responsibility. Strauss & Corbin (1990) refer to this as the 'flip-flop' technique whereby a particular concept is turned upside down and looked at from a contradictory or

opposite perspective. Extensive use of the 'flip-flop' technique was made as a means of finding conflicting examples to avoid merely fitting the data to preconceived models. Comparisons with other industries were made to develop new perspectives. For example, comparisons with data collected from other sports business organisations as well as finance sector firms were made as a means of developing as rich a picture as possible of what was being communicated from the interview data.

In addition to the interviews, arrangements were made to visit a number of clubs to observe matchday operations. These included 3 Premier clubs, four First division clubs, and two each from the Second, Third and Scottish Divisions.

#### **3.4.1 Consolidation**

The third stage of the research project built upon the second two stages in that it sought to take the grounded data and themes and place them within the context of existing knowledge. The relationship between the two ideal forms of learning identified above and cultural readjustment has already been discussed. At this stage the contribution of those researching in the field of organisational learning and crisis was considered alongside the data and an attempt to integrate them made.

The system's map shown in figure 2.1 highlights a number of variables identified in the literature as key influences on active learning or organisational behaviour. Learning or cultural readjustment is equated with a shift in beliefs, norms and assumptions. Drawing upon Pauchant & Mitroff's (1988, 1992) Onion Model these elements can be seen to lie hidden at the core whilst behaviour remains on the outer layer. The richest picture of organisational culture will emerge from an analysis that seeks to explore and understand the relationship between behaviour and the assumptions that underpin it. Data from the grounded research provided

some insights regarding the assumptions of key decision makers regarding safety management, the causes of disasters, organisational objectives and structural arrangements. The work of Pauchant & Mitroff (1988, 1992) provided an opportunity, through the use of an adapted form of their questionnaire, to analyse the football industry utilising an existing research instrument. This is fully discussed in section 3.6.

In the principal hypothesis it was argued that there was no fundamental cultural change following the disasters at Bolton, Ibrox, Bradford and Hillsborough. Cultural readjustment suggests complex learning of the double loop variety as shown in figure 3.1. Such learning strongly infers the absorption or transfer of knowledge into changed operating norms and procedures. Most importantly, the double loop learning associated with cultural readjustment requires a questioning of the mental models, heuristics, etc. that provide the frameworks in which decision makers and operators decide. The motivation for changed behaviour can be expected to come from within as new insights and understandings are translated into action

The first proposition is that full cultural readjustment did not occur. Figure 3.1 summarises the groups of key factors by which the extent of cultural readjustment will be assessed. Reference should be made to figure 2.1 which provides a systems map identifying the relationships between the key variables of communication, structure and culture which underpin figure 3.1. The second proposition is that learning from the public inquiry process tended towards the translation of explicit knowledge within a paradigm of single loop learning. That is, the learning did not lead to a change in operating norms and assumptions as hypothesised by Turner (1976, 1978). The third proposition relates to the second group of elements shown

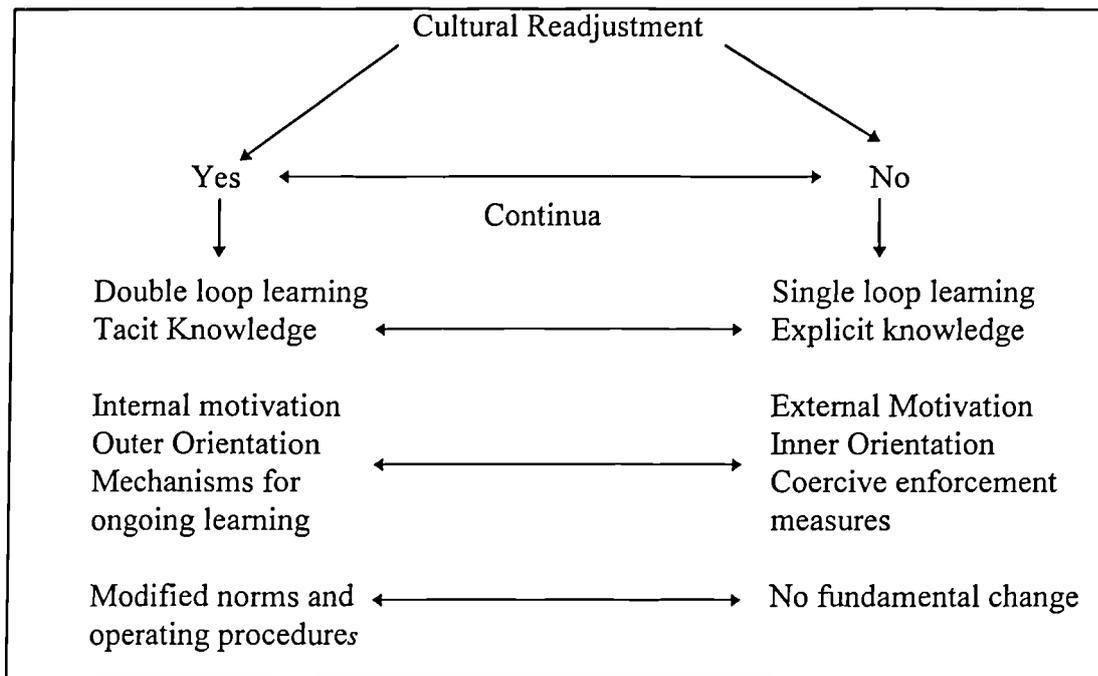


Figure 3.1: Factors that indicate degree of cultural readjustment

in figure 3.1 and concerns the primary motivators for change within the industry. In essence it is argued that football clubs have not been open to external influence and that many of the visible improvements observed since 1989 are the result of coercive enforcement measures with a focus upon minimal compliance. Gouldner (1954) and Mintzberg (1983) have argued that organisational characteristics, particularly in the form of deep seated assumptions, will play an important part in translating regulatory changes into patterns of behaviour. A range of patterns of behaviour are identified by these authors suggesting that there is no simple dichotomy between non-compliance and full compliance. From the grounded data it emerged that: a punitive oriented regulatory approach appeared to be linked to a compliance only response; the focus of football club Chairmen upon playing success appeared to contribute to a low priority given to safety management; perceptions and assumptions regarding the underlying causes of the stadium tragedies were also identified as key factors influencing the implementation of crowd management activities.

Data collected from the semi-structured interviews (for example related specifically to perceptions of various guidelines) and direct observations were used to identify examples of single and double loop learning. Previous studies (see for example, Gouldner 1954, Mintzberg 1983, Shrivastava 1987, Smith 1990, 1995, Smith & Tombs 1995) have indicated that regulation, and its enforcement, is insufficient to fully change behaviour as groups and individuals may actively resist imposed measures unless their deep lying assumptions and beliefs are successfully challenged. In the light of this observation Turner's (1976, 1978) notion of full cultural readjustment appears too clear cut. The frameworks suggested by Gouldner (1954) and Mintzberg (1983) imply a range of alternative scenarios of changed values and behaviour as opposed to Turner's seeming dichotomy of either no or full cultural readjustment. The range of instruments employed (i.e. the combination of qualitative and quantitative methods) sought to create the rich picture required to understand the role of legislation in changing behaviour. In addition to the data already collected from semi structured interviews with football club executives, data were collected from those agencies tasked with formulating and implementing the regulatory framework. In the questionnaire to football safety officers, numbers 39 - 42 dealt with perceptions of safety and the extent to which clubs complied with regulation.

With regard to assessing the extent of learning, figure 3.1 identifies the key indicators that were identified in Chapter 2. The data collected sought to identify the type of learning within the industry. In particular, data, collected in the course of interviews, direct observation and questionnaire survey, sought to identify the cultural and organisational framework in which learning took place, in addition to searching for evidence of both single and double loop learning. A related factor

concerned the motivation for action and the research design sought to elicit the reasons for changes to behaviour.

The primary instruments employed in using the model to examine cultural readjustment included data collected from the semi-structured interviews, direct observations of events and the questionnaires despatched to football club safety officers.

In the case of double and single loop learning, respondent views regarding the causes of previous incidents, their clubs tangible responses to these, and their questioning of technical guidance provided indicators. In particular responses (see appendix 3.1) concerning perceptions of the causes of the Hillsborough and Bradford tragedies in addition to the club's responses to these provided insights regarding the type of learning that occurred. A further measure included the responses of local authority officers responsible for overseeing implementation of the 'green guide' (the introductory letter sent to local authorities is shown in appendix 3.4 and provided the basis for semi structured interviews).

For tacit and explicit knowledge, closely related to single and double loop learning, the semi structured interviews provided evidence of the extent to which knowledge was transferred to those with administrative responsibilities and more specifically those tasked with safety management, for example in the training of stewards. A theme that emerged from the semi-structured interviews concerned the type of formal and informal training that stewards received. For example, the use of female stewards by some clubs reflected the view that stewards were not there to deal with crowd control but safety - the underlying assumption being that women could not deal with rowdy males. Direct Observation provided an opportunity to witness how such knowledge was translated into behaviour. In the course of the

direct observation attention was focused upon identifying the organisation and co-ordination of the stewards, in particular the extent to which a regimented approach was pursued. In the questionnaire administered to football club safety officers, respondents were requested to indicate the primary factor in improved safety (question 41).

With regard to internal or external motivations the interviews provided access to views concerning the Chief Executive's motives to change, the role of significant events, regulators or pressure from supporters. In the course of the direct observation the interaction between club and regulatory agencies including the police, FLA and local authorities was observed. The questionnaire also sought to identify the key stimuli and barriers to change. Closely linked to the previous factor, the degree of inner-outer orientation was assessed firstly by eliciting the views of Chief Executives re. various stakeholder groups; second, by talking with safety officers, police and stewards during the direct observations; third through the safety officer questionnaire. Fourth, through the interviews with local authority officers. An assessment of the strength of mechanisms for ongoing learning concerned not just appropriate forums but an attempt to measure commitment. For example, Safety Advisory Groups exist for each club in the FA Premier and Football Leagues. However, more important was the reported commitment of clubs to use these as mechanisms for learning. From the semi structured interviews and questionnaire items focused upon assessing whether these were in place to implement guidelines or to monitor and review. From the direct observation it was clear that some clubs had in place a system of regular debriefs to feedback operational problems to either the club or the safety advisory groups. These

operated informally at some clubs where in some cases the knowledge thus acquired was not passed to those with authority to respond.

The final category concerned actual behaviour and as such the direct observation was the key instrument used. In summary, the direct observation provided insight regarding many of the elements shown in figures 2.1 and 3.1. First and foremost, it provided evidence of actual practice. Second, it provided the opportunity for 'a look behind the scenes' of behaviour that would have been extremely difficult to orchestrate. Third, it provided an opportunity to observe the interaction between the various agencies which revealed evidence of the nature of relations between clubs and regulatory agencies. Fourth, it provided what might be called the acid test of commitment to safety. For example, in the course of the exercise I attempted to gain employment as a steward in order to assess the effectiveness of steward training from inside the organisation. The results of this experience is included in Chapter 6.

The principal research question focused upon those factors which influenced organisational learning, examining in particular those changes that have occurred within the football industry, including the extensive redevelopment of stadia, since the 1989 Hillsborough Disaster. Such changes may represent largely technical modifications which do not challenge the previously held mindsets and operating norms. Further, the decision to require extensive redevelopment was taken by government and not by the owners of the stadia themselves. Physical redevelopment may reflect the view that the safe management of crowds is a technical problem. In Chapters 1 and 2 it was argued that that the stadium disasters represented socio-technical failures. Technical modifications only deal with one element of the total system. As Chapter 5 argues, this emphasis on technical

solutions to solve one problem has been a key factor in subsequent disasters. A widely cited analogy concerns the introduction of legislation making it compulsory that all car passengers wear a seat belt. Evidence indicated that the introduction of this legislation was followed by an increase in the accident rate. An explanation put forward was that as car drivers felt safer by wearing a seat belt the standards of their driving fell to maintain the same level of perceived risk.

### **3.4.2 Can Organisations Learn?**

A difficulty in assessing learning concerns the question, who or what learns? Argyris & Schon (1996) suggested that acceptance of the notion of the learning organisation has been gained only recently, reflecting a growing agreement that the development of corporate strategy frequently follows an active, iterative process involving whole organisations. Levitt & March (1988) defined organisational learning as the “encoding of inferences from history into routines that guide behavior”(p319). They concluded their review of the literature on organisational learning by stating that:

“There is adequate evidence that the lessons of history as encoded in routines are an important basis for the intelligence of organisations. Despite the problems, organizations learn”(p336)

Chapter 2 discussed the organisational impediments to effective learning. These factors included structure, communication and organisational culture. An additional dimension, however, concerns the beliefs and assumptions of individuals working within an organisation. There is some agreement, as shown in Chapter 2, that an important element of corporate culture concerns the beliefs and values of individuals.

### 3.5 Direct Observation

Following each interview, arrangements were made to observe the management of specific events. Observations of events invariably followed the format:

1. Arrive three hours before the game and meet with Contact.
2. Attend police and stewards briefing.
3. Talk to stewards and police.
4. Remain with Safety Officer or Deputy for the duration of the event.
5. Short post event debrief.

As Buchanan et al (1988) report:

“The practice of field research is the art of the possible. It is necessary to exploit the opportunities offered in the circumstances” (p55).

Freedom was given to roam with a security pass for all areas and in many cases the opportunity to wander around stadia during events was used to advantage. This provided an opportunity to talk to stewards, police, local authority officers and to observe what was done, how it was done and what was not done (especially that which should have been). A pocket tape recorder was used to collect notes and a transcript was typed up after the event. This direct observation performed a key element of the triangulation approach. It permitted some cross checking of evidence collected during interviews by observing actual practice, providing a less formal scenario for discussions with the original interviewee and the freedom to interview significant others (e.g. stewards, visiting local authority officers). It also provided an opportunity to discuss safety issues with operational staff and identify the quality of training and communications.

The data collected from direct observation provided a valuable means of double checking data collected from semi-structured interviews. Interviews with executives provided a view of how things should be, whilst direct observation permitted the identification of how things were. Thus direct observation permitted an investigation of actual behaviour. The results are discussed in Chapter 6.

### 3.6 Questionnaire Survey

Given the focus of this study upon the Professional Football Population within the UK the total population amounted to some ninety two clubs in England and Wales, zero in Northern Ireland and twenty in Scotland (the remaining twenty Scottish League clubs are considered semi-professional). The questionnaire was issued to all clubs that had membership of the Football Safety Officers Association (FSOA), which included all 92 clubs in England and Wales and only two in Scotland. The questionnaire was distributed by the FSOA with a covering letter outlining the aims of the research. A questionnaire (identical) was also sent to the eighteen Scottish Premier and First Division clubs who did not have a member of the FSOA on their staff.

Responses were received from some 60 clubs (see table 3.4), giving an overall response rate of 65%. There was some variation in the response rate when it was examined by division. Fourteen responses were received from Scottish clubs, a response rate of 70%. The lower response rate of second and third division clubs may be explained by the fact that their safety officers are often part time, many working on matchdays only. The poor response is itself indicative of the resource problems facing these lower division clubs. As the Bradford Fire illustrates however, these clubs are not immune from stadium disasters.

	No. Respondents	% of Division
Premier Division	17	85
First Division	19	79
Second Division	12	50
Third Division	12	50
Scottish Premier & First divisions	14	70
Total	74	100%

Table 3.4 Survey Respondents

### 3.6.1 Questionnaire Data Analysis

The mailed questionnaire survey included an adapted form of Pauchant & Mitroff's (1992a) attitudinal questionnaire tool, as well as a section used to provide evidence of safety management practices which have been referred to in the previous sections. The inclusion of an adapted version of Pauchant & Mitroff's (1992a) questionnaire provided the basis for examining their Onion Model of organisational culture (questions 45 to 66). This provided a basis for identifying the presence of defence mechanisms that would provide evidence of barriers to active learning. A copy of this questionnaire is included at appendix 3.2. A key problem that emerged concerned the methods to be used to examine the data. Standard independent variables had been identified and included the division of respondent's employers, as well as personal information concerning respondents including age, previous employment, current role and time in post. A summary of these characteristics is included at appendix 3.3. One aim of the questionnaire was to collect data regarding perceived improvements with regard to safety within the football industry. A second objective concerned an attempt to identify the perceptions of respondents regarding the four levels of the Onion model. SPSS was used to generate cross tabulations of a wide range of variables and explored the data for correlations. Additionally factor analysis was used to assess Pauchant &

Mitroff's (1992a) findings and to search for the presence of underlying factors. A full description of the procedures followed are included in Chapter 6. Although widely used, few authors identify the full limitations of these techniques nor do they allude to their origins. Gould (1988) noted that both Pearson and Spearman, responsible for two widely used correlation techniques, were both eminent psychologists and Gould (1988), commenting on the origins of the technique, asserted that:

“Factor analysis, despite its status as pure deductive mathematics, was invented in a social context and for definite reasons. And though, its mathematical basis is unassailable, its persistent use as advice for learning about the physical structure of intellect has been mired in deep conceptual errors from the start.... in this case, the notion that such a nebulous, socially defined concept as intelligence might be identified as a thing.... and that it might be measured as a single number, thus permitting a unilinear ranking of people according to the amount of it they possess.”(pp238-239).

Gould's criticism of reducing intelligence to a number may be extended to any attempt to summarise individual personality and corporate culture. However, factor analysis was used as only one component of this study and was examined alongside data collected from other sources. In this way triangulation was used to facilitate flexibility in the collection and analysis of data (essential given the complexity of the subject under investigation), whilst ensuring that the various data collected were integrated and cross checked. As Jick (1979), amongst others, notes, there can be greater confidence in the results of a study that has used various means of data collection.

Given the central role of culture in the process of organisational learning, there was a danger that Pauchant & Mitroff's (1992a) 'attitude scales' be used in a simplistic way (i.e. to rank organisations). It should be made clear that they also adopted a triangulated approach combining survey data with extensive interview

data. Pauchant & Mitroff's (1992a) questionnaire tool, although supported by rigorous statistical analysis, provided no more than pointers towards potential weaknesses. For this study of the football industry it did provide evidence of core assumptions, but, as Chapter 6 demonstrates, the validity of this study's findings is based upon the use of a mixed methods approach.

Factor analysis and grounded theory share a number of characteristics despite their obvious dis-similarities. Both are tools for exploring a mass of data to identify a small number of themes, categories or factors. Both lead to conclusions for which it can be claimed that they are 'grounded in the data'. Similarly both depend upon the data that is input, 'garbage in, garbage out'. The value of using the two techniques together, was that it permitted a mixed method's cross check, leading to increased confidence in the validity of this study's findings.

Gould (1988) was keen to counteract the assumption that 'abstract measures summarising large tables of data must express something more real and fundamental than the data themselves' (p239), citing correlation as the most misused technique. As the data analysed on SPSS was ordinal, this cross checking was vital. The necessity to combine quantitative with qualitative data became evident throughout this study. Although particular problems encountered in the analysis of the questionnaire data are discussed in Chapter 6, conscious efforts were made to ensure that all data were treated in an open, if critical, way, particularly with regard to the 'hard' data produced from the questionnaire.

### **3.7 Local Authority Interviews**

In late 1996 and early 1997 a series of interviews were conducted with the lead officer for each Safety Advisory Group (SAG)<sup>1</sup> of the Clubs that had been visited. Respondents' views are identified within the text by the prefixes LA1, LA2 etc. The first step of this process consisted of a letter despatched to each officer outlining the purpose and background of this study (see appendix 3.4). The support of the football authorities was also highlighted to encourage participation. A very positive response was received with many respondents making contact directly rather than waiting for a telephone call. Although it was intended for these interviews to last for no more than 15 minutes, in practice the average interview length was in excess of 40 minutes and in one case 90 minutes. Respondents also passed on further information including minutes of SAG, inspection reports and other items of correspondence. Although the interviews were semi-formal in nature they were sharply focused to elicit data regarding the development of safety management practices at football clubs. Such an approach was necessary, given the difficulties of designing a questionnaire to examine the evolution and current state of safety practice.

### **3.8 Final Interviews**

In addition to preliminary interviews with the various football authorities, the findings of the research were discussed at length with the Chief Executive of the FLA. This provided an opportunity to test the findings with an individual closely involved within the industry, and to collect data regarding the work of the FLA.

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<sup>1</sup> The Safety Advisory Group was set up, following Taylor's recommendations, to act as a forum for the various agencies and interested parties to meet and discuss crowd safety.

### 3.9 Methodological Perspective: Reliability and Validity

There is a growing literature that argues against the application of quantitative terms, such as validity and reliability, to qualitative research. Marshall & Rossman (1995) for example, citing Lincoln & Guba (1985) argued that all research must meet certain 'criteria of soundness,' the term which they used in place of validity and reliability. Soundness, Marshall & Rossman (1995) defined as the credibility of findings, their transferability to other settings, the confidence with which the replicability of a study can be achieved in the same context and with the same participants and finally the confidence that the findings are reflective of the subjects' views rather than the researcher. There is a strong logic to Marshall & Rossman's (1995) argument that, given the different logic of quantitative and qualitative methods, different criteria should be used to demonstrate the soundness of both. This is not to state that anything will do in qualitative research but that any attempt to demonstrate soundness should reflect the particular approach. However, although this study makes use of quantitative methods in what is essentially a qualitative study, this section aims to establish the soundness of this study with reference to reliability and validity.

The methods selected for the collection and analysis of data for this thesis included semi-structured interviews with key executives, surveys of safety officers, analysis of documents and direct observations of events. In so doing an attempt was made to assess safety policy, assumptions, beliefs and safety practice by developing theory grounded in observation. Glaser & Strauss (1967) argued that theory that develops out of empirical research (i.e. grounded theory) is 'more likely to fit the data and to be useful, plausible and accessible' (p9). Theory or experience, which comes first is like the chicken and egg debate. Grounded theory method was

used to avoid the potential pitfall of applying a completely preconceived framework to the data and simply selecting that data which fitted. This aided the creative process and led to the use of Gouldner's (1955) study of *'Patterns in Industrial Bureaucracy'* which had not been considered relevant prior to the study.

This section deals with the methodological issues that arise from the foregoing description of what was done. The social sciences present a sometimes confusing array of appropriate alternative research methods. As Bryman (1988a) has noted, there is a good deal of confusion over what constitutes qualitative and quantitative research. Part of this confusion arises from a narrow association of quantitative methods with 'experimental', hypothetico-deductive' or 'positivist' positions and qualitative methods with 'contextual' or 'interpretative' positions. In this study a number of methods or techniques were employed. The rationale for the chosen blend lies with a number of factors including the nature of the research problem; a desire to match the complexity of the subject with the tools employed to examine it; and a deliberate intention to employ triangulation to improve the reader's confidence in the results and conclusions. Silverman (1993) argued that:

"It is an increasingly accepted view that work becomes scientific by adopting methods of study *appropriate* to its subject matter. Sociology is thus scientific to the extent that it uses appropriate methods and is rigorous, critical and objective in its handling of data."(p144, no added emphasis).

### **3.9.1 Reliability**

Validity and reliability, therefore, may be defined as the core concepts of rigour in scientific research. As has been shown, these terms are value laden leading some qualitative researchers to avoid using these terms. For example, positivist notions of reliability assume an unchanging universe where research can quite logically be replicated. This contrasts sharply with the interpretivist or

qualitative tradition which asserts that change is ever present and always possible. Kirk & Miller (1986) described the search for such replicability in a social context as 'quixotic reliability'. For example, the notion of test-retest reliability may be of value for a thermometer but less appropriate for the measurement of the experience of human stress, which may be expected to change over time.

For an essentially qualitative study such as this one reliability may be aligned to confidence in the consistency of categorisation. The rigorous procedure used for the analysis of the interview data represented an attempt to ensure this consistency (table 3.3). A continual re-reading and reflection upon the interview data were the means used to ensure that the subject's responses were properly reflected in the categorisation and subsequent analysis. Additionally, the questionnaire was piloted on four safety officers.

### **3.9.2 Validity: Respondent Validation**

The validity of the findings of this study can be asserted on a number of grounds. First, throughout the research process preliminary findings and analysis have been circulated to a number of football club officials, local authority representatives, the Football Licensing Authority and the various football associations for comment, discussion and feedback. Where the subjects verify one's findings it is argued that there can be greater confidence in their validity or credibility (see for example, Lincoln & Guba 1985, Bryman 1988a, 1988b, Silverman 1993, Marshall & Rossman 1995). Of course the strength of analysis that is grounded in observation is that it can not help but be valid as Marshall & Rossman (1995) assert.

### 3.9.3 Validity: Triangulation

The second basis for asserting the validity of this study concerns the use of a triangulated multimethods approach. Data were collected from a variety of documentary sources and from all agencies involved in the management and regulation of football stadia. Additionally, a number of methods were used to collect data including document analysis, interviews, questionnaires and direct observation. The overall research design permitted data collected in different ways and from different sources to be evaluated as a whole *reducing, but not necessarily eliminating*, the risks associated with researcher bias. Although each source of information has its own limitations, taken together they provide a foundation of hard evidence against which the limitations of each can be assessed.

A distinct tradition exists within the social sciences, that advocates the use of multiple methods commonly known as 'triangulation' (see for example, Denzin 1970, Jick 1979, Silverman 1993). Where there is agreement between two or more methods greater confidence in validity may follow. As Jick (1979) notes however, 'simpler' triangulation methods consisting of five variations of a particular method will not necessarily generate five distinct varieties of triangulated data, and whilst it might aid reliability it says little of validity. To deal with this potential weakness triangulation was employed in two ways. First, all agencies with a formal responsibility for safety management were interviewed (i.e. Football club executives, safety officers and other safety personnel, local authority enforcement officers, members of the Football Licensing authority, representatives of the various football authorities and members of the police service). Differences in perceptions provided fresh insights into the subject. Second, data collected via interviews was complemented by other methods. For example, direct observation provided an

opportunity to examine safety practice in action rather than in theory. The use of an adapted form of Pauchant & Mitroff's (1992a) questionnaire in the survey of football safety officers provided an opportunity to compare the data collected from interviews with data collected using an instrument that has been widely used in other crisis management studies. The analysis of data included in Chapters 5 and 6 draws upon evidence collected from the variety of methods employed, thereby promoting greater confidence in the validity of that analysis and the conclusions drawn from it.

#### **3.9.4 Validity: Representativeness**

With regard to the Representativeness of the study a number of observations can be made. Of a total population of 112, in-depth interviews were conducted with representatives of twenty clubs (18%) and nearly 68% completed the questionnaire. The stratified sampling ensured that those subjects interviewed were representative of the whole population according to the criteria held to be appropriate. A strong case can therefore be made for confidence in the Representativeness of the sample and hence for the validity of the findings to the population as a whole.

A further problem associated with qualitative studies is that necessarily the final report can only contain a small fraction of the data collected. There is a danger that only those fragments that support an argument are cited. To combat this danger 'deviant cases' are cited and explained where appropriate. The summary tables in Chapter 5 and 6 include data from cases that suggest differences..

#### **3.9.5 Validity : Grounded Data**

As Marshall & Rossman (1995) report, a qualitative study that aims to explore a problem through describing a pattern of interaction cannot help but be valid. An in depth study and description of the complexity of interaction between variables

will be thoroughly grounded in the data. In this study of organisational learning in the football industry, the participation of two thirds of the total population provides a strong indication of its validity.

### 3.10 Summary

As Bryman (1988a) has observed:

“Anyone who has ever conducted social research knows that the content of the textbooks on methods bears only a partial relationship with research itself ... (R)esearch involves much more than and is very different in texture than that implied by the text books”(p1)

Bryman's further observations, that researchers commonly make mistakes, gradually recognise the fragility of their methods and redefine their research towards less ambitious aims, all apply to this thesis. The whole process was of learning and it was not always pleasant. Whilst the above description of the process is true it does not tell the full story. Unfortunately there is insufficient space. None of this detracts from its ultimate value, but the process was more about learning a craft than following a systematic process. Working with organisations, forging links with gate keepers, overcoming missed appointments, diary clashes, illness and an initial grand view of the PhD were all barriers that had to be overcome. The purpose of this brief digression is to highlight that the actual process was much messier than the necessarily brief description given above.

The links between the various stages were important. The collection of data using semi structured interviews and the subsequent analysis, using grounded theory, during the second stage was intended to ensure that premature conclusions were not reached. In this sense this stage may be seen as a 'devil's advocate' stage in which the assumptions from stage 1 and the frameworks from crisis management were put aside and the data were considered afresh. For this reason, this stage may

be represented as at the cross over between an inductive and a deductive approach. In the first stage the purpose was to develop a plausible explanation of the phenomena under investigation without allowing preconceptions to determine the outcomes; although it was difficult to put aside powerful assumptions and early conclusions. Tversky & Kahneman (1974) highlight the every day use of heuristics such as first impressions which remain as very powerful influences. However, this stage permitted the researcher to be immersed in the data, to re-read transcripts, to re-listen to the interview tapes whilst reading the transcripts, so that subtle intonations could be recorded to ensure that the data were interpreted as closely to the interviewees' meaning, as possible. The researcher resorted to pen and paper and recorded a total of forty nine themes. These were subsequently modified to twenty five and again down to eleven. At this stage, consciously, the researcher compared the results from this grounded analysis with the crisis management frameworks and conclusions of stage one. This stage was particularly painstaking. As Marshall & Rossman (1995) have indicated, certain dangers confront the qualitative researcher. These include personal bias and a potential tendency to make value judgements during data collection. Certainly at the start of this study there was a clear expectation of what the conclusions would be. In the course of the research for this study, however, there was less certainty regarding the eventual conclusions. With regard to the second potential weakness, the use of tape recorded interviews and word for word transcripts helped ensure that value judgements were not made during the data collection stage. Early transcripts were summarised to facilitate analysis but these were soon found to be inadequate, and complete transcripts were completed for all interviews. A further strategy employed to prevent premature closure on ideas, was to search for negative instances of themes

raised. For example, the notion of displacement, held to refer to the expressed belief that safety was someone else's responsibility, was twinned with a category of non-displacement where a club executive suggested that they were responsible for safety.

This second stage also included participant observation at a number of sporting events. For logistical reasons this was undertaken, whenever possible, when a visit was made to a particular club or when the researcher was next in that area, supporting Buchanan et al's (1988) contention that the researcher has to be opportunistic. On a number of occasions this also permitted observation of the interaction between club officials, police and members of the regulatory authorities such as representatives of the FLA and Local Authority Safety Committees. This enabled the researcher to verify the recorded views of club officials and provided an opportunity for the collection of data from other sources. Ostensibly, however, the purpose of participation was to see the safety management procedures in practice and thus provide a means of verifying what had been communicated in the course of the interviews.

The hybrid methodology incorporated elements of what Harrigan (1983) has described as 'fine' and 'coarse grained' approaches to research to cope with the complexities of the study area. Fine grained or qualitative methodologies permitted the researcher to understand the nuances of the football industries environment and the peculiarities of each club and gave access to a wide range of viewpoints within the industry. The supplementary use of 'coarse grained' or more quantitative approaches facilitated the collection of data from across the industry and promoted the validity of the study findings by ensuring that the phenomena were looked at from multiple perspectives in such a way, that deeper dimensions,

that might have been missed, were permitted to emerge. The use of a grounded theory approach in particular avoided premature closure regarding the key variables to be studied. The use of a revised version of Pauchant & Mitroff's (1992a) questionnaire and the subsequent statistical analysis, allowed the integration of established tools and techniques within the overall study. Given the complexity of the industry and the historical nature of much of this inquiry, this mixed methods approach offered the best means of data capture, and appears wholly suitable to achieve the research objectives relating to the industry currently and in the period prior to 1989.

## **Chapter 4**

**Structure, Finance and Culture and the UK Football**

**Industry**

#### **4.1 Introduction.**

The purpose of this Chapter is to introduce and examine the various agencies and organisations which constitute the football stadium system. Particular attention is placed upon the environmental context and the structural and communication patterns evident within the industry. The Chapter is largely based upon documentary sources, supplemented where appropriate with data collected in the course of this study. It provides essential background to our examination of organisational learning. A commonly used framework for examining the environment of organisations is the Political-legal, Economic, Social and Technological (PEST) .

#### **4.2 Political-legal context**

As Chapter 5 deals with the response of the football industry to legislation and regulation in the post-war period, this Chapter will confine itself to a number of observations. First, the political framework that has evolved owed much to concerns with hooliganism culminating in the Football Spectators Act 1989. Second, following the public inquiry process outlined in Chapter 2, the legislative framework has developed in a piecemeal way in response to specific incidents or perceived problems. Third, the analysis demonstrates the reluctance of Government to introduce and effectively enforce regulation regarding safety management. Indeed the 1989 Football Spectator Act, which recommended the introduction of an identity card scheme, remains on the statute book, although large parts of it have never been introduced. Fourth, the 1989 Act covers England and Wales but not Scotland where a self-regulatory system still exists. Only two Scottish clubs employed safety officers in 1994; this figure had risen to twenty in 1997.

### 4.3 Economic Context

The period 1946 to 1997 witnessed a number of changes in the economic prosperity of the football industry. From 1946 to 1958 attendances rose continuously at a time when costs were restricted by the presence of the players' maximum wage. From 1958 until the early 1990s attendances fell continuously. During this period Chester was commissioned (1967, 1983) to investigate the economic viability of the industry reflecting Government concerns. It should be noted that despite the fall in attendances in the period 1958-90, gate receipts actually increased at a rate higher than inflation (see table 4.1).

	Division 1	Division 2	Division 3	Division 4	All Divisions	General Index of Retail Prices
1958/9-1963/4	+ 3.1	+ 4.2	+ 4.1	- 1.7	+ 3.1	+ 2.3
1963/4-1968/9	+12.3	+ 5.9	+ 3.0	+ 8.0	+ 8.9	+ 4.2
1968/9-1974/5	+ 9.8	+11.4	+ 9.2	+ 1.7	+ 9.6	+10.0
1974/5-1978/9	+17.8	+15.8	+15.6	+27.5	+17.6	+14.7
1978/9-1983/4	+ 6.7	+11.4	+ 7.9	+ 2.5	+ 7.8	+10.7
1983/4-1988/9	+ 9.0	+10.8	+12.8	+13.7	+10.3	+ 5.0

Table 4.1 : Annual Averaged Percentage changes in Football League Gate Receipts (after VAT deducted) 1958/9-1988/9

Source: Based upon Football Trust Annual Digest of Statistics (1993).

Arnold & Benveniste (1987), in an extensive examination of the English Football League, provided an explanation for this seeming anomaly reporting that this had been achieved through:

“successful pricing policies, whereby price increases have exceeded inflation and taken advantage of inelastic demand. .... [P]roduct extension has taken place into new competitions.” (p202)

Other factors reported by clubs include the increased income sharing arrangements through the Football League (from a central pool collected from sponsorship and a levy on televised football).

Despite these successes, however, rising costs, including the abolition of the players' maximum wage in 1961, contributed to a decline in the industry's

prosperity. An Economist survey (22/04/89) claimed that all league clubs would be considered bankrupt if they were to be judged by criteria in the Insolvency Act (see also Arnold 1991, Bird 1982, Gratton & Lisewski, 1981). As the majority of clubs were privately owned there was little detailed data concerning their individual financial status. However, it is evident from a number of studies (see for example Arnold & Benveniste, 1988, Gratton & Lisewski 1981) that there has been, and remains, a wide gap between the richest and poorest clubs. For example, in early 1997 Manchester United were estimated to have a stock market value of £460m. Other clubs, e.g. Brighton FC however, were facing bankruptcy. Indeed a feature of the 1990s has been a reduction in income sharing arrangements, partly due to the creation of a separate Premier League in England and Wales and a 'go it alone' deal with BSKyB. Despite this reduction a number of respondents in the English Second and Third division identified this income as vital. For a Third division club the Football League distributed approximately £160,000 in the 1994/5 season (Whalley, 1994).

The effects of new commercial opportunities and TV income created by the FA Premier League, enabled its member clubs to switch an average annual loss of £1.86m to an average profit of £2.24m between 1993 -5 (Deloitte & Touche 1996). Deloitte & Touche (1996) identified that in the 1993-4 season only 36% of all clubs were profitable at an operating level, a figure that falls to 20% for divisions 1,2 and 3. Coopers & Lybrand (1997) reported that the flotation of football clubs has led to dramatic increases in value, in addition to providing further financial resources. Charlton's 1997 flotation, despite seeing the price of shares marked down from 80p to 66p at the end of the first day of trading, raised some £5.5m the club desired to pay for ground improvements. The Guardian provided details concerning ten clubs that have

been transformed into public companies (see table 4.2). Although Coopers & Lybrand (1997) claimed that these valuations vastly exceed the real value of certain of these football clubs they concluded that on the basis of these figures, the professional football industry in the UK is currently worth between £2-2.5 billion. They suggested that a valuation of approximately £1.5 billion would more accurately reflect the real value of the industry. Nevertheless, this valuation provides an indication of the changed economic prospects for the more successful clubs. The threatened demise of a number of lower league clubs indicates that this 'prosperity' is not evenly shared.

Club	Flotation Date	Initial Value	Value as at 01/04/97
Manchester United	June 1991	£47.4m	£410m
Glasgow Rangers	October 1995	£20.7m	£230m
Arsenal	October 1995	£39.3m	£210m
Chelsea	March 1996	£56.7m	£150m
Tottenham Hotspur	October 1983	£ 9.1m	£112m
Leeds	June 1996	£20.2m	£110m
Celtic	October 1995	£14.5m	£110m
Sunderland	December 1996	£47.5m	£53m
Queens Park Rangers	October 1996	£26.0m	£31m
Manchester City	October 1995	£ 7.85m	£15m

Table 4.2 : Stock Market Value of Clubs, April 1997  
Source: Guardian (1997)

In summary, the period since the initiation of the FAs Premier League has seen a growth in the profitability of Clubs playing in the top divisions in England, Wales and Scotland. However, in the preceding period (i.e. the period covering the 1960s, 1970s and 1980s) few football clubs were profitable. The ability of so many clubs to keep operating despite their financial position may explain why so many football club executives expressed the view that the second and third divisions could continue indefinitely. S2, S4, T1 and T4 all reported that they would 'muddle through' as they always had done (the prefixes were explained in Chapter 3). No respondent indicated the view that the lower divisions would go part time as a means of reducing costs. With regard to the stadia disasters, it seems clear that lack of financial resources, in part explains the reluctance of football clubs to spend money on stadium

redevelopment or upon any activity (e.g. stewarding) other than their core activity of playing football.

#### **4.4 Social Context : Hooliganism Permeates the Debate**

Close links exist between the social and political-legal context. It has been argued that the identification of hooliganism as soccer's main problem acted as a key barrier to effective learning from stadia disasters. The problems associated with soccer hooliganism defined the context in which Government sought to intervene within the industry.

“The media have - over an historical period of thirty or forty years - created a condition of football as a signification of violence. It has become almost impossible to research into the regulation of football without being seen to be an integral part of discourses about football hooliganism” (Redhead, 1991, pp481-2).

The prominence given to hooliganism affected the debate concerning crowd safety and control. Williams (1995) suggested that for many

“Hooliganism has become dangerously close to being the national sport's key defining characteristic for the past 25 years”(p160).

Bale (1990) reported that the scale of the hooliganism problem has been grossly over-rated, citing Trivizaz (1980) who suggested that people committing offences at football grounds were treated more severely than those committing similar offences elsewhere. This context, Redhead continued, has set the scene for ‘football legislation’ even where the official purpose of legislation was to improve safety. The Government's ‘rapid’ reaction to the Bradford Fire supports this view. New regulations were decided in early June, some months before Popplewell's interim report.

The dominance of sociology in football research is highlighted by the establishment of The Sir Norman Chester Centre for Football Research within the

Department of Sociology at Leicester University. Canter et al (1989) argued that these sociological studies have 'delighted' football clubs as it has allowed them to blame the hooligans for all their problems. Support for this view emerged from this study.

Following the Heysel tragedy (1985) English football clubs were barred from participating in European competitions. Giulianotti et al (1994) suggested that in this period the Government pursued a paradoxical approach to dealing with the issue of hooliganism:

"Giving rise to deamplification (to confirm the efficacy of existing measures) and amplification (to legitimise further legislation)" (p21).

Giulianotti (1994) identified seven distinct phases of the treatment of the issue of hooliganism by researchers, media and government (summarised in table 4.3). Most pronounced from Giulianotti's (1994) analysis is that football hooliganism appears to have been 'discovered and rediscovered' politically on several occasions; alternating between 'amplification and deamplification' of the issue as politically required. Cohen (1973) observed that football hooliganism bore all the signs of moral panic that had been associated with the public's response to 'mods' and 'rockers'. The football hooligans were labelled as social deviants in order to reinforce middle class perceptions of the correctness of their own way of life. This moral panic provided some justification for the increasingly punitive sanctions developed during the 1980's. Contradicting such views Bale (1990) reported that local residents consider traffic and parking as greater nuisances than hooliganism. Whannel (1979) argued that the press had generally treated hooliganism as a new

Time Period	Focus
Post-war- 1968	Irregular disturbances, concern with maximising working hours. Little government concern apart from Moelwyn-Hughes (1946) report on Bolton Disaster. Media deamplification of phenomenon.
1968-70	Perceived escalation in fan violence and 'hooliganism' defined as a definitive social policy area with Harrington (1968) and Lang (1969) reports in hooliganism and crowd behaviour. Corporatist framework for problem solving applied to problem with setting up of committees between state, police and football authorities. Media amplification of phenomenon.
1971-78	In academic circles a Marxist perspective developed (Hall & Jefferson 1976, Taylor, 1971- Hooliganism reflects deterioration in social relations centred on local football club). Response to Ibrox disaster with technical solutions put forward and Safety in Sports Ground Act, 1975. Safety and Control perceived of as separate concerns. Introduction of segregation in English grounds. Perception that technical solutions being effective. Hooliganism viewed as a temporary phenomenon as mods and rockers had been in the 1960's. By 1974, political efforts to deamplify phenomenon.
1979-84	Identifies transition of government from Corporatist framework to a 'New Right' administration. Greater sensitisation of executive towards hooliganism and switch towards punitive judicial policies. The Leicester School dominates debate in search for understanding of phenomenon. Hooliganism, it is argued, has always been there, it is simply that public expectations have become less tolerant of such behaviour. Soccer violence perceived as an international embarrassment. Political and media amplification of issue.
1985	Deaths at Birmingham and Heysel linked to hooliganism, death of further 57 fans in Bradford fire. Giulianotti describes shift from 'New Right' approach to Prime Ministerial crusade against the enemy within. Government announces measures before Popplewell Inquiry reports back. Indefinite ban on English football clubs playing in European competitions. Rethinking of earlier conclusions on part of some researchers (e.g. Taylor). Growing interest in subject from a range of international researchers from Western and Southern Europe. South America, and Africa. High amplification.
1986-Hillsborough 1989	Giulianotti identifies a paradoxical executive approach towards football hooliganism, 'giving rise to deamplification (to confirm the efficacy of existing measures) and amplification (to legitimise further legislation). CCTV introduced into football grounds, compulsory membership scheme planned. Emphasis upon containment and extension of technical fixes of 1970's.
Post Hillsborough 1989:-	Scale of Hillsborough tragedy led to Taylor Report and far reaching changes in the industry. Emphasis on presence of hooliganism elsewhere. Problems of football industry recognised as not being simply concerned with hooliganism. To early 1996 deamplification of hooliganism as a phenomenon.

Table 4.3: The seven phases in analysis of hooliganism

Source: Adapted from Giulianotti (1994)

phenomenon despite evidence of its much longer history. Dunning (1994) offered evidence that the extent of hooliganism has remained relatively stable and that it is media reporting or perception has changed. He wrote:

“Media sensationalism contributed to the pattern of football hooliganism that emerged in the mid 1960's and lasted until the 1980's, namely the pattern whereby football matches came to be used by more or less organised groups of young, primarily working class males as a focus and context for fighting.” (p137).

Contradicting Dunning, Williams (1995) argued that hooliganism has declined since Hillsborough. Dunning (1994) writes of its continuance, despite the failure of the media to report hooliganism. There is evidence to support both arguments. Hooliganism inside stadia has certainly dwindled, as indicated by Middleham's (1993) survey of police forces, and may have declined in surrounding areas. Incidents in Dublin (1996) and at Queens Park Rangers' Ground in 1997 illustrate that it has not gone away. Tombs (1997) suggests that hooliganism may have been subject to media blackouts, a tendency that has coincided with the repackaging and commodification of football as a middle class leisure industry. A difficulty which emerges is the absence of a precise, commonly held definition of hooliganism. This makes measurement of the phenomena extremely difficult.

In late 1988 and early 1989 the Government was developing plans to introduce a compulsory "National Membership Scheme" for football spectators. At a national level the Government desired to introduce an identity card scheme. Before the scheme could be implemented a further tragedy occurred. In April, 1989 ninety five spectators were crushed to death at the Hillsborough Stadium. As Ian Taylor (1991) has argued this latter disaster was an:

"End point..... of those forms of political and journalistic discussion of football which had developed throughout the late 1960s, the 1970s, and the 1980s, articulated almost entirely around a 'law and order' theme and the identification of soccer's problems almost exclusively with the issue of hooliganism."(p3)

The close identification of hooliganism with the football industry effectively determined the context in which solutions were prepared and discussed. Prior to the Hillsborough tragedy Government intervention focused upon controlling spectators, culminating in the attempt to introduce a national identity card scheme for football spectators. The efforts of clubs, as Arnold & Benveniste's (1988)

survey suggested, were focused upon lobbying government to change its mind on the identity card scheme. The issue of hooliganism and the alternative means of its control dominated the debate. This attempt to control football spectators supports the view that policy makers and media perceived of the stadia disasters as being caused largely by unruly spectator behaviour. Lord Justice Taylor himself, was reported (by a senior RFU Official) to have commented upon a visit to Twickenham that his recommendations had not been intended to impact upon Rugby Football Stadia (anon, 1994). The implication of this view being that the problems of management of stadia were unique to the football industry.

The perceived close links crowd safety and control are illustrated by the terms of reference of Lord Justice Taylor's Report (1989):

"To inquire into the events at the Sheffield Wednesday football ground on 15 April 1989 and to make recommendations about the needs of crowd control and safety at sports events" (p1)

The main recommendations of the Taylor Report included the requirement for all football stadia to become all-seater. Although this may be interpreted as a high level technical fix, Taylor's criticisms of the football industry marked a significant development from previous reports in that a more thorough critique of the industry and other grounds was developed, than had been the case in earlier inquiries. Although there was debate about the particular role of hooliganism in triggering the events at the Hillsborough stadium, it was accepted by Taylor (1989) that the potential for disaster had been created by those agencies with responsibility for preparing for and overseeing the event. Taylor was critical of the complacency shown by football club directors and the tendency for ground development to occur in a piecemeal manner with, little consideration of how small changes might impact upon the overall stadium system. Taylor argued that his report should not be seen

as a one off solution to the problem but that safety could only be improved with ongoing reviews of arrangements.

Ian Taylor (1989) argued that the stadia disasters must be socially and politically contextualised. Citing the examples of a range of different disasters, unprecedented in scale and frequency within the UK, Taylor identifies a number of themes common to each:

“Rampant disregard for safety in private and public services; poor communications once disasters occur; inadequately trained and overworked staff and, especially, dilapidated public facilities” (pp108-9).

In a later article Taylor (1991) makes more explicit reference to the football industry:

“The Hillsborough disaster was the product of a quite consistent and ongoing lack of interest on the part of owners and directors of English League clubs in the comfort, well being and safety of their paying spectators: this particular failure within football that I am condemning is a generalised problem in English culture - the lack of regard by authority (and thereby what we now call service providers) for the provision of well being and security of others” (p12).

Here, neatly, this thesis returns to one of its first points, that is, that the search for lessons requires looking at the appropriate level of generality. Examination of the stadia tragedies has too often focused upon either specific ‘technical’ problems or upon hooliganism. From the analysis above, the debate surrounding the issue of hooliganism can be seen to have hindered effective organisational learning by dominating the discussion of the problems facing the football industry.

Using the football industry as a vehicle, this dissertation examines the development of crises paying particular attention to the nature of organisational learning prior to and following crisis incidents. As our earlier discussion has indicated, hooliganism has been seen by many to be a defining characteristic of football in England and may, thus, have distorted any examination of the industry’s

problems. The high prominence given to 'soccer violence' research has contributed to a mindset in which the issues of crowd safety and crowd control have become inseparable in the minds of official agencies. This mindset has arguably dominated football stadia design and crowd management. Such a mindset permitted the conclusion that if crowd disorder could be contained, then crowd safety could be ensured, as depicted in figure 4.1.

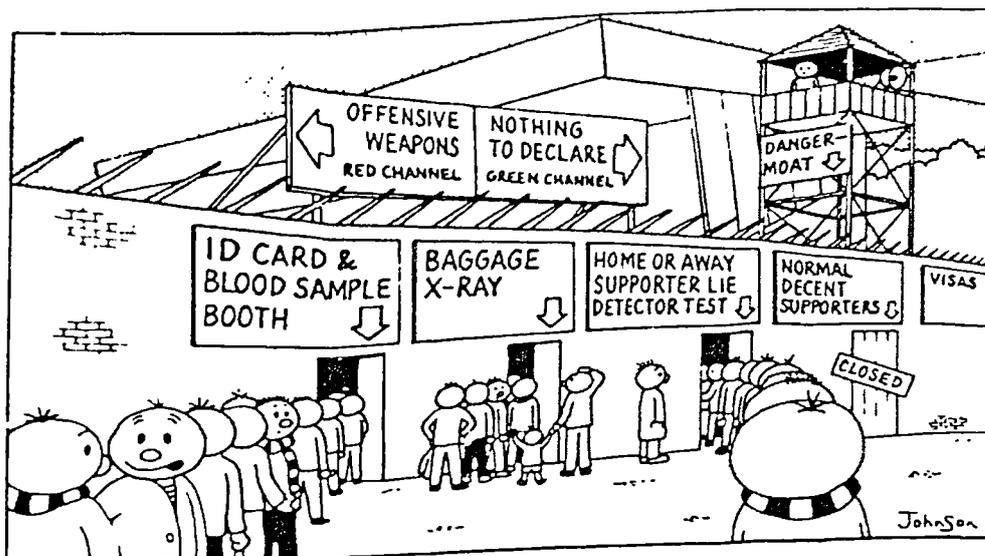


Figure 4.1: Fortress Football  
Source: Bale, J (1990) cited from *When Saturday Comes*, No. 25 pp10-11

Figure 4.1: Fortress Football

Source: Bale, J (1990) cited from *When Saturday Comes*, No. 25 pp10-11

Figure 4.1 illustrates a fans' perspective. 'When Saturday Comes' is a popular national football fans' magazine that seeks to represent the views of supporters. It summarises the views of a number of football supporters who felt themselves to be treated, increasingly, as trouble makers. The cartoon sought to demonstrate how the experience of attending a football match had become dominated by security and control. The guard tower, closed turnstile for 'normal decent supporters' and the ID card for normal supporters portray a very strong image of how many supporters were, or believed themselves to be, treated.

## 4.5 Organisational Context: Power and Influence within the UK Football

### Industry

Governance of the football industry within Great Britain is through a number of

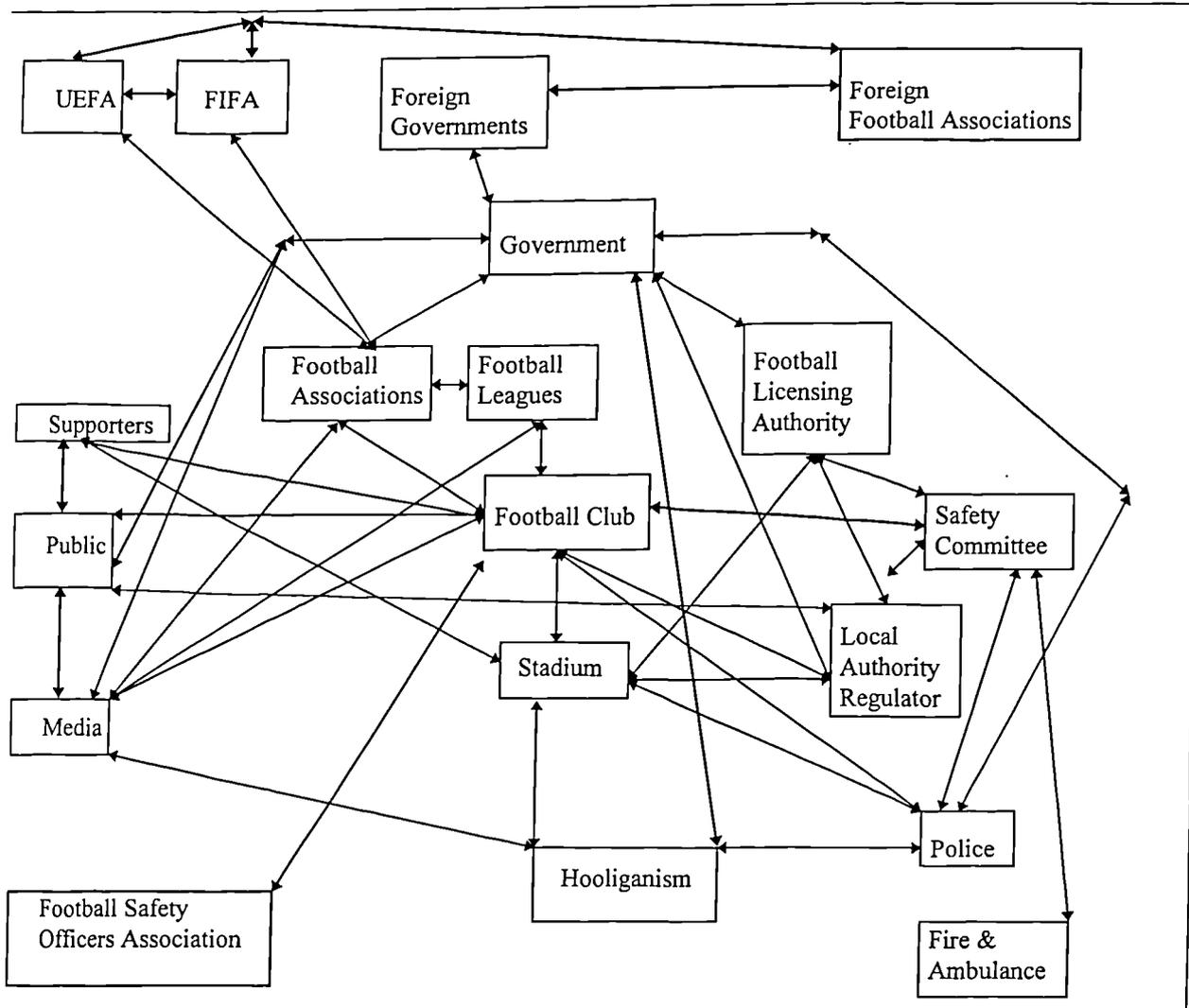


Figure 4.2: The 'Football Stadium' System Organisational System

related, but independent bodies. A systems map of the various agencies involved in football stadia is shown in figure 4.2. This illustrates the range of agencies involved within the industry, the potential complexity of relationships and the likelihood that some organisations are likely to exert political influence whilst other groups may be easily overlooked. The stadium and the football club are shown at the centre of the map as these represent the hub of the system. Although obviously complex, even this system's map fails to capture the full richness of this particular

system. The right hand side of the model depicts those with a regulatory interest within the industry. The left hand side identifies those 'agencies' with a close, if unstructured relationship with the industry (supporters and media).

#### 4.5.1 The Football Association

Founded in 1863, the FA's amateur roots are reflected in the current composition of its ruling council. The FA's Council consists of a majority of representatives from non-professional County Associations, the Universities of Oxford and Cambridge, the three armed forces and the Amateur Football Alliance (who represent business houses, banks, Old Boys' clubs and similar organisations).

The professional football leagues share some fourteen seats. The FA's view of its own primacy is clearly stated in its 'Blueprint for the Future of Football' (1991):

"The future of Association Football depends, fundamentally, on confirming and strengthening the position of The Football Association as the Government of the game in England. All other Associations, Leagues and Clubs should be subordinate to The Football Association" (p29).

The influence of its amateur roots has extended to the current day, as is shown by the make up of the FA Ruling Council and it has certainly contributed to past failures to seize commercial opportunities (Inglis 1988). Dougan (1981) described the battle that he had with the FA over shirt sponsorship. As manager of the semi-professional Kettering Town, Dougan was called to face a committee of the most senior FA Board members. In summing up his views of that meeting he stated:

"I have also gone on record as saying that if the FA or Football League could horsewhip a player in public or, possibly get away with hanging one of us, they would do so, because some of them are convinced that the ills of the world today and certainly of the UK, stem from professional footballers. That attitude is still prevalent today."(pp49-50)

Recent developments however, have seen the FA embrace commercialism in a hitherto unseen manner. 'The Blueprint for Football' (1991), much of which was

subsequently discarded, identified the enhanced commercial opportunities of a smaller, but better, First Division. The establishment of the FA Premier League in 1992 caused the transfer of twenty of the most commercially viable clubs from the Football League. The commercialisation of football in the form of sales of TV rights and sponsorship has developed rapidly since then. A part of the justification for setting up the FA Premiership was that the historical hostility between FA and Football League had been to the detriment of football as a whole. The FA also argued that a smaller First Division, resulting in fewer fixtures, would support the national team.

Apart from its new role within the professional game the FAs main tasks have been to represent and govern the game within England. The Scottish and the Welsh FAs perform similar roles within their respective countries, although the senior Welsh teams play in the English League. The national FAs work alongside UEFA and FIFA (the European and World-wide ruling bodies). The popular view of the various Football Association is that they are staid, bureaucratic organisations with little vision. This view was held by many respondents from all divisions; a view not helped by the average age of their council members, where one was younger than sixty years old and the eldest were in their late eighties (Guardian 1996).

Further evidence of outdated systems comes from the FAs Director of Public Affairs, David Davies. Davies (1997) reported that on his appointment in 1993:

“After the royals and the government this organisation, arguably, gets more column inches than any other. But there was no structure for dealing with that at all... There were only two phones and you would get hundreds of calls in a day. The first might be from a 15-year old in Sevenoaks who wanted to know who played centre-forward for England in 1897. Meanwhile, on the other line, would be Brian Woolnough from *The Sun*” (Davies, 1997 p4)

Davies reported that when he applied for the post he advised the FA that the role they had identified was simply not broad enough for the task in hand. The fact that Davies was appointed indicates, however, some willingness to change.

The FA employ their own 'security' advisers, whose role combines planning and managing the security and stewarding arrangements for international matches with advising individual clubs. At the time of this study the security adviser devoted the majority of his time to planning for the 1996 European Championship, held in England (Titcombe 1994). The task of advising clubs on safety and security matters therefore, fell to the various leagues.

#### **4.5.2 The Football League, Scottish Football League and FA Premier League,**

The Football Leagues (FL) are the main co-ordinating bodies of professional football in the UK. The Football League, as distinct from its Scottish counterpart, was founded in 1888 by twelve Northern and Midland clubs who were believed to have the largest potential support. The role of the FL may be summarised as looking after the collective interests of its members, collecting monies from the sale of TV rights and Pools, enforcing FL regulations and overseeing the fixtures process.

Despite the egalitarian values of its founding members, from the start clubs were more interested in self rather than collective interests as shown by the 1888 decision not to share gate receipts, agreeing instead on a fee of £15 to be paid to the visiting team (Inglis 1988). In the sharing of monies raised from other sources however, (e.g. pools, sale of TV rights etc.) it was not until 1986 that the equal share per club regardless of division, was amended to a fifty per cent of monies granted to First Division clubs, twenty five percent to Second division clubs and the remainder shared between the two lowest divisions. Amendments to the voting structure for the FL's Committee also saw further concentration of power in the hands of the First division.

From a cultural perspective, the FL may be described as an inner oriented and conservative organisation. Prior to the 1980s and 1990s little attempt was made by the FL to communicate directly with spectators or to canvas their views. Rules were used to exclude up and coming semi-professional clubs from entering the League. Conservatism hindered many attempts of the FL to exploit new commercial opportunities. The non-conformist, anti-gambling views of a number of its influential committee members allowed thirty years to pass before an agreement was reached with the Pool's companies. When agreement was reached in 1959, the FL's commercial income jumped from £1,256 to £275,000. The sales of TV rights and development of Sunday football were hindered by a distaste for change on the part of the FL's Committee (Inglis 1988 pp210-213).

A number of key changes occurred during the 1980s, a period that saw internal amendments combine with increasing environmental pressure created by a combination of the high profile of hooliganism, the financial problems of clubs, the various stadium disasters and arguably, the persistent perception of the England team's failures. The 1980s saw the development of a number of innovations such as the development of live football on TV, permission for the appointment of paid club directors, the creation of end of season play offs and "automatic" promotion from the semi-professional conference league to the old Division four. The reality of this latter change demonstrates how structural changes can be subverted as the requirements for potential entrants (in terms of ground, facilities and finances) appeared to be increased and applied more rigorously than for those already within the FL

Historically, this inconsistency has not been restricted to relations between league and non-league clubs. Inglis (1988) reported that during the late 1960s Manchester United received a £7,000 fine for a misdemeanour that saw Port Vale and

Peterborough punished by demotion. This inconsistency highlights a weakness of the FL, that without the support of its clubs it is like a 'toothless tiger'.

From a structural perspective the FL is best described by Mintzberg's (1983) Divisionalised form. It differs from the pure type in the extent of power held by the clubs, power expressed in electing the committee and in their observance of the rules. Our earlier reference to the inconsistency in the enforcement of these rules suggests a lack of power within the FL. Much power resides therefore with the clubs. However, this power is not evenly spread. Wealthier, and frequently more successful, clubs have worked to amend the rules in their favour as the 1980s reforms to the FL and the creation of the FAs Premier League demonstrate. Certain charismatic individuals have also played key roles throughout the history of the FL either blocking or engineering change. Mintzberg (1983) described this process as 'balkanisation' as the middle managers (club chairmen in this case) have sought to increase their own power. In the case of the FL, as has been shown, this has led to the increased concentration of power and resources into the hands of the larger and increasingly wealthy clubs in the upper divisions.

The involvement of so many in decision making has proved a powerful barrier to change, which combined with the innate conservatism of many of its members saw the FL struggle to cope with the changes of the 1970s and 1980s. Inglis' (1988) and Walvin's (1994) histories of the football industry depict the various football authorities over much of the twentieth century in a Canute like pose seeking to prevent the tide of change. As Mintzberg (1983) argued the structural type is best suited to a simple and stable environment, a label that could not be applied to the FL's context in this period. The changing economic context outlined earlier is one factor in this. Since the formation of the FAs Premier League in 1992 the FL has been left

with a rump of seventy two of the smaller professional clubs. Talk of extending the FAs Premier League threatens to weaken further the FL with the transfer of a further twenty of its largest members. The financial position of many members of the FL remains precarious at a time when the FA Premier League is exploiting many of the commercial opportunities available to the industry.

In 1994 the commercial earnings collected and distributed by the FL proved the largest source of income for a number of clubs in the lowest two divisions. Requirements to develop their grounds and improve the quality of stewarding have led the FL to develop programmes to assist clubs (Whalley 1994).

In summary, the football leagues do devote resources to the development of guidelines for issues such as stewarding. These are produced in booklet format and distributed to clubs. This provides a useful means of disseminating explicit knowledge but the implementation of guidelines is very much dependent upon individual clubs.

#### **4.5.3 Football Clubs**

If the FL shows some similarity with Mintzberg's (1983) Divisionalised form the clubs tend towards the simple structure. That is, towards little formality with minimal specialisation. Despite their superficial differences there are many similarities between the various football clubs. One common feature is the centralisation of power in the hands of one or a very small number of directors as the following quotes from three premier league clubs indicate. Respondents were asked to describe the role of their Board and Chairman in decision making; first the responses of the FAs Premier League executives:

“Very hands on, Chairman appointed old business staff to sort the club out, he restructured the club, he sees it as part of a jigsaw” (P1)

“At the end of the day the Chairman is the Chairman, and he is the major shareholder he's the person that's put most of the money into the club and would, if he felt it necessary, impose himself on everyone else.” (P3)

“If there is any expense the Chairman is involved, there is no delegation there. The chairman is the Board, the other Board members just nod and say yes.” (P4)

No common style emerged from interviewees from the lower three divisions.

F1, S1 and T4 identified Boards in name only, with the Chairman taking all decisions whilst for the others a more democratic system was reported:

“6 directors, all with a responsibility, instead of going to the Board every three weeks with a great list of issues, each individual has a specific priority such as the shop, or catering or commercial or ground or medics.” (S2)

“Normally decisions go up to the Board and then it's left to the chair and I to sort out.” (S4)

“I haven't got a demagogue running the club, we've got 6 directors who are equally placed.” (T2)

However, despite this appearance of democracy it emerged in the majority of cases that some directors were more equal than others and held key responsibilities that gave them more influence. For example, in the case of S2, one director was a medical doctor and liaised with St John's Ambulance, whilst another director authorised stock purchases for the shop that was open on matchdays only. For a number of clubs, particularly those in the Third Division, the Chairman and other Board members were largely distant, keeping in touch with a daily phone call to the Club Secretary (T1, T3, T4).

As Mintzberg (1983) identified, the success of such a structure depends upon the 'whim and health' of an individual as the difficulties Everton F.C. and Raith Rovers F.C. experienced illustrates. In the former case the long illness of Sir John Moores made it difficult for long term decisions to be made (Swift, 1994,); for Raith Rovers

the Chairman returned to Canada and was not heard from for ten months, virtually paralysing the club's administration.

A further danger identified by Mintzberg is that the Chief Executive may become so focused upon strategic issues that the more routine operations 'wither for lack of attention'. In the case of football clubs, this trait manifests itself in a focus

Objective:	Arnold & Benveniste (1988) % of Respondents	Safety Officers (Elliott 1997) % of Respondents England & Wales	Safety Officers (Elliott 1997) % of Respondents Scotland*
Playing Success	93	83	83
Financial Success	55	28	58
Financial Stability	24	67	42
Entertainment	19	7	8
Marketing of Club	8	n/a	0
Crowd Safety	n/a	73	75
Ground Improvement	7	35	8
Success for Locality	5	3	0

Table 4.4 : Football club objectives

Source Arnold & Benveniste (1988, p6), Elliott 1997, survey data.

\* of the 12 respondents, 1 did not complete the section on club objectives

upon achieving playing success, as identified by Arnold & Benveniste (1988) and subsequently confirmed in our survey (see tables 4.4 and 4.5). Respondents were, in both surveys, asked to indicate their clubs top three priorities. It should be noted that Arnold & Benveniste's survey was aimed at club executives whilst this survey was targeted at Football Safety officers. The breakdown by division also offers further insights. That lower divisions identify crowd safety as a lower priority objective than the higher divisions may reflect a view that small crowds do not pose a problem. It should be noted that the Bradford Club were in the old third division at the time of the fire. The data included in table 1.1 illustrated that lower division clubs are also susceptible to problems of crowd safety.

These data support Sloane's (1971) argument that football clubs do not seek to maximise profits but are utility maximisers subject to basic financial constraints .

Routine matters such as ground improvements (in the aftermath of the Bradford Fire) were reported by a paltry 7% of respondents as one of their top three objectives.

	Premier Division	Division 1	Division 2	Division 3	Scottish Respondents
Playing Success	71%	84%	92%	92%	83%
Financial Success	24%	32%	33%	25%	58%
Financial Stability	59%	58%	83%	75%	42%
Entertainment	6%	5%	0%	17%	8%
Crowd Safety	88%	74%	67%	58%	75%
Ground Improvement	47%	37%	17%	33%	8%
Local Area Success	0%	11%	0%	0%	0%

Table 4.5: Objectives of football clubs by division 1997

This lack of interest in routine matters was also identified in our interviews when respondents were asked to describe their own role, their business practices and to describe their planning processes. There is always the possibility that respondents will over emphasise their work burdens but careful analysis of the interview data showed a high level of consistency, with many uses of the first person singular to describe the various activities performed within this club. Data collected during the direct observation also supported the pivotal role played by the club secretary or chief executive in all but the Premier Division Clubs and one Scottish club. The pattern that emerged suggested that for clubs in the Premiership, and for some in the First Division, planning processes had been developed recently. P1 for example, commented that the Club was:

“Better managed now, but before, I didn’t have enough time to concentrate on the issues that really mattered because you’re bogged down with the day to day issues.”

P1’s comments about recent change were supported by the evidence of new IT equipment and the obviously recent investment in office accommodation. For some clubs in the senior divisions a growing division of labour was observed, with the appointment of specialist staff to deal with marketing, ticket sales, safety and legal

issues - all tasks that had previously been undertaken by the Club Secretary, or as one interviewee stated:

“Ashes to ashes, dust to dust, what the others won’t do the secretary must.”(S4)

F4 suggested that a lack of resources for administration combined with the uncertainty of professional football prevented proper attention being given to planning:

“Unfortunately football being what it is most people do two or three jobs... everybody has more roles than they should have, you just do not have the time, it’s not an excuse, it’s a fact, football clubs can’t afford to pay that number of people because the financial structure of clubs is wrong... in football it is impossible to do a cash flow for the next month, there are so many unforeseen things that can happen and it is all down to kicking a football on the pitch or drawing a number out of a bag.”

For T3, planning was limited to the re-signing of their best player to ensure that he could be sold for more at the end of the season. T4’s prioritisation consisted of:

“You live by the seat of your pants, basically, you just do what you have to get through, whoever shouts the loudest, you do that next. There is no other more methodical way of doing it, you learn as you go on and if you’re lucky you don’t learn too often by your mistakes.”

A view echoed by S3 who observed:

“I’ve usually got 6 or 8 balls in the air, and I probably should do something about these things and when people shout aloud, they do happen”

The reluctance of Directors to invest more resources in administration and support was noted by two interviewees. S2 indicated a desire to appoint staff in preparation for promotion, directors wanted to wait until they achieved it before committing any resources. Of the twenty English, Welsh and Scottish respondents only three provided evidence of any formal planning. These three were all in one of the Premier divisions.

The evidence collected suggested that there was a growing gap between those clubs who were secure in their Premiership status and the rest. This was supported by

the financial evidence of a growing gap between Premiership clubs and others. In Scotland the recognition of the dominance of two clubs meant that the others were more realistic in their expectations (SC1). Each of the Scottish Clubs (SC) identified the existence of some form of planning process (SC1, SC2 SC3, SC4). A growing commitment to planning, in two cases reported as stemming directly from the arrival of a new Chairman and investment in new technology and in customer services was evident in the three clubs secure in the Premiership. Similar strategies were identified in three other clubs, two of which had recently been acquired by a new management team. As the quotes above indicate, the role of the Club Secretary in many clubs covers many areas of responsibility. There was little evidence of significant investment in IT in the majority of clubs visited. The low priority of administration was indicated by a reluctance to provide cover for illness or to replace staff quickly. (F4, S2, S3, T1, T2, T3, T4).

Despite this seemingly poor treatment many staff appeared to genuinely enjoy their work and involvement with a Football club and were willing to work a six day week during the season. Mintzberg (1983) had previously identified this characteristic of the simple form with the explanation that people frequently enjoyed working for a small, intimate company that retained a sense of mission. A potential problem when people are requested to master a variety of tasks is that none are completed properly because of either inexperience or lack of time. This problem appeared most pronounced amongst the lower divisions. A number of secretaries (S3, T1, T2, T4) retrieved a pile of correspondence that they had not been able to deal with through lack of time. A number stated that they had been fined for not following FL or FA procedures, mistakes made because of a lack of time or because they had not had time to read fully the guidelines.

It was argued in Chapter 2 that structure and communications could act as barriers to learning. The examples provided above illustrate how this may occur. Lack of time, too many tasks, lack of training and a reactive rather than proactive culture may combine to ensure that only the most obvious tasks are undertaken. The physical distance between many clubs and key directors means that only the most pressing matters are dealt with. The contribution of this type of structure and organisational problems are examined in Chapters 5 and 6. For example, our discussion of the causes of the Bradford Fire highlights the problems of inadequate investment in what should be the routine tasks of administration and maintenance. T4 stated that the phasing out of the Youth Training Scheme would leave the club short staffed and remove those who had the task of cleaning the stadium.

The simple structure does not provide the time needed for individuals to collect and analyse data. The centralisation of control means persuading the owner, of the value of new learning; otherwise passive learning takes place - learning without action. Similarly, the culture of what was called 'crisis management' perpetuates a myth that 'we' will survive whatever happens.

Historically, the majority of clubs trace their roots back into the late nineteenth century and many have altered little with regard to administrative structures since then. Walvin (1986) described the clubs as:

"Victorian and Edwardian institutions, often fiercely resistant to change, determined to maintain their methods and traditions - most of which were forged in an earlier and quite different epoch. Clubs have been 'old fashioned' in the worst of senses; reluctant to change their outlook and their mode of operations. But the clubs were also desperate to benefit from whatever lucrative deal could be clinched with new commercial interests. The end result has been a particular amalgam, of old and new; of clubs whose appearance has, in many cases changed little since the early years of the century but who adopt a host of modern money making tactics and often flamboyant methods of fund raising." (p17)

The structures of the clubs lend themselves to their domination by powerful individuals. Although some of the larger clubs (e.g. Manchester United, Tottenham Hotspur) are publicly quoted companies, particular individuals still play an influential role. Others are private companies with shares passed down through families whose involvement with a particular club may stretch back almost to the turn of the century (e.g. Shipman family at Leicester, Moores family at Liverpool and Everton). Other clubs are controlled by businessmen who have made a fortune and have subsequently become involved with the team they supported during their childhood (e.g. Jack Walker at Blackburn, Steve Gibson at Middlesborough). A related group are those who form a partnership of local businessmen supporting their club (e.g. Burnley and Darlington). Yet other investors have been attracted by the high profile of the football industry and have sought to develop their other interests alongside through football (e.g. David Sullivan at Birmingham, Robert Maxwell at Oxford and Derby during the 1980s ). Others have mixed motives combining as Sir John Hall at Newcastle does a desire to promote the success of the football club as a piece of the jigsaw for increasing the profile and prosperity of the North East. (Cushing 1994).

Regardless of their particular motive, a trait common to the vast majority of these individuals and families is that they have created their own financial fortunes outside the football industry, and their involvement with a club satisfies a need other than that of making money. Although S3 spoke of stewardship of their club rather than ownership, the majority suggested that the club was an executive toy or a means of satisfying the ego of the chairman (P2, P3, P4, F1, F2, F4, S1, S2, S4, T2, T4). The importance of this is, that it reinforces the importance of playing success to the detriment of the routine, unexciting back room activities which may act as a barrier to effective learning. The status of the safety officer was not high in many clubs.

Following a match the chairman and directors would retire to the directors lounge. On a number of occasions, when invited to join, I had to be escorted into the lounge. In the meantime the Safety Officer was left to a private gathering of 'junior' staff who often sat in an office with a bottle of Scotch. There was a real potential for learning at these impromptu meetings, as few of those present had seen the match and they inevitably discussed problems they had encountered during the day. There appeared to be no mechanism for communicating this valuable information to the senior executives. The 'protected' world of the football club director means that they never have to use the crowded toilets, push their way through turnstiles or sit on a broken seat drinking tepid tea. Generally their experience is far removed from that of many spectators. Three clubs (P1, P3, S3) stated that occasionally directors would deliberately join the spectators to gain a new perspective. Those respondents interviewed after this data came to light expressed positive support for this activity, although believed it unlikely that their Board would be so 'enlightened'.

From a cultural perspective the focus upon activities on the pitch may be seen as a key influence on core assumptions, reflecting the beliefs and values of the main shareholders. The entrepreneurial background of many club chairmen mitigates against their acquiescence to the many rules and regulations to which they are subject. Scott et al (1989) have reported that small firms are particularly poor at complying with regulations, especially where there is a good chance that this behaviour will remain undetected. A survey of business compliance with environmental regulations indicated that up to three quarters of small firms had been in breach of regulations (see Elliott et al 1997). Inglis (1988) described how, despite the collaboration of clubs in setting up the rules of the League, from the start, individual club directors worked to test the rules and see how far the Management Committee would bend.

There was early conflict between the larger, wealthier clubs and the FA when in 1901 the maximum wage was introduced. The maximum wage restricted the amount that wealthier clubs could pay their best players. Inglis (1988) suggested that when the opportunity to remove this restriction appeared, the wealthier clubs had already found ways of circumventing the regulation and poorer clubs benefited from the restriction.

“What developed was a kind of silent conspiracy in which subterfuge became the accepted norm; the public face nodded approval while the private hand slipped cash into the players’ pockets.”(Inglis, 1988, p54).

Such behaviour was effectively endorsed by the FL’s punishments, where Sunderland in 1904 were fined £50 in public records, the amount was reduced to £5 in the confidential minutes. The age of these examples may suggest that they do not reflect a fair picture of the industry in the present day. However, a key theme of Inglis’ (1985, 1988) analysis is that persistent rule breaking and scandal have been rife within the industry throughout the twentieth century. Collecting evidence of ‘illegal’ payments, fraud and other scandals is difficult for obvious reasons and has often come from disgruntled employees (Inglis, 1988). The closure of parts of twenty seven FL grounds in 1985, following the Bradford Fire, indicates that clubs had not been complying fully with the Safety at Sports Ground Act (1975). In the course of interviews with club executives not one indicated that they had been personally involved in any fraudulent activity, although the majority claimed to be aware of ‘dubious practices’.

“Within the Industry, back handers and corruption exist to a greater or lesser extent in many clubs which is why I’m not an advocate of footballing people being involved in football clubs. There is always the temptation to do it and always the difficulty of proof ... I will not compromise my principles... we may not attract some players because we do not offer the same incentives.” (S3)

A final characteristic of clubs identified from the interviews was their inner orientation. This insularity has been described as narcissistic by Pauchant & Mitroff

(1992) who identify this as a key factor in determining the propensity of an organisation to crisis. S3 was particularly critical of standards across the industry suggesting that it was too insular, linking this insularity with poor business practice :

“They wouldn't know best practice if it got up and bit them, they don't know planning, they don't know best practice, procedures, they don't know because too many people have been in it for too long, working for a football club is very isolating, it is a very unique type of job, it is like nothing else...They don't have standards, they don't have vision, they lose track of an insight into business and a keenness and sharpness.”

With regard to customers although each club reported excellent relations with supporters this was not supported by their evidence. Few clubs held regular meetings with supporters, although five had carried out some market research. For example, P2 and F3 had convened supporter groups to assist in drawing up plans for future redevelopment. A number of interviewees commented that the closest the Board ever got to the supporters was ‘by driving their cars through the crowds on their way to the ground’. At Rangers’ Ibrox Stadium, in addition to Market Survey and Customer Comment cards littered around the ground, a number of senior administrators walked around the stadium prior to each match to meet with supporters. Leicester City organised a series of six forums offering an opportunity for “straight talking debates between supporters and Club representatives on issues with regard to the Club’s operations” (Leicester City Programme, 1997, p33). These proved to be the exception rather than the rule. Contact between clubs and supporters was often restricted to responding to letters, a task that was taken seriously, reportedly, by many chairmen.

For example:

“We don’t have spectator involvement at board level, we do have forums twice a year with the chairman and manager but we have none at board level, the chairman isn’t very interested but he answers every letter, but his attitude is why should you run the club when I’ve put in all my money” (P4)

Where contact was reported, it often appeared half hearted or contained a low opinion of what supporters could offer:

“We listen, we are probably the worlds worst, I wouldn't like to be disrespectful to them but going back to the safety forum and the Taylor Report where we were talking about liaising with supporters, we don't invite them to come in and say give us your views, but like a lot of clubs actually do, because I don't think they can really be constructive, because I think that you would get some daft ideas out of them, you really do, plus who can actually generate good ideas that can work within the framework? What if you reject some ideas? Fanzines will have great fun, giving them self importance, raising expectations (S2)

“That is the thing that fans have to understand, they think that they can have everything their own way, and we get it here, you get a lot of criticism and I'm sure that all clubs do. Why are you doing that? Why is it this way? Why can't we do that? ... Football must be the only industry where everyone thinks they have a right to tell you how to run your business.” (S3)

The responses reflected a failure on the part of clubs to communicate with spectators. S2 contradicted his opening statement “We listen” with a clear indication that he does not. However, these three statements reflect the view that supporters have a very strong interest in all aspects of a club's operations and are not reticent in coming forward. Bale (1990) highlights the key role played by supporters in keeping Charlton Athletic from bankruptcy, illustrating a positive aspect of supporters. Decisions concerning the use of turnstiles for season ticket holders (T3) or a prohibition on tickertape (S3) or over the allocation of cup tickets (T4) were implemented and not communicated in advance to supporters. The result in each case was to cause much dis-satisfaction amongst spectators, which timely communication could have avoided. One explanation for this failure to communicate may concern the perception of many supporters as daft, uninformed or hooligans.

Football supporters occupy a particular place within the industry. The direct financial contribution of spectators will decrease as a proportion of total income for

the industry as clubs rely upon fees and sponsorship linked to televised matches. However, fans are also a part of the product which football clubs sell, they provide the atmosphere which is integral to the product.

The attitudes of many football clubs towards spectators were indicative of an inner orientation or self centredness, identified as a key element of the innermost circle of the Onion Model. In Chapter 2 it was argued that an inner orientation could act as a barrier to double loop learning as it prevented the consideration of multi-perspectives.

These characteristics of football clubs directly influence safety management inside stadia. The lack of specialisation, somewhat altered with the appointment of safety officers, acts as one barrier to learning. For many clubs the safety officer's is a part time job, ensuring that much of the time is spent on supervising stewards and maintaining records. Inevitably the safety officer's job is reactive rather than proactive. In Scotland only two clubs had a safety officer in 1994. In many instances (see appendix 4.1) the safety officer is employed in a part time capacity, often on matchdays only, in a chief steward capacity. In other instances the post is full time with responsibility for training stewards and overseeing maintenance of the stadium. Safety officers have day to day responsibility, with executive decisions being taken by the Club Secretary and Chairman. The lack of time on the part of the safety officer and his lowly status prevents him from dealing with the board directly. Typically, the safety officer reports to the Secretary or Chief Executive. The 'jacks of all trade' roles of many secretaries illustrates the difficulties these individuals have in dealing with the many issues for which they have responsibility. The tendency for chairmen to focus their efforts upon a club's playing activities may prevent them from dealing properly with safety issues as our

earlier evidence indicates. Culturally, the focus of clubs upon playing success and the 'soccer star syndrome' acts as a further barrier to communication and active learning, preventing the free flow of important information. However, decisions regarding crowd safety are not taken in a vacuum but within a framework that has evolved over the past two decades, including other agencies such as the police, football licensing authority and local authority.

#### **4.5.4 Local Regulation : FLA, Local Authority, Emergency Services**

The stadia of all teams competing in the English and Scottish senior leagues are designated. In England and Wales the relevant local authority is required to produce a Safety Certificate specifying the terms and conditions for using a particular stadium. A safe capacity figure is calculated on the basis of a stadium's infrastructure and the safety management practices implemented by the owning club. A local authority has responsibility for determining the contents of the safety certificate but, is required to consult the police, fire authority and ambulance service, through a forum called the Safety Advisory Group (SAG). It is also expected to consult other agencies with 'relevant skills or experience.' (FLA 1991). The Football Club is also expected to participate in discussions and 'wherever possible representatives of supporters should be consulted' (FLA 1991). In practice few supporter's groups are represented at SAG. In some cases (e.g. LA4) although no supporters attend, copies of SAG minutes are sent to the Club's official supporters association. In the case of LA5 the decision not to invite supporters was taken because it was feared that their attendance might prevent the relevant club from being open.

From telephone interviews it emerged that the Building Control function had a major input to the work of the SAG, advising on structural and electrical

engineering issues. This reflected the early enforcement of legislation regarding safety inside stadia, with its focus upon the improvement of the physical infrastructure of football grounds. However, this focus upon the tangible or technical elements of stadium safety appeared to have been to the detriment of other safety management areas, such as the quality of stewarding and the development of an 'appropriate safety culture'. This issue is covered in greater detail in Chapter 6.

Frosdick's (1995) analysis of the post-Hillsborough response of the football industry is particularly concerned with the interaction between these groups, arguing that their different cultures, possibly conflicting priorities and risk assessments may lead to very different 'safety cultures' between stadia. The role of the FLA is to promote consistency but not uniformity. de Quidt (1997a, 1997b) argues that uniformity would prevent proper consideration of the tangible differences between stadia and the clubs which own them. Middleham (1993) in a survey of all Police Authorities with responsibility for football stadia reported 'wild' inconsistencies in policing arrangements and costs. Persistent concerns with the quality of stewarding was identified by nearly 25% of Police Authorities who reported that stewarding at their club was either 'not good' or 'poor.' (Middleham 1993, p122)

A system of self regulation still exists in Scotland, so no role is played by the Football Licensing Authority. Some Scottish Clubs complained that the Strathclyde Regional Council attempted to force them to do too much (SC1, SF1). A notable difference between Scotland and the rest of Great Britain was the prominent role played by the police. Three out of four interviews were conducted with the Police Commander present. Visits to the Rangers ground were also conducted with the police. Stadia management therefore, is considered to be a Law and Order matter.

Whilst Rangers might be considered a model of good practice, assisted by a charismatic Safety Officer who was obviously held in high regard (by Chairman, Club Secretary, Spectators) and the fact that the majority of seats are sold to season ticket holders, the presence of the police at other interviews at Scottish clubs appeared to be linked to a heavy handed approach to maintaining order. 'Cuff's around the ear', a 'sharp shock' etc. were all comments repeated off tape as means of dealing with spectators.

#### **4.5.5 Football Supporters**

Although the FLA recommend consultation with football supporters in developing the terms and conditions for a particular stadium, the problem is how is this achieved and who is to be consulted. The views of some club executives have been reported above, suggesting that ongoing consultation is unlikely to be embraced enthusiastically by the clubs. LA5's deliberate decision to exclude supporters from SAGs, despite an expressed awareness of Taylor's recommendation, illustrates one difficulty regarding the involvement of spectators. LA5 however, reported that clubs had been directed to make improvements based upon complaints and observations from spectators, indicating that such views are collected, albeit informally. Bale (1990) reported the activities of football spectators who have made an important financial contribution to clubs beyond paying their entrance fee; he also suggested that they can be a good source of knowledge as they use the facilities every week. Harnessing unlikely groups can prove extremely profitable. A Business Week report (1997) reports on the use of computer hackers to check IT security. However, a football crowd is not one homogenous block but formed by many disparate elements with varying modes of behaviour, interests and motivations. Many clubs have a supporters club which

may be held to represent the interests of one group. In parts of the country the Football Supporters Association, a national pressure group, has many members. A development of the 1980s and 1990s has been the growth of the football fanzine, each reflecting a different view of a particular group. A difficult question concerns the identification of a representative group. At Leicester City, attempts have been made to form a representative group of supporters for Market Research purposes. No such attempt appears to have been made to elicit views from supporters for Safety Advisory Groups.

The inner orientation of football clubs appears to act as a barrier to their learning from the experiences of supporters. This may mean that they lose an important opportunity to learn from those who use the facilities each week and are well placed to comment on problems, overcrowding, hazards etc. Indeed spectators could play an important role in assisting the 'self generated turbulence' that Smith (1995) identified as a valuable means of encouraging double loop learning.

#### **4.5.6 Technology: The Stadium**

Bale (1990) illustrates the development of stadia over the past century from an open space with few rules through enclosure to a highly regulated 'complex space' in which spectators are ordered and monitored (see figure 4.3). As Chapter 1 identified, British stadia have typically been in situ for a period of over ninety years, more than twice as long as their counterparts in Germany, Spain, France and Italy. For example, the Hillsborough Stadium developed within the tight constraints of a residential area and a small river. This evolution of stadia has not, in the UK at any rate, occurred in revolutionary steps with greenfield sites but as the result of piecemeal changes. The nature of this development, it will be argued in Chapter 5, was one of a number of factors underlying the Hillsborough Stadium disaster.

As the preceding section has argued, spectators do not form one homogeneous group but consist of many small groupings. Robins & Cohen (1978) identified that a complicated socio-spatial pattern emerged on the terraces, in which distinct groups took up relatively fixed positions. Bale (1990) suggested that the behaviour

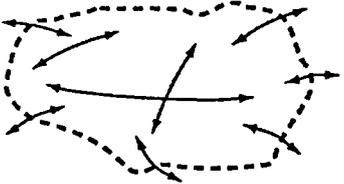
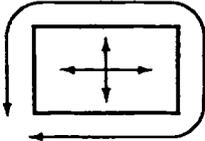
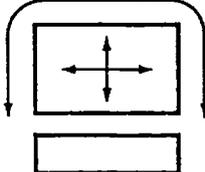
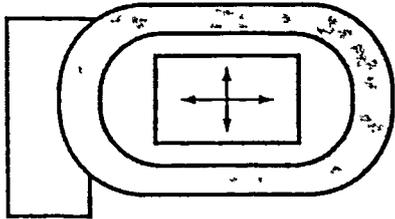
STAGES	ENVIRONMENT
	<p><b>PERMEABLE BOUNDARIES</b>  <b>WEAK RULES OF EXCLUSION</b>            No spatial limits;            uneven terrain;            spatial interaction between            'players' and 'spectators';            diversified land use.</p>
	<p><b>ENCLOSURE</b>            Limits of pitch defined;            players segregated from            spectators.</p>
	<p><b>PARTITIONING</b>            Embankments,            terraces, grandstands;            payment for entry;            segregation of spectators by            social class;            start of segregation within crowd;            specialized land use.</p>
	<p><b>SURVEILLANCE</b>            Enclosed ground;            synthetic pitch and concrete bowl;            TV replay screen;            total segregation within crowd;            panopticism;            diversified land use.</p> <p><b>RULES OF EXCLUSION</b>  <b>STRONG</b>  <b>IMPERMEABLE BOUNDARIES</b></p>

Figure 4.3 : A Four Stage Model of the Evolution of the Modern Stadium  
 Source: Bale, J (1990) p12

of these different groups can be predicted. Yet there is no mention of this research, subsequently supported by later studies (see Marsh 1977), in either the Popplewell or Taylor Reports, nor in the Football Stadia Design Advisory Councils guidelines. Marsh (1977) identified six main groups including convicted hooligans, confirmed 'aggro,' novices, and older mixed groups. The design of stadia has taken no account of this evidence nor have clubs devised strategies to deal with the likely types of behaviour.

#### **4.5.7 The Football Industry: A Summary**

A number of past studies of the Football Industry have used the word 'conservative' to describe its culture (See for example, Walvin 1986, Inglis 1988). The histories of the FA and FL led both of these institutions to resist greater commercialisation of the industry. As our description of the clubs themselves has shown, whilst they have been quick to exploit certain commercial opportunities themselves, they have done little, until recent years, to re-engineer themselves. The role of a Club's commercial manager was frequently to oversee the running of a lottery and a club shop that was only open on matchdays. Lack of development in non-playing areas reflects the conservatism of the clubs as well as the realities of the administrative resources that they created. As this Chapter has shown, new tasks such as ground safety was often passed onto the already overstretched administrative framework. A lack of planning and training frequently blocked the development of new ideas. As our analysis has shown there is now evidence that the larger clubs are switching from their internal focus and are seeking to exploit commercial opportunities through customer satisfaction and a greater awareness of the value of the product they provide. Amongst the smaller clubs there was little

evidence of a sea change and it may be that the point of no return has been passed and that lack of resources will prevent the re-emergence of such clubs.

Despite the financial problems that Chester (1968, 1983) highlighted, the focus of media attention has been upon the issue of hooliganism. A plethora of books and learned articles has been published, particularly during the last fifteen years. It is our view that this focus has deflected attention away from the more fundamental financial and organisational problems of clubs. Indeed hooliganism has provided an opportunity for clubs to 'displace' their own responsibility for the poor ground infrastructure of the 1980s onto the 'hooligans' who achieved the status of 'folk devils' (Whannel 1979). Hooliganism, although included in our systems map of the industry, differs from other components in that it refers to a concept rather than an individual or agency. The discussion of Hooliganism however, is vital to an understanding of the evolution of the industry and the effect it has had upon the stadium. The first perimeter fences to be erected in a UK stadium were put up in 1963, at Everton, in response to missile throwing incidents.

#### **4.6 Chapter conclusions**

The various agencies and key influences upon the stadium have been identified and key characteristics discussed with reference to the literature review of Chapter 2. Safety management for each club may be seen as a fluid process influenced directly by the concerns of a number of agencies as well as indirectly, by the broader political and media context. Figure 4.4 illustrates this process. Spectators and the media are seen to exert pressure by demanding improved safety standards whilst the various regulatory bodies seek to push football clubs towards better practice. Many spectators are passive yet they possess the potential to exert

significant power in moving clubs forward. This potential, however, may reduce as the proportion of gate receipts to total income, declines.

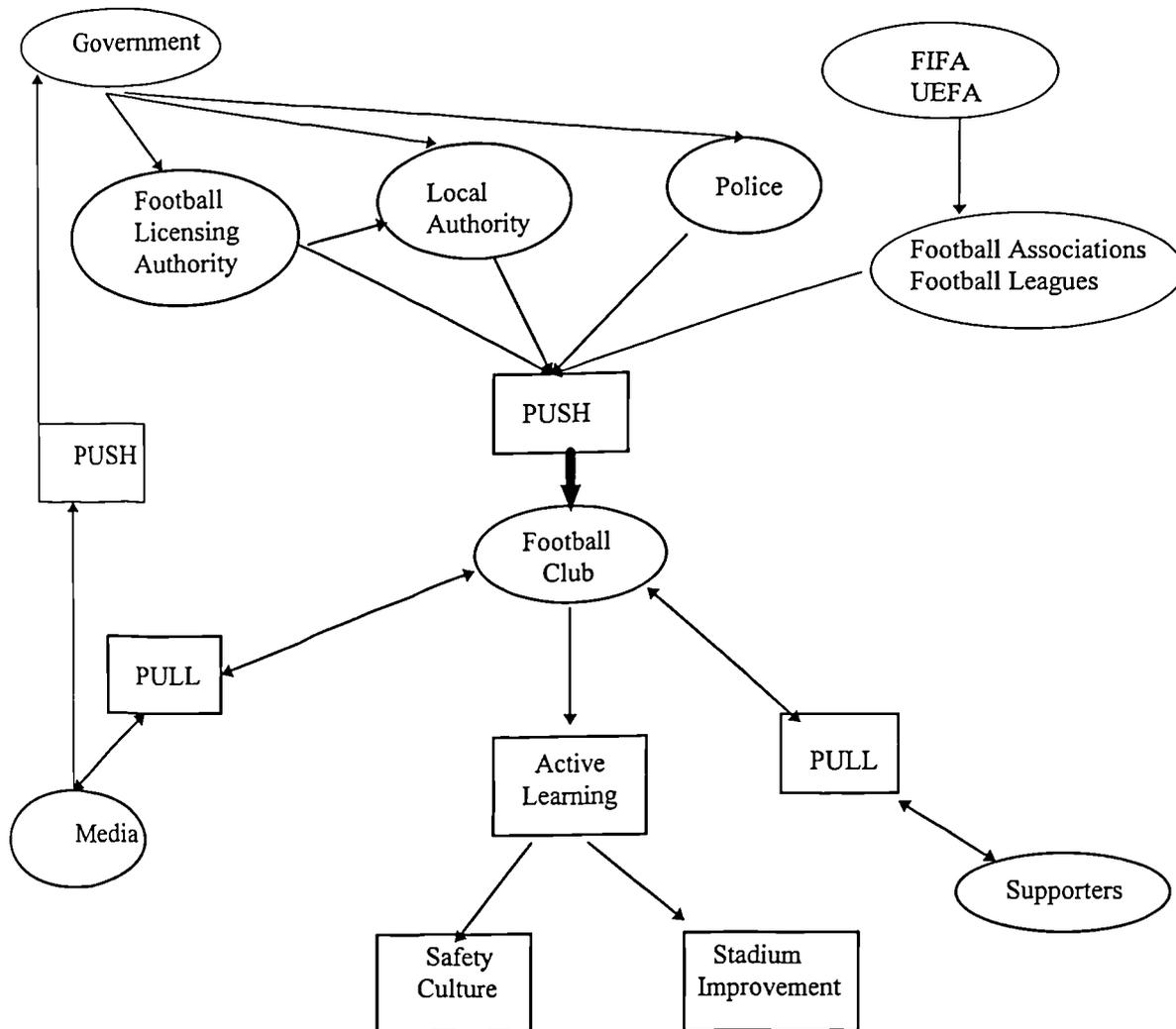


Figure 4.4: Football Systems Map

This thesis now moves onto a detailed consideration of the stadia disasters and an assessment of the regulatory frameworks that were in place. The key research question to be examined is ‘What factors prevented a major cultural readjustment and thus effective learning, from taking place?’ Chapter 5 examines the period from the Bolton Disaster in 1946 up to, and including, the Hillsborough tragedy of 1989. Although a detailed analysis of each incident is included, the issue of learning in the period between the crises is addressed. To assist in this analysis,

a brief review of the literature concerned with regulation is provided, including Gouldner's (1954) framework from his study of Industrial Patterns of Bureaucracy. Chapter 5 draws from official accounts of the stadium disasters as well as from primary data collected from a variety of agencies in the course of this study.

## **Chapter 5**

### **Disasters, Regulation and the Football Industry 1946 - 89**

## 5.1 Introduction

This Chapter presents an analysis of the football industry in the period between 1946 and 1989 (from the Bolton Stadium Disaster to the Hillsborough Tragedy respectively). The first section deals with the technical emphasis of the industry's response to the disasters. The Chapter then proceeds to a discussion of regulation and introduces Gouldner's (1954) theory concerning *Patterns of Industrial Bureaucracy*. Gouldner's work did not form a part of the initial review of the literature, but, following reflection upon the data, it seemed extremely relevant to this study. The final part of the Chapter examines in detail, each of the main crisis incidents and the intervening periods between them. This analysis makes use of Gouldner's framework in addition to those identified in Chapter 2. The principal objective of this Chapter is to determine the extent of cultural readjustment that followed the Bolton, Ibrox and Bradford Disasters respectively. The analysis also provides an examination of those factors that hindered organisational learning in this period.

A detailed account of each incident is provided alongside a critique that seeks to examine the three factors identified in Chapter 2 as the filters through which knowledge is processed and actual learning achieved (i.e. culture, structure and communications). Each critique deals with the period between the disaster incidents and explores evidence of these and other drivers of the learning process.

## 5.2 Background

Until recently, as the opening Chapter identified, the issue of managing crowds, as opposed to managing hooligans has received a low priority. Indeed Inglis (1987) commented:

"A century ago clubs did virtually nothing to protect spectators. Thousands were packed onto badly constructed slopes with hardly a wooden barrier in sight. About the best that can be said of the early grounds is that with only ropes around the

pitches there was little to stop a build up of pressure sending hundreds pouring onto the pitch." (p28)

Indeed this happened during the first FA Cup Final to be held at Wembley in 1923 which led the Government of the day to commission Lord Shortt to inquire into the events of that day.

The first recorded sports stadium death in the UK had occurred in 1888 at Bradford's Valley Parade ground during a Rugby League match. In April 1902, at Ibrox Park Glasgow, a 'temporary' wooden and iron structure collapsed killing 26 and injuring a further 500 spectators. As Chapter 1 reported there have been forty-five separate incidents and some nine public inquiries since 1900. Taylor (1990) commented:

"There is no point in holding inquiries or publishing guidance unless the recommendations are followed diligently. That must be the first lesson."(p4).

At the time of Taylor's Inquiry in 1989/1990 it seemed that both the scale and frequency of such disasters was increasing.

A remarkable degree of similarity may be seen in terms of the response of regulators to the various stadia disasters. In the initial post crisis phase, legislative controls were developed to deal with the demands of a particular incident; reflecting the tendency for learning to be constrained to incident specific lessons (Toft & Reynolds 1992); and a focus upon technical solutions (Turner 1976, 1978, Canter et al 1989, Elliott & Smith 1993a) leading to the development of a piecemeal framework of control. De Quidt (1997b), Chief Executive of the FLA, reported that:

"All football legislation might be described as tombstone legislation, driven by emotion, hurried, things overlooked, the end result is that we finished with legislation that is flawed"(private communication, 1997)

More fundamental problems associated with managing crowds in 'complex space' were not addressed in any holistic way (Sime 1985). For example, the Moelwyn-

Hughes Report (1946) recommended that the maximum capacities for grounds be determined and enforced. 'The Guide to Safety at Sports Grounds' (or Green Guide) was published as a response to the Ibrox disaster as an attempt to provide guidelines to clubs on ground safety, paying particular attention to the problems of crowd egress from grounds which had triggered the tragedy. The Popplewell Report (1985) sought to control the sale and consumption of alcohol in and around football grounds. In the wake of the Bradford fire, specific recommendations concerning the maintenance and construction of grounds were put forward. The Fire Prevention Association (FPA) Journal (1969) had published recommendations following a series of 'near misses' in which fires had broken out in football stadia. These recommendations were not acted upon until Popplewell's inquiry some seventeen years later, an example used by Toft & Reynolds (1992) as an example of 'the failure of hindsight'. That is, the knowledge had been collected and disseminated through 'appropriate' channels, but it was not acted upon. Finally the Taylor Report (1989) made specific recommendations about the control of crowds and the use of wire cages to prevent pitch invasions. This fragmented approach brings particular problems as Canter et al (1989) argued:

"As a consequence there is never any possibility of examining the system of legislation as a whole, of seeing the directions in which it is accumulating or of developing radical solutions that will deal with fundamental problems. A further problem is that rules and principles get built into the legislation in the early years and provided it cannot be demonstrated that somebody has been injured because of these rules, there is a powerful inertia in the system of controls operating against changing the rules." (p92).

Canter et al's argument, that once the problem of crowd safety and control is seen as a technical question (for example, determined by barrier strengths, the width of passageways etc.) the mind set becomes one that seeks only technical solutions. In essence a technical paradigm is created which then becomes impossible to shift. This

culture of technocracy (Fischer, 1989) is important in luring organisations into a false sense of security. As discussed in Chapters 1 and 2, a technical approach ignores the social components of a system. Solutions based upon a technical paradigm will therefore, be incomplete.

The evidence presented above is supportive of the view that no full cultural readjustment occurred in this period as was hypothesised in Chapter 1. The ongoing emphasis upon technical issues indicates a reliance upon explicit knowledge and single rather than double loop learning.

### **5.3 Regulation versus Self Regulation**

Safety through compulsion is unlikely to be achieved unless it is accompanied by an organisational desire to change. The current regime in Scotland is of self-regulation. In England and Wales the FLA seeks to avoid conflict, preferring instead a policy of promoting good practice. The reasoning behind this approach is that it is better to educate than coerce, and de Quidt (1997b) expressed pride that the FLA had yet to use its powers of sanction, although it was reported that these had nearly been applied in four cases. However, the role of the FLA to date has largely been concerned with the implementation of Taylor's (1990) all seater stadia and safe standing for the lower divisions. Technical guidance is available but as safety management develops there is a danger that the less tangible safety management systems and culture that are so necessary, will remain underdeveloped. In such intangible areas it can be argued that regulation is likely to be less effective. de Quidt's (1997a, 1997b) view is consistent with Mintzberg's (1983) conclusions concerning the best means of controlling corporate behaviour. Mintzberg (1983) suggested that effective control is extremely difficult and that in the first instance, corporate executives must be trusted. Echoing this view, Kharbanda & Stallworthy

(1991) concluded, from their study of the chemical industry, that self regulation is an effective means of control:

“We have demonstrated that in industry management inevitably know more than anyone else about the type of risk involved in the operations within their plants, and the implications for the community at large. This means that it is in their own interest for management to self regulate.....it is in the larger interest of management to regulate their own affairs and to do their best to ensure that such disasters never occur” (p88)

Mintzberg’s (1983) formula for effective control is based upon a similar pragmatic observation. Trust, however, is insufficient on its own. Mintzberg argues that executives should be relentlessly pressured and work within a framework of regulation. Additionally, efforts should be made to democratise the process and integrate the full range of stakeholders into decision-making processes. Braithwaite & Fisse (1987), supporting the view that self regulation is effective, identified five characteristics of companies that effectively self regulate:

- “1. A great deal of informal clout and top management backing is given to their compliance personnel.
2. Accountability for compliance performance is clearly defined and placed on line managers.
3. That performance is monitored carefully and managers told when it is not up to standard.
4. Compliance problems are effectively communicated to those capable of acting upon them
5. Training and supervision (especially for front-line supervisors) for compliance are not neglected.” (pp 97-8)

In a critique of Kharbanda & Stallworthy (1991), Smith & Tombs (1995) provide some examples of self-regulation and suggest that attempts to permit firms with a good safety record to ‘self regulate’ have not been successful. These authors concluded that a more appropriate regulatory strategy would include:

1. “A shift from a compliance-oriented to a more punitive-oriented regulatory approach”
2. “A greater empowerment of regulators”
3. “An empowerment of ..... trades unions, the third set of actors in the existing tripartite regulatory system”

4. “A move towards more participative form of decision making concerning hazard management.... including local publics”.

(Smith & Tombs 1995, pp 632-3)

Smith & Tombs (1995) observations are particularly concerned with the Chemical Industry. They identified the limitations of self regulation recognising that whilst managers may understand more about the risks associated with particular technologies, decisions are made on economic and political grounds as well as upon safety considerations. Implicit within Smith & Tombs' (1995) model are the push and pull strategies discussed at the end of Chapter 4. Push comes from the regulatory bodies whilst Smith & Tombs (1995) refer to the empowerment of trades unions who can work to 'pull' higher safety standards. In the case of the Football Industry it will be demonstrated how the current regulatory framework has developed. The evidence collected lends support to Smith & Tombs' (1995) hypothesis that self regulation on its own is unlikely to be an effective means of ensuring safety management practices.

#### **5.4 Regulation within the football industry**

The legal framework for regulating football stadia has changed significantly since the Ibrox tragedy in 1971. This section examines the development of regulation through four key stages. First, in the period prior to the Safety at Sports Ground Act (1975); second, from 1975 to the Bradford Fire (1985) and the subsequent Popplewell Report; third, from 1985 to the Hillsborough tragedy and the Taylor report (1989); and fourth from Taylor until 1994. Central to this analysis is the problem identified by Gouldner (1954) of how rule makers establish the legitimacy of their authority given the frequent refusal to consent on the part of those being governed. Gouldner's (1955) analysis illustrated the limitations of regulation when a conflict exists between the beliefs and assumptions of regulated

and regulator. It reported the findings of a longitudinal study of a gypsum mine and described the effects of the introduction of increased regulation over work

<b>Indulgency Pattern:</b>	Rules applied leniently or ignored. Infrequent checks Second chances Relaxed attitudes
<b>Bureaucratic Patterns:</b>	
Mock Bureaucracy	Rules imposed on group by outside agency. Neither supervisors or staff identify themselves with rules, nor do they consider them legitimate. Rules are not enforced, and all gain status by violating them. Comply only when visited by rule makers. False returns indicate compliance. "People spend a lot of time going through the motions" 'Participants are bolstered by the joint violation of rules in order to get on with the real job'
Punishment centred Bureaucracy	Rules arise in response to pressures from either management or staff. (e.g. introduce clocking in or a work to rule) The attempt is made to force compliance. Deviations are interpreted as wilful disobedience
Representative Bureaucracy	Rules are devised by experts whose authority is acceptable to all the members of the organisation . Support for those rules which fit with their values and confer status on those who conform. Gouldner uses the example of a safety programme and suggests that rules are enforced by managers and obeyed by staff with little conflict. Deviations are either carelessness or ignorance since the values underpinning the rules are not disputed.

Table 5.1 Patterns of Organisational Behaviour

Source: Gouldner (1955)

activities, onto what Gouldner describes as the 'indulgency pattern' of the previous management system. The study highlighted the need to bridge the dissonance between regulator and regulated, if behaviour is to be changed. Three types of 'bureaucracy' were identified. The key characteristics of these types are summarised in table 5.1. Within any organisation Gouldner suggested, the three patterns of behaviour may co-exist in different degrees. These patterns of behaviour refer to the 'cultural climate' in which regulations are devised and enforced. The patterns may be thought of as lying on a continuum from an extreme indulgency pattern with few rules, to a representative pattern in which rules are

accepted, understood, obeyed and enforced. From the data collected during this study elements of these patterns emerged.

### **5.5 Pre 1975 : Indulgent Pattern**

The Shortt (1924) Report provided the first example of an inquiry into crowds and disasters. Commissioned in response to the 1923 Wembley Cup Final incident, the Report's brief was to look at all sports stadia. Notably the FA refused to furnish the information requested by the enquiring committee, displaying an early example of the Industry's inner orientation. Shortt concluded with a statement in support of self-regulation:

“Where then, a measure of self government has been developed, it would seem a pity that, without real need, it should be destroyed for the sake of concentrating in the present system of national and local government the immediate administration of regulations affecting sports grounds” (p27)

Shortt continued:

“We are assured that these governing bodies are only too anxious to secure that their sport is carried on under conditions which will promote public safety, and we feel at this stage that it is safe to leave the matter to them” (p27)

This observation appears optimistic, given the failure of the FA to co-operate with the committee by its refusal to provide evidence (Shortt, 1924). It was to be another twenty years before the question of crowds and sports stadia was to be addressed again.

In 1946 thirty three people died at the Burnden Park stadium. The subsequent Moelwyn-Hughes Report (1946) concluded, in contrast to Shortt:

“The preceding safety measures cannot be secured without legislation..... Compliance with the recommendations of this report will cost money. They will involve grounds in a loss of gate money on popular days. Human beings will not station themselves scientifically on a terraced enclosure; among the crowd there will be thin patches and gaps to grieve the sight of club directors and secretaries. The insurance for greater safety for the public demands a premium.” (p11-12)

Moelwyn Hughes concluded with the ominous warning:

“The helpful representative of the Football Association ... feared that the disaster at Bolton might easily be repeated at 20 or 30 other grounds and would welcome such measures as I have suggested for securing a safety capacity.” (p12)

Despite Moelwyn-Hughes' recommendation for legislation, a voluntary system of licensing for grounds with a capacity of 10,000 or more, was introduced by the FA. This system did not however, establish specific standards or guidelines and Inglis (1987) reported that the FA accepted each licensing report without question, reflecting an extreme 'indulgency pattern of behaviour' and indicating a refusal to acknowledge a threatening reality, an example of the defence mechanism denial.

It can be argued that, despite the deaths of many spectators, the disaster did not have a significant psychological effect upon the football industry and certainly did not challenge the basic assumptions of those with responsibility for crowd safety inside stadia. The failure to introduce legislation reinforced the view that the Bolton disaster, though unfortunate, was an aberration. As table 1.1 illustrated, another fatal accident was not recorded until 1957. The lack of data concerning 'near misses' prevents any analysis of less critical incidents in this period. As shown in Chapter 4, the period 1946 - 57 was one of rising attendances for the football industry. These peaked in the 1950s and began to decline steeply throughout the late 1950s, 1960s, 1970s and 1980s.

The late 1960s saw an increase in Government interest in football and its problems. This interest may have been triggered by a number of factors including the success of the World Cup held in England in 1966, declining attendances and the growing media interest in soccer hooliganism. The Chester (1968) Report was requested to examine the organisation, management, administration and finances of the football industry. Its main observation concerning crowds was to note an

increase in spectator disorder; an early example of 'hooliganism' deflecting attention from issues of crowd safety. Indeed spectator disorder was an issue deemed sufficiently serious to require its own investigation in 1968, commissioned by the Minister for Sport. Harrington's (1968) investigation into crowd behaviour, a euphemism for hooliganism, called for legislation:

"The absence of national legislation outlining minimum standards of safety and amenity at football grounds means that some club managements do not feel obliged to put their grounds into a state considered by the police to be necessary for crowd control....Clubs often seem keener to spend money on the purchase of players than to undertake any major spending on ground improvement which would increase safety and make hooligan control easier..... Letters from members of the public suggest that already some are staying away because of their dislike of poor facilities... so that the neglect of ground improvement may ultimately be self defeating. (pp33-4).

Harrington's (1968) observations indicated the continued existence of an 'indulgency pattern' of behaviour in which guidelines were frequently ignored and club executives demonstrated relaxed attitudes to safety. Following publication of the Harrington Report (1968) the then Minister for Sport commissioned a further study, chaired by Lang (1969), to investigate crowd behaviour. Lang (1969) recommended a voluntary system of licensing through the sports' governing bodies, echoing Shortt (1924) some forty years earlier and ignoring Moelwyn Hughes' (1946) earlier call for legislation. The Lang Report (1969) can thus be considered as further endorsement of the indulgency pattern of behaviour that was well established within the football industry. It was to take another disaster to lead to legislation. As Popplewell (1986) reported:

"Almost all the matters into which I have been asked to inquire and almost all the solutions I have proposed have been previously considered in detail by many distinguished Inquiries over a period of 60 years"

Gouldner's analysis suggested that a key factor in explaining the persistence of the indulgency pattern is that neither side, regulator or regulated, can see a real need

for rules. That is, no cultural readjustment had occurred. In the case of the football industry, the lack of data collected regarding smaller incidents combined with the occasional major incident never challenged the core assumptions of Government nor football agencies. As the data collected from the clubs illustrates, these accidents were seen as freak or acts of God. Thus, there was little to be done to prevent them. The data regarding accidents inside football stadia, shown in table 1.1, was collected over a period of five years in the 1990s. This pattern was not discernible to policy makers or football authorities prior to 1989. The problem was to a large extent hidden. Although aware of the potential dangers the lack of information may have prevented remedial action. There may have been some convenience in this ignorance. Although the scale of the problem was hidden, that a problem did exist cannot be denied. As Taylor noted (1989) :

“Despite all the accumulated wisdom of so many previous reports and guidelines {That Hillsborough was allowed to happen] must indicate that the lessons of past disasters and the recommendations following them had not been taken sufficiently to heart” (p4)

Even Moelwyn Hughes described the Bolton disaster as unique, and despite the FA’s concerns that those events could have happened at any first or second division ground, the view that Taylor (1989) identified as “It couldn’t happen here” appears to have pervaded decision making. Table 5.2 summarises key developments in this pre-1971 period. Most striking is the continuity of an indulgency pattern of behaviour with the half hearted development of a mock bureaucracy in which the FA merely registered the licensing reports of member clubs.

There is little evidence to support the view that a cultural readjustment occurred following the 1946 Bolton Disaster. Lax practices, denial that a problem existed and the FA’s policy of accepting each Safety Report without question all

indicate that little learning took place in this time. The influence of culture, specifically regarding the lack of critical questioning by those within the industry and the employment of a range of defence mechanisms appears clear. In 1971 a further 66 people died at the Ibrox Stadium.

Patterns of Behaviour in the UK Football Industry 1946- 1975	
Indulgency Pattern	Despite calls for legislation in 1946 a voluntary licensing scheme developed despite fears that thirty stadia were dangerous. No specific guidelines produced concerning what the voluntary scheme might enforce. No procedure for inspection of stadia.
Mock Bureaucracy	Taylor (1989) cites evidence of clubs regularly exceeding capacities. FA do not reject any Stadium report in this period.
Punishment centred Bureaucracy	Little evidence.
Representative Bureaucracy	No evidence.

Table 5.2: Development of Regulation and Response 1946 - 71

## 5.6 The Ibrox Stadium Disaster

The Ibrox Stadium was, and still is, the home ground of Rangers FC, one of the richest clubs in the UK. It is ironic perhaps, that such a club should play host to a major accident. The disaster took place on the Stadium's Stairway 13. This particular stairway had already been the scene of three major incidents ( see table 1.1). Incidents in 1961, 1967 and 1969 had led to the deaths of two and injuries to eight and twenty four respectively. Stairway 13 was long and steep, similar to some of the entrances to the London Underground system. Some modifications were made to the stairway in response to each incident although no major restructuring took place (Inglis 1987).

At the end of the derby match against old firm rivals Celtic, spectators leaving by the stairway fell. Canter (1989) reports the incident happening:

"When spectators who had started to leave early from a new year local derby match turned back at the sound of cheering from the stands. In the crush which resulted between those leaving and those returning, 66 people died and 140 were injured.

Steel barriers were bent in the crush, which suggests that a force of at least 4,450 newtons was exerted at that point." (p89)

Inglis (1996) suggested a more straightforward description of the disaster in which the crowd had stayed on until the end of the match and were all moving in the same direction. The added detail of the late goal and the return of leaving fans suggested to the Times (6/01/71) parallels with the incident with the Bethnal Green Underground Station disaster<sup>1</sup>, and provided a further example of the potential value of isomorphic learning:

“That the disaster was caused by a number of people losing their self control at a particularly important time and that no forethought in the matter of structural design or practicable police supervision could be any real safeguard against the effects of loss of self control by a crowd.”(p11)

If this were the case then blame, if it were to be apportioned, could be deflected from those with responsibility for providing the facilities and for controlling the crowd, to the spectators themselves. The warnings of the previous incidents, that is, were largely ignored. This view was repeated in a series of newspaper articles following the Bradford Fire (see for example Guardian 13/05/85). The subsequent inquiry, whilst not apportioning blame, found the Ranger's management complacent in their attitude to previous problems and their ignoring of warnings from the Scottish FA. The response of the club was to make a few modifications to Stairway 13.

“For a few years after the tragedy, Ibrox was merely patched up as the old, now tainted regime resolutely hung on..... compared with developments at other major clubs at this time, the work was a cheap mish mash, hardly commensurate with Rangers' stature.” (Inglis 1996, p467).

Inglis (1996) linked the 1977 complete redesign and redevelopment of the ground with the death of the old chairman and the designation of the stadium under the 1975 Act. With a new leadership:

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<sup>1</sup> People crowding down a stairway into the Underground station during the war were crushed to death.

"Rangers rejected piecemeal development such as had plagued other grounds. They refused to compromise in size or materials"(Inglis 1986, 294)

The reluctance of the club to act, illustrated by the six year break between the disaster and redevelopment of the ground, highlighted the inadequacy of the regulatory regime and the ongoing failure of the club itself to take responsibility for crowd safety. Although no detailed observations can be made given the lack of reliable data, the refusal to listen to warnings, the piecemeal development of the stadium in response to specific incidents and the lack of a safety culture formed a pattern to be reflected in later disasters. These factors reflect the cultural and structural barriers to learning identified in Chapter 2. There was awareness however, that such a disaster could happen elsewhere. For example, within Parliament there developed growing pressure for a scheme of formal licensing for sports grounds that went beyond learning from the specifics of the Ibrox disaster.

"This is the sort of thing that could happen with a smaller number of people. The clubs should make civilised accommodation available for their supporters - give them seats under cover -instead of herding them into areas where they are pushed and jammed like animals." (Maurice Miller MP, The Times, 5/01/71)

Despite the number of deaths, there was limited coverage of the disaster in the national (British) press reflecting a low degree of public interest and indicating that, like the Bolton Disaster which was also investigated via the public inquiry process, the Ibrox tragedy did not have a major symbolic impact. The wider problems facing the football industry received some attention. For example, a leading article in the Economist (9/1/71) referred to the bleak year for football with only a dozen clubs paying their way. Regarding safety and the announcement that Lord Wheatley had been commissioned to inquire into "Safety at Sports Grounds" the Economist (1971) commented :

"It is sure that after half a century of neglect by successive governments, the safety of crowds at football matches will be taken seriously at last."

The Wheatley Report led to the passing of the 1975 Safety at Sports Ground Act, although, it is argued, this was implemented in a half hearted way that encouraged the continuation of a lax regulatory regime.

The Ibrox stadium disaster highlighted the inadequacies of the voluntary licensing scheme. That four serious incidents could happen upon the same stairway within a ten year period indicated that a problem had been clearly identified but that no effective learning had taken place. The ongoing reluctance of the Club to act following the 1971 tragedy is difficult to explain. Turner (1976) and Toft & Reynolds (1992) suggest that in the aftermath of a disaster the organisation that experiences it is at least expected to undergo a major cultural adjustment. The behaviour of the Ranger's board, delaying a fundamental redevelopment of the Ibrox Stadium for six years, demonstrates that this does not necessarily occur.

Table 5.3 identifies some of the key factors associated with the Ibrox disaster. It utilises Smith's (1990) three stage model of crisis and the 7 C's checklist introduced in Chapter 1. It highlights the combination of social-organisational and technical system components and particularly the key role of culture in the pre and post crisis incident stages. The technical elements of the system are identified as resulting from the original structure and a series of minor modifications following each incident that preceded the 1971 disaster. The continuance of the pre-crisis complacent culture is demonstrated by the length of time that it took the Club to redevelop the stadium.

Table 5.3 emphasises the combination of factors that contributed to the disaster, from the club's failure to respond to previous incidents and redevelop the clearly dangerous stairway. This indicates the persistence of the indulgency pattern of

Crisis Phase	Ibrox Stadium Disaster: A Socio-Technical Systems Failure
<b>Crisis of Management Culture</b>  Configuration	Indulgency Pattern of regulation Ignored previous incidents (failure of hindsight) Ignored official warnings No complete redesign of stairway 13 Complacency  No individual with responsibility for safety.
<b>Operational Crisis Control</b>  Coupling & Complexity  Contingency Planning	66 people crushed on stairway, asphyxiated No means of stopping flow or gaining rapid access to those fallen  Design of stairway and terraces, confusion on day, inability of stadium staff to assess severity of problem  No contingency Plans
<b>Crisis of Legitimation Culture/Cost</b>  Culture (no challenge to assumptions)  Culture, blocks learning	Focused upon piecemeal changes  Myth of late goal and returning spectators, apports blame to fans or Act of God (scapegoat)  Licensing scheme introduced in 1975 Act but not rigorously enforced Tainted board refuse to learn lessons, not until 1977, when new board appointed that comprehensive redevelopment occurs.

Table 5.3 The Ibrox Stadium Disaster: Three Stages of Crisis

behaviour that continued from before until many years after the tragedy. Although a number of contemporary explanations placed blame, if that is the appropriate word, upon the crowd itself, it is clear that the context in which the incident occurred was created through the actions and inactions of the club and regulatory agencies.

### 5.7 1975-85: The Safety at Sports Ground Act (1975)

The Safety at Sports Ground Act (1975) and the first edition of 'The Guide to Safety at Sports Grounds' (popularly known as the Green Guide) were published as a result of Wheatley's (1972) report. The Act introduced a formal licensing system. Wheatley (1972) reported that he was lobbied by representatives of football clubs and administrators who were concerned that the costs of compliance could

threaten the existence of some clubs. His response echoed that of Moelwyn-Hughes in 1946, Wheatley (1972) replied:

“My answer to that is this. My task was to consider the problem of crowd safety at grounds. Clubs which charge the public for admission have a duty to see that their grounds are reasonably safe for spectators.....some standards should be imposed and observed.....There is nothing new in this proposal. It has been mooted for almost fifty years. It can come as no surprise to the football world, and in light of happenings over the years the demand for an independent appraisal and determination of the safety of grounds becomes almost irresistible. I certainly cannot resist it.”(p17)

Notwithstanding this statement Wheatley recommended that the licensing system be spaced out, with clubs in lower echelons given a longer period before the new system be applied to them. When it was first introduced, the Act applied only to First and Premier Division clubs in England and Scotland respectively. In 1979 it was extended to include Second Division clubs. Designation therefore, was not on the basis of a ground's size, or related to the potential hazard, but based upon a club's league position.

Wheatley envisaged a flexible licensing system based upon the Green Guide, a system that would take account of individual grounds. Views of the effectiveness of the measures introduced in 1975 were mixed. Inglis (1987) reported that:

“In general, however, clubs have done everything demanded of them in a spirit of co-operation with their local authorities” (p34)

This contrasts sharply with the view of F1 in response to the question ‘why hadn't the club spent more on ground improvement?’:

“Basically because there was no one kicking them up the backside and as we've said before just look at the odds, to put our terrace into the state where it would totally comply with the green guide would probably have cost us a couple of million, virtually the same as the all seater, as the finance dried up we had to look at the odds and see whether it was worth spending or whether it was worth spending on the team, draw in more crowds, so that you can afford to do the work.”

F2 stated that :

“It was only as a result of Bradford and Hillsborough that clubs came to realise that what they were doing was not sufficient.”

prior to Hillsborough and Bradford F2 reported:

“There was a feeling that the clubs were positively doing what they thought was necessary.”

In support of this Popplewell (1986) asserted that:

“My enquiries into the working of the Act have shown that in designated stadia it has proved effective in securing improvements in safety.” (p18).

The incidents listed in table 1.1 question Popplewell’s assertion. The fact that the Bradford Fire occurred in a non-designated stadium meant that there was no perceived need to question the efficacy of the standards of regulation pertaining at the time.

In Scotland the 1975 Act appears to have had a more significant impact. SC1 reported that their stadium had been all seater since 1978 following the Safety at Sports Ground Act:

“We have seen continuous improvements at a number of Scottish grounds, we’ve balanced our needs better than in England where there is a greater emphasis on getting a team capable of winning the league, in Scotland pressures are less so we don’t spend the huge amounts on transfers and we’ve toddled along keeping our stadia in good order”

SC3 commented that they had had to comply since 1976

“And we’ve been aware of safety ever since.... we had nothing specific after Bradford or Hillsborough because of our safety certificate”.

A possible explanation for this reportedly greater impact of the 1975 Act is that having been initiated by an incident in Scotland that greater notice of it was taken in that country. The role of local government may also have been key given that the Strathclyde regional council was the largest in the UK and may have had the resources necessary to enforce the Act properly. SC2 complained:

“Strathclyde are talking about a new blue guide as an upgrade on the green guide - I think that its just an overkill, why should we have to go above the green guide, either it’s safe or it’s not”

The latter part of the sentence is revealing of the assumptions made about risk, safety and legislation. It suggests that the respondent conceived of safety in absolute terms. The comment also suggests a confidence in technical guidelines from an approved source.

In summary, a number of observations can be made about this period (see table 5.4). First the persistence of the ‘indulgency pattern’. There is little evidence to support the view that a major cultural adjustment had taken place, even within the club experiencing the disaster. That the triggering disaster occurred in Scotland may explain why the Scottish response appeared to have been more effective than in England and Wales. Second, the emphasis upon technical issues was marked. Appended to Wheatley (1972) is a technical report, almost as long as the findings of the main report. Its inclusion reinforces the view that the causes of stadia disasters are largely technical. Inter organisational co-ordination is dealt with in one sentence when Wheatley recommended that:

“Consultations between the club and the police (and the first aid and ambulance services as well) to see what is required for the efficient discharge of their duties should be held at least at the beginning of each football season.”(p18)

There was no recommendation for ongoing communication between the various agencies or for the formalisation of arrangements for co-ordinating their activities. Third, there was an official view that clubs were in general complying with regulations. However, as the examination of the next period illustrates, there is evidence that in many cases a ‘mock bureaucracy’ existed in which rules, for example on capacities, were regularly flouted (Taylor 1989). Inglis (1987) reported that some 27 grounds in England and Wales had stands and terraces either closed or

their capacities dramatically reduced at the start of the 1985-6 season as local councils implemented regulations more vigorously, fearing that they too could suffer as the West Yorkshire Authority did as a result of the Bradford Fire. This evidence indicated the continuation of the ‘indulgency pattern’ in England and Wales in which rules were rarely enforced. It suggests that clubs may have been doing all that they felt necessary, but that the regulatory agencies were ineffective in drawing their attention to their responsibilities, as indicated by the post Bradford closure of twenty seven stands and terraces.

There is little evidence to support the view that either a ‘representative’ or ‘punishment centred bureaucracy’ developed in this period, although Inglis (1996)

	Patterns of Behaviour in the UK Football Industry 1975 - 1985
Indulgency Pattern	More rigorous enforcement leads to closure of terraces & stands in some 27 grounds following the Bradford Fire, indicating previous leniency. Lower division clubs exempt from 1975 Act - little attempt for such clubs to abide by recommended guidelines.
Mock Bureaucracy	Taylor (1989) cites evidence of clubs regularly exceeding capacities.
Punishment centred Bureaucracy	Limited evidence of fines levied on three clubs in this period. Scottish clubs report active local authority enforcement.
Representative Bureaucracy	P2 reports good relations with Local Authority discussing issues, although suggests that LA were harsh and part of the ground was closed after the Bradford Fire.

Table 5.4: Development of Regulation and Response 1971 - 85

reported that in three cases, clubs were fined between £200 and £1,750 for minor infringements. The evidence suggests that investment on the part of clubs was limited and half hearted and that generally, the regulatory authorities failed to ensure compliance.

In summary, the post Ibrox period may be summed up as ‘business as usual’. The focus of the licensing system was upon technical considerations. The role of the local authority licenser was in many instances to check crush barrier strengths and the structural condition of the stadium. In many cases this task was delegated

to Building Control officers, whose main duties include providing advice on building regulations, plans for new build and inspecting work in progress in new developments or house extensions. This is significant because the skills required for dealing with members of the public are not necessarily the same as those required for dealing with businesses. It also indicates that enforcement of the Green Guide was seen as a technical task to be undertaken by building technologists. There was no suggestion that the police and club should meet regularly to discuss crowd control, nor was there a suggestion that football clubs should appoint specialist staff to deal with crowd welfare. It is clear from the data collected, that administrative tasks, including crowd safety, were usually the responsibility of an administrator who also had responsibility for all the other day to day functions concerned with running a club. That is, the structure of clubs, with its overburdened secretary, acted as one powerful block upon learning. For example, Popplewell (1985) reported that a visit from the Health and Safety Executive (HSE) to the Bradford stadium in 1980 produced the following opinion:

"There was very little compliance with the Guide to Safety at Sports Grounds, and Mr. Newman (club secretary) said that although he knew of the existence of the Guide it was not really his responsibility to see whether or not particular recommendations of the Guide were met."

This 'begs the question'; If it was not the Club Secretary's (equivalent to the Chief Executive) responsibility to enforce the particular recommendations then whose was it? At the very least, the lack of awareness regarding the Green Guide points to a weakness on the part of the Local Authority to communicate with the Bradford Club. Poor inter organisational communication (through lack of forum, time and information) acted as a second powerful block. Culture, in the form of Club objectives, beliefs about disasters and the importance of crowd safety acted as a

third powerful force blocking learning. The technical emphasis of the Wheatley Report (1972) simply reinforced the view that Ibrox and other disasters were technical failures; from which it can be inferred that inspection of a stadium's structure and fixtures and fittings would be sufficient to ensure crowd safety.

A final issue that held a high priority in this period concerned hooliganism. In October 1970 the FA advised all Football League clubs that they should introduce more stringent methods of confinement. Bale (1993) reported that the erection of barriers to segregate fans at Old Trafford cost in excess of £100,000, a considerable sum in 1974. In Chapter 4, Guilianotti's (1994) description of the period between the Ibrox and Bradford disasters divided into two periods (see table 4.3). In the first (1970-8) the rise of hooliganism as a national problem was identified. The response of the authorities was to employ technical fixes. In 1979, with the election of a new Government, Guilianotti (1994) identified the greater sensitisation of the executive to hooliganism, and notes a switch to punitive judicial policies. Whether hooliganism was a more serious problem during this period or whether, as has been suggested (Williams et al 1993), it was a problem amplified by the media, many of the executives with responsibility for administering within the football industry believed this to be so. The introduction of close circuit TV and the erection of segregating barriers were investments reflecting the belief that hooliganism was problem number one. It may be argued that the hooliganism debate created a smokescreen, behind which further stadium incidents (see table 1.1) went unnoticed or were interpreted as being caused by hooligans.

A difficulty for this thesis concerns the question of balance. The problems of hooliganism were, it has been argued, exaggerated, and in seeking to counter this imbalance, there is a danger that the actual role played by hooliganism is

understated. Directly, hooliganism played an immediate role in the Birmingham<sup>2</sup> and Heysel disasters. Indirectly, the response to hooliganism had an important influence upon the redevelopment of football grounds prior to 1989. However, as the analysis in this Chapter identifies, hooliganism is only one amongst a number of issues. There has been no suggestion that hooliganism played a part in either the Ibrox or Bradford Disasters. In the case of Hillsborough there is less clarity with some commentators (Ingham 1997 for example) placing blame firmly upon the spectators. Conversely, it has been difficult for others to criticise the behaviour of some spectators without being accused of adopting an anti-spectator stance.

### **5.8 The Bradford Stadium Disaster**

Bradford City FC was founded in 1903 and by 1908 the club had successfully achieved promotion to the first division and its main stand, eventually to be burnt down, had been built. By the 1950s, despite its successes in the earlier half of this century, Bradford City had slipped into the lower divisions. The ground was never designated under the 1975 Act and the club was not required to bring standards up to those specified in the Green Guide. Its lack of success was reflected in a worsening financial situation. The club was threatened by closure in both 1965 and 1983 (Shaw, 1985). Regarding safety, two stands at Valley Parade were demolished during the 1950's because of concerns about their safety (Inglis, 1987). During the early 1980's the HSE expressed similar concerns about the main stand as reported above.

Only designated grounds were obliged to meet the guidelines expressed in the Green Guide. Although Bradford, because of its low league position, was not

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<sup>2</sup> The Birmingham disaster occurred on the same day as the Bradford Fire. One person died when a wall collapsed as he, with many others, sought to escape from thrown missiles.

amongst these it was expected to use the Green Guide for guidance. Herein lies one key weakness of the way in which the 1975 Act introduced regulation. Responding to pressure from clubs and the Football Authorities it was targeted at those clubs believed to be at greatest risk and in possession of resources to comply with it. As Inglis (1985) writing in the Guardian reflected:

"No club wants to have an unsafe ground, but the third and fourth division clubs have always resisted moves to include them in the Act because they argue that the costs involved would bankrupt them or be inappropriate in view of their rapidly declining attendance figures."(p2)

Correspondence between Bradford AFC and the HSE included a letter from the latter the following September (1980) indicating further hazards, including :

"In the main stand the void area between the concrete supporting structure and the wood floor should, after the removal of rubbish, be completely blanked off."

Further inspections in 1981 included questions regarding evacuation from the main stand:

"I would also ask you to consider the evacuation procedure for the main stand, this is largely constructed of wood and from paragraph 8 of the code you will see that it should be capable of evacuation in 2.5 minutes. Please consider the above points and write to me detailing your proposals." (p23)

There was no response to this letter.

The HSE were not the only Statutory Authority aware of the potential risks. The poor state of the ground had led the club to seek financial support from the Football Trust. A letter (18/7/84) from West Yorkshire County Council was written, at the request of the club, in support of this application:

"As the West Yorkshire County Council is the Licensing Authority under the Safety at Sports Ground Act 1975, it may assist you to know what some of the Council's other considerations would be, should at some time in the future the provisions of the Act apply to Bradford City AFC ground:

These are :

1. Main Grandstand

(a) The unusual construction of this stand makes an appraisal of structural adequacy desirable.

(b) The timber construction is a fire hazard, and in particular, there is a build up of combustible materials in the voids beneath the seats. A carelessly discarded cigarette could give rise to a fire risk.

(c) Egress from the stands should be achievable in 2.5 minutes "

(Quoted in Popplewell, 1985, p20)

The letter was despatched in July 1984. A copy was also sent to the Fire Service.

Popplewell (1985a) reported that :

"They took the view that it was a matter of good housekeeping for the occupiers of the football ground to deal with and saw no reason to take the matter any further."(p19)

The earlier discussion of regulation suggested that whilst managers frequently understand more about their organisation's processes than regulators and thus must take a lead in safety management, the role of regulators is to push and ensure that essential work is undertaken. The HSE stance demonstrates the persistence of an indulgency pattern, perhaps due in part to a lack of resources,.

With regard to the 'crisis of management stage' (Smith 1990) a number of observations can be made. It is clear that in the five year period prior to the incident, the club's attention was drawn to the potential for the disaster. That these warnings were ignored parallels the pattern of behaviour at Ibrox pre 1971. The simple organisational structure of the Bradford club did not lend itself to providing sufficient resources to deal with all matters, leading arguably, to the failure to respond to letters and to the admission that it was not the secretary's responsibility to oversee compliance with safety guidelines.

The main stand was about 90 metres long and set on the side of a hill. There was a void between the weathered floor of the stand and the ground below. Over a period of at least twenty years, papers, sweet wrappers and litter had collected in this void, creating a fire hazard. The stand was divided into two length way sections separated by a solid wooden barrier of about 4-5 feet high. Two gaps in this barrier allowed

access between the front and rear parts of the stand. These were located approximately one third of the way in from either end. To the front of the stand there was a small terrace. Access to the stand was from the rear, through a dark passageway which ran its length. The exit gates and entry turnstiles were located off this passageway. To prevent the admission of non-paying customers many of these gates and turnstiles were locked shut during the game, thereby preventing exit during any match. Toilets and refreshment bars were also located here, meaning that it became crowded at half time. The stand was covered by a wooden roof covered with felt.

A crowd of some 11,000 attended the ground on May 11th to celebrate the team's success for the final match of the season. Shortly before half time a fire broke out in the main stand. Witnesses report seeing a small fire in the void beneath the floor of main stand. The fire caused little concern, at first, as is evident by photographic evidence. Popplewell (1985a) reported :

“Those in the immediate area of the fire seemed not unreasonably to think that it was simply some paper which had caught fire, that it was of no particular significance, and that within a short period of time steps would be taken to deal with it.” (p7)

One spectator left his nephew to get a fire extinguisher from the rear of the stand. Fire fighting equipment, however, had been removed due to fears of its misuse by unruly spectators. PC Lyles, called to investigate the fire, requested colleagues on the touchline to get a fire extinguisher:

"Owing to the background noise they thought he had asked for the fire brigade and they therefore radioed to the fire brigade."(Popplewell, 1985, p7)

This request was made at about 15.42, by 15.44 flames were clearly visible and within two further minutes the whole stand was on fire. Spectators proved reluctant to move as PC Lyles reported:

"We did not get much reaction from people in the stand, obviously they were watching the match and in fairness the fire did not look much from where they were sitting. A few of them moved out into the aisles towards the top of the steps."(p7)

An absence of loud hailers and an inability for the police to access the public address system hindered police attempts to direct spectators. Eyewitness accounts indicated that no attempt was made via the p.a. system to direct spectators to leave [Siggins, 18/05/85]. The police radio sets, which were designed for only one officer to speak at a time, also caused communication problems. Two people speaking at the same time meant that neither was properly understood; a problem exacerbated at Bradford, by the background noise. Further, the problems of communicating in a crisis for a machine bureaucracy type organisation was highlighted in Chapter 4, with reference to the fire service. Similar problems face the police when they work in large numbers. At times of a crisis incident it is likely that radio channels will be overloaded with requests for orders or permission to deviate from contingency plans.

Eventually, when the seriousness of the fire became clear, spectators began to move, some escaped onto the pitch, many sought to leave by the usual exits, many of which were locked shut. Sime (1985) reported that this behaviour is normal and rational. People may avoid taking the shortest route to safety, preferring instead to exit the way they came in, following a route that is familiar and one that they have confidence will permit their escape. The existence of the wooden barrier may have influenced many, particularly the less mobile, to move towards the rear of the stand. Whilst some exits were forced open and other non-signposted exits were used as escape routes many spectators were caught in a trap, caught between the fire and the barred exits. Popplewell (1985) summarises the causes of the tragedy:

"The answers to the question therefore, why the fire started and caused casualties are that, firstly the stand was a wooden structure, with a void under the seats, in

which debris could and did collect; and secondly that the available exits were insufficient to enable spectators to escape the devastating effects of the rapidly spreading fire."(p9)

In the aftermath of the tragedy Justice Popplewell was commissioned to undertake an Inquiry into the disaster. Less than three weeks later, thirty nine spectators were killed at the Heysel Stadium in the European Cup Final between Liverpool and Juventus and Popplewell's terms of reference were extended to include this disaster. Before the Heysel Stadium disaster is examined, a number of observations can be made. First, the linking of the two incidents refocused attention onto the problem of hooliganism. Second, that hooliganism played no part in the Bradford tragedy (evidence that contradicts the first of the three explanations of the stadia disasters in Chapter 1). Third, the behaviour of spectators at Bradford did not conform to assumptions. For example, people proved reluctant to move when the first signs of the fire were noticed. Evacuation times were based on identification of a problem rather than upon human behaviour. That is, a period of time will elapse between identification of a problem and a human response. (Sime 1985).

Although no previous incidents had been reported within Bradford's main stand the correspondence from the Fire Authority and County Council illustrates that a problem had been identified some years prior to the disaster. As was the case at Ibrox no remedial action was taken. The availability of data regarding the Bradford disaster enables us to make a number of observations. From the analytical framework (figure 2.2) and summary of the crisis incident in table 5.5, it can be seen that the dire financial straits of the football club acted as one barrier to the taking of remedial action. However, the comments of the Secretary, that it was not his role to ensure the Club's compliance with the Green Guide is revealing. Observations such as these lead to the identification of a further type of 'defence mechanism' in the course of this study, which

The Bradford Stadium Fire: A Socio-Technical Systems Failure	
<b>Crisis of Management</b> Cultural Context	Focus on hooliganism. Ignore warnings from Fire Service & HSE.
Culture: Assumptions	Lower division club and therefore not a designated ground. Reluctance of spectators to move on first signs of Smoke (response time not included in evacuation calculations) Locked exit gates to prevent admission without payment. No exit gate stewards. Low priority of backroom activities. Confusion re. responsibility between HSE and Fire Service.
Culture/Finance Culture/Finance	Previous financial problems, at time on brink of insolvency. Inadequate cleaning and maintenance.
Configuration	Secretary an administrator, chairman and board distant from housekeeping matters.
<b>Operational Crisis</b> Communications	Too few radio channels and communication overload
Coupling & Complexity	Design of stand, poor housekeeping, lack of fire exits, poor communication between regulatory agencies.
Culture	Exit and entry gates locked for security reasons, no stewards or keys available.
<b>Crisis of Legitimation</b> Culture:	Commission Popplewell Report. Link to Heysel (Hooliganism). Local Authorities close 27 stands. Focus on fire.
Incident specific learning blocks learning	Safety measures focused upon fire hazards rather than on meeting requirements of Popplewell Report. Technical recommendations. Focus upon hooliganism, Bradford an unfortunate aberration .

Table 5.5: The Bradford Stadium Disaster: Three Stages of Crisis

has been termed ‘displacement’; that is, the tendency to ascribe responsibility for a task or role to another agency, and thereby avoiding having to deal with a threatening situation. Responsibility for safety had been added as one of a long list of duties for the club secretary. In view of the reluctance of the authorities to do more than identify a problem, that is to hold back from pressuring the club to act, such behaviour remained largely unchallenged. As with the Ibrox tragedy it was a collection of factors, cultural, structural and economic that combined to create the conditions in which the fire occurred

With the benefit of hindsight, the Bradford disaster can be seen as one of a series of high profile crisis incidents. In May 1985 of course, it was merely the first major incident since 1971. It was easy to consider it as another aberration or freak accident. Indeed as table 5.6 illustrates, this is a view that has persisted to the current day for some football administrators. Respondents were asked to identify the primary causes of the Bradford disaster. The identification of wooden stands and locked gates as key factors rather than ineffective evacuation, communications etc. highlights that technical causes of crises are easier to identify and act upon. Despite this, a number of instances during my observations of safety management practices, suggested that lessons had not been learned by 1994-5. In many clubs, locked gates were left unattended. In another case, an attempt by a deputy chief steward to investigate a fire alarm in a crowded stand was delayed for 10 minutes because a steward had left a fire door locked and had moved off to watch the match - no disciplinary action was taken because the deputy chief steward knew that the individual would lose his job if the stadium manager were informed, providing further evidence of the continuation of an indulgency pattern of behaviour. For other administrators the Bradford Club was at fault, and a number were quick to assert that such sloppy management would not be tolerated in their clubs.

Table 5.6 summarises the views of respondents regarding the causes of the Bradford Fire. The criteria used to determine the appropriate \* result was as follows. Where \*\*\* are shown the respondent indicated that this particular factor was either the only one or the most significant. Where two factors were identified, \*\* were allocated. Finally, where a respondent indicated a combination of factors, \* was used. The virtual absence of \* indicates that few respondents attributed the causes of the fire to any complex combination of factors.

Club	Primary Cause						Primary Responsibility	
	Wooden stands/ construction	Locked gates/ exits	Fire!	Poor maintenance & cleanliness	Lack of finances	Freak accident	Smoker	Club
P1	-	-	-	-	-	-	-	-
P2	-	-	-	-	-	-	-	-
P3	**	**				-	-	-
P4	**	**				-	-	-
F1	**	**				-	-	-
F2				***				***
F3		**		**				***
F4			***			***		
S1			***			***		
S2				***				***
S3	-	-	-	-	-	-	-	-
S4					***			*
T1	-	-	-	-	-	-	-	-
T2	-	-	-	-	-	-	-	-
T3	**					*	**	
T4		**		**				***

Table 5.6: Summary of views of respondents on causes and responsibility for Bradford tragedy

\*\*\* Sole or primary cause  
 \*\* Secondary or one of a no. of key factors  
 \* Contributory

\*\*\* One group with prime responsibility  
 \*\* Balance of responsibility  
 \* Contributory (fleeting mention)

## 5.9 The Heysel Stadium Disaster

The Bradford disaster emphasised that peaceful, law abiding spectators could be victim to tragedy in a football stadium. The disaster did much to focus public attention on the plight of the football industry and upon the poor state of many grounds. The Heysel disaster, just over two weeks later, returned the focus towards hooliganism once again. The Heysel Stadium, Brussels, was chosen as the venue for the final of the European Cup between Juventus of Italy and Liverpool of England. Although this disaster did not occur in the UK and the stadium was not subject to UK legislation it is included in this analysis because of its profound affect upon Justice Popplewell's recommendations.

The Heysel stadium, built by the City of Brussels municipal authority, was opened in 1930 and was a regular venue for football matches and other sporting

events. The condition of the ground was questioned at the investigation into the tragedy. Popplewell (1986), reported:

"Having regard to the state of the crush barriers and fences, and the general condition of the terraces it seems unlikely, had it been located in this country, that a certificate would have been issued under the Safety of Sports Ground Act 1975 for this part of the ground."

He continues:

"However, the poor state of the terraces played no part in the tragedy."(p4)

Popplewell's (1986) comment may reflect a desire to avoid openly criticising the Belgian Authorities given the role of British supporters in triggering the tragedy. It thus reflects the political nature of such inquiries, a weakness identified by Toft & Reynolds (1992). The suitability of the stadium as a venue for such an important match must be questioned. A more balanced view was put forward by Miller (1985) who wrote :

"Nobody of whatever nationality could attempt to defend England's wretched record of crowd behaviour, but it must be said that the Heysel Stadium..... was ill equipped both in its structure and in its segregation of rival supporters to cope with a match in which there were bound to be such tensions." (pp1-2)

Inglis (1990) reports allegations that the UEFA inspectors spent less than 30 minutes checking the suitability of the ground for the Cup Final.

The Belgian authorities determined that Juventus and Liverpool fans would be segregated. In addition areas for "neutral" spectators would be located in block "M" beside Juventus supporters in blocks "N" and "O" and in block "Z" beside Liverpool supporters in blocks "X" and "Y" (Appendix 5.1). Additional barriers around the neutral areas were also erected.

"This composite construction, whilst forming a physical barrier, was not of sufficient strength to resist the determined efforts to breach it." (Popplewell, 1986, p4)

t'Hart and Pijnenburg (1989) report that these barriers:

"Were neither designed properly, nor constructed adequately, to stop a determined and angry crowd"(p203)

To the flank of block " Z", the site of the disaster, was a wall rising from 2 metres high at one end to 3 metres at the other. It was a brick wall which was not fixed in anyway to the concrete wall it sat upon.

Responsibility for policing was split between the Brussels Police and the National Gendarmerie. Problems of communication were evident as the two forces maintained separate communication and co-ordination networks (t'Hart & Pijnenburg 1989). The Gendarmerie officer in charge (OIC) at the stadium failed to attend any of a number of meetings to discuss arrangements for the match with his counterpart in the Brussels police and other official bodies. (Popplewell, 1986). The lack of apparent planning by the police was commented upon by a number of observers. (See Times, Guardian and Financial Times of 30 & 31st May 1985). Peter Robinson of Liverpool claimed in an interview that :

"When we arrived at the stadium on Wednesday, I immediately said that police were needed in the empty security zone, because it was clear that the neutral zone was predominantly filled by Italians with predominantly black and white colours and that the barriers, which they say the police had approved the day before would not be adequate."(The Times, 31/5/85, p3)

The attempts to segregate the opposing fans had broken down. Many Italian fans were able, one way or another, to acquire tickets for block "Z". The security arrangements had assumed that opposing fans would not be located in such close proximity to one another. Police reports indicated a series of incidents throughout the afternoon before the game. At 17.15 a police report indicated a mass invasion of block "M" (neutral) from blocks (Juventus)"O" and "N" which were overcrowded (Popplewell 1986, p6). At the other end of the ground:

"Somewhere between 18.15 and 18.30, the English fans fired flares and rockets and threw stones into Block "Z", which was beginning to be occupied by what were clearly Italian supporters. There was also a number of English supporters in Block "Z" who sought to escape into Block "Y"...It appears there were about 15,000 spectators in Blocks "X" & "Y" and about 5,000 in Block "Z". (Popplewell 1986, p7)

Precise figures for the numbers of spectators, were unavailable owing to the lack of specific turnstiles for each block, and gaps in the boundary wall sufficiently wide to enable admission without a ticket or payment.

Between 19.15 and 19.30, according to a Times report of 31/5/85 and supported by further evidence to the Popplewell Inquiry, three charges by English spectators from Blocks "X" and "Y" on block "Z" took place. The first two were repulsed, the third successfully broke through the security barriers. The Times suggests that the Belgian police had withdrawn at this stage to await reinforcements. The Popplewell report is deliberately vague (it appears) on this point. As the Juventus supporters sought to escape from the onslaught of English supporters they were forced along the boundary walls furthest from block Y. As the crush built up more pressure was exerted on the perimeter wall. A section of about 6 metres length collapsed. People tumbled down among the rubble, others followed close behind, unable to stop themselves owing to the pressure of people behind them, seeking to escape from the English supporters. Most of the victims suffered death from suffocation or crushing. Thirty eight people died in the disaster, some four hundred were injured.

Table 5.7 highlights that despite the identification of hooliganism as the main cause of the tragedy by some commentators, a range of social and technical factors came together to create the potential for the deaths to occur. These factors, as shown in table 5.7, influenced the preparations for the match as well as the immediate response.

	Heysel Stadium Disaster: A Socio-Technical Systems Failure
<b>Crisis of Management</b>	
Cultural Context	Assumption that ground is safe leads to a quick check by UEFA official
Culture:	Claim that ground would not be certificated in UK, sub-standard grounds perceived to be OK in countries that had not suffered a major stadium accident.
Configuration/Communication	Different police forces responsible for different parts of the ground causes problems in communication and implementation.. One police force does not attend pre-match briefing making co-ordination very difficult.
Finance	Poor condition of ground
<b>Operational Crisis</b>	
Communications	Too few radio channels and communication overload
Coupling & Complexity	Design of stand, poor quality infrastructure, close proximity of British and Italian spectators, poor policing, hooligan behaviour all combine.
Configuration	Presence of different crowd control agencies makes co-ordination difficult
<b>Crisis of Legitimation</b>	
Incident specific learning blocks learning	Identified as a problem of hooliganism rather than mismanagement. Political Concerns, Government embarrassment and desire to avoid being seen as blaming the Belgian authorities.  Subsequent Popplewell Report focuses upon problems of hooliganism and violence, diverting attention away from problems of poor quality stadia  Immediate closure of grounds in UK soon relaxed.  Government act before Popplewell Reports.

Table 5.7: The Heysel Stadium Disaster: Three Stages of Crisis

The political context in which Popplewell prepared his reports is further demonstrated by the announcement of specific measures to deal with hooliganism some four days after the Heysel tragedy, and some months before Popplewell's interim report was written and published. The comment that the Heysel Stadium would probably not have been awarded a safety certificate under the provisions of the 1975 Act demonstrates the difficulty in transferring lessons between countries, even where obvious and close similarities exist.

#### 5.10 1985-9: Response to the Bradford Fire

Following the two disasters, the interview data, collected from club executives, suggests an immediate tightening up on the part of the regulatory

agencies, indicating a switch to a 'punishment centred bureaucracy' - a view supported by Inglis (1987) who identified the closure of some twenty seven stands across England and Wales. P1 complained that after Bradford, the Local Authority compelled the club to spend some £450,000 on an old stand despite the fact that it was to be rebuilt the following year. The nature of the complaint, that such a requirement was absurd, suggests that there was still a gap between the values of many regulators and clubs. It also raises the question why the improvements had not been required at an earlier date if they were so pressing. A similar gap was identified by F1:

“Even prior to Taylor, unless the fire brigade on one of their annual inspections or us, in the police force as a result of something that happened during a game, my impression is that they wouldn't have done anything unless it was brought to their attention somewhat forcibly because other things keep coming up and dropping on your desk.”

P2 suggested that after the 1975 Act the Local Authority had maintained very high standards which “we used to think that they were being a little bit harsh”, but that this had stood them in good stead. Later on in the interview it emerged that immediately following the Bradford Fire, a wooden terrace below a wooden stand had been closed. The wooden stand above it however, remained in use for another nine years. Such a view reflects the use of 'denial' as a defence mechanism, a refusal to acknowledge the potential for danger. Only F2 identified the Bradford Fire as a catalyst to greater co-operation between the club and the regulatory authorities, in this case the police. Where respondents identified the Bradford Fire as a stimulus to action, it concerned the regulatory authorities compelling clubs to act as in the cases of P1 and F1 cited above. For a number of clubs this involved the closure of specific stands (P2, S4, T1).

Despite this immediate response to the Bradford Fire there does not appear to have been a significant shift in values. The analysis of the views of interviewees concerning the causes of the Bradford Fire sheds light on one aspect of this (reported in table 5.6). For many within the industry Bradford was a freak. The focus upon hooliganism, discussed earlier, switched the focus of attention away from clubs and their regulators and onto means for crowd control and spectator behaviour. Five clubs identified the Bradford Club as having primary responsibility but believed that this was an extreme case of poor housekeeping that would never have been permitted within their own organisations. Note, one of these clubs was subsequently reprimanded for permitting the build up of combustible materials beneath a wooden stand. As F1 put it:

“Poplewell tended to get forgotten; a couple of things that he recommended continued but he certainly didn’t have the influence that Taylor did.”

In summary, the evidence suggests a flurry of activity following the Bradford Fire and a shift towards a ‘punishment centred bureaucracy’, a shift that subsided after the initial shock.. Although an additional fifty grounds were designated to come under the provisions of the 1975 Act there is little evidence for the development from the indulgency patterns and ‘mock bureaucracy’ of the preceding period. Indeed Inglis (1987) in a review of safety in sports stadia appears to mock cases where the fine detail was applied. In one example, a match was almost called off because a senior police officer found that the bulbs in an exit corridor were broken. Fortunately, ‘staff were sent to the corner shop for replacements and the game was saved’[p38]. An alternative interpretation of this story is that the exit corridor was an important emergency exit and that lack of lighting could have severely hindered the escape of spectators. Given the quantity

of lighting inside any building, the lack of spare bulbs indicates either the poverty of the club or an example of the type of poor housekeeping that contributed to the Bradford Disaster. Ground improvement was not a high priority for football clubs in the 1985-9 period (Arnold & Benveniste 1988).

The problems of hooliganism received extensive attention from the media as well as from academics. The period 1985-1989 saw the rapid growth in the treatment of the football industry from a sociological perspective. There was a lack of any research however, from either a risk management or organisational perspective. Near misses continued, frequently unreported (as was the case at the 1981 and 1988 FA Cup semi final fixtures at the Hillsborough stadium).

Patterns of Behaviour: 1985 - 1989	
Indulgency Pattern	
Mock Bureaucracy	T3 "There wasn't the safety concerns before Hillsborough even though Bradford had happened.... you wouldn't have a safety officer before Hillsborough or fluorescent jackets or insufficient [sic] first aid cover"
Punishment centred Bureaucracy	Closure of 27 stands and terraces on instructions of Local Authority License bodies following Bradford Fire. Legislative focus upon hooliganism including sale of alcohol ban
Representative Bureaucracy	F2 cites example of better relationships with local authority regulator

Table 5.8: Development of Regulation and Response 1985 - 89

Although this period witnessed a knee jerk reaction immediately following the Bradford Fire, there was little evidence for the development of a punishment centred bureaucracy and no evidence of a representative bureaucracy (see table 5.8). The emphasis of the licensing scheme may have been extended to incorporate fire safety, but there was little evidence of a safety culture developing.

### 5.11 The Hillsborough Stadium Tragedy

Hillsborough, the home ground of Sheffield Wednesday, was widely considered to be one of the better quality grounds in the UK, described by Inglis (1987) as the

Wembley of the north. The West Stand, built in 1965 in readiness for use as a venue for the 1966 World Cup. It was described in 1987 as:

"Hillsborough is a stadium, with all the grand connotations the term implies.....To the left is the West Stand, with 4465 seats in an upper tier, and open terraces in front. Next to the other two stands it looks rather ordinary, but the view it provides is excellent, as are its facilities, and it does close off the ground effectively without cramping the style of either of its neighbours." (Inglis, p97)

The terraces to the front of the West or Leppings Lane stand, had a capacity of about 10,100. The terracing was split into a number of separate pens, each surrounded by fencing on three sides. The division into pens was the result of an overcrowding incident during the 1981 FA Cup semi-final. Capacity for each pen was determined by a process of fans finding their own level, despite the fact that approximate capacities for each pen had been calculated. Access between the pens was possible by gates located to the rear of each pen. When these gates were open the back row of terracing had access between pens.

"In practice, when substantial numbers are present, those gateways are not readily visible or accessible. The present layout of the pens, fences, crush barriers and gates has resulted from a series of piecemeal changes." (Taylor 1989, p5)

Crush barriers were also located parallel to the goal line. To the front of the terraces lay a 2.5 metre high fence, turned inwards at the top, preventing access to the pitch. Gates were located at intervals, along this fence, and none was wider than 1 metre.

Entry to the West Stand and terraces was from the Leppings Lane. Owing to the close proximity of housing and the River Don, there was not as much room for turnstiles as there was for access to other parts of the ground. Lack of room also meant that the area immediately outside the ground could become quickly congested. Thus access for 29,800 spectators on the south and east sides of the ground was through 60 turnstiles (500:1) compared to 23 turnstiles serving the 23,250 capacity (1,000:1) on the north and west sides.

From Leppings Lane, spectators made their way through a set of perimeter gates to the turnstiles. Seven turnstiles were available for the potential 10,100 standing spectators (1450:1). A rate of 600 admissions per hour was considered quick, given good conditions.

The layout of the turnstiles was confusing; the use of letters and numbers out of sequence to denote groups of turnstiles as well as individual ones made the individual spectator take time to make sense of. This confusion was exacerbated by the presence of a dividing fence running from the perimeter fence to the ground itself. Any spectator who found himself on the wrong side of this would be forced to fight against the tide of people onto the other side. Entrances A and C were located on one side of this fence, Entrance B on the other. Turnstiles for the former two entrances were denoted by numbers, for the latter by letters.

Having successfully made sense of the external layout, spectators, on entering the ground were drawn by a combination of signposting and layout towards a tunnel which led to terracing in pens 3 and 4, directly behind the goal. Where the tunnel emerged onto the terraces, the way ahead was bisected by the radial fence separating pens 3 and 4. A short spur of wall projected forward on either side of the tunnel opening, guiding those emerging forward into pens 3 and 4, rather than into other adjacent pens. Overcrowding of pens 3 and 4 had been so severe in 1988, at the identical semi-final fixture also between Nottingham Forest and Liverpool, that this tunnel had been blocked off by police officers. However, no record of this was made in the post match de-brief and it was not included in the operational order for 1989. It should be noted that there was virtually no control of the numbers of spectators going into each of the pens.

In summary, the layout of the Leppings Lane end had developed, both internally and externally, in a piecemeal manner. Despite these changes the safety certificate was not amended. Crowd density was monitored manually. This layout was to have a key impact on the disaster of 15 April.

Liverpool FC and Nottingham Forest FC were to meet one another in the semi-finals of the FA cup in an exact duplication of the previous year's match. Despite having the larger average attendance Liverpool supporters were given the smaller side of the ground, accessed from Leppings Lane, to assist in ensuring strict segregation.

By 2 p.m. , although pens 3 and 4 were filling quickly a surprisingly small number of Liverpool fans had taken their places upon the terraces, in pens 1,2 and 5. By 2.15 p.m. the numbers in pens 3 and 4 were large enough to warrant a request, via the public address system, for fans to move forward to make room. Outside the Leppings Lane entrance large crowds of fans were beginning to collect. By 2.50 p.m. pens 3 and 4 were reportedly:

"Already full to a degree which caused serious discomfort to many well used to enduring pressure on the terraces. The numbers at that time were clearly in excess of the maximum density stated by the Home Office Guide to Safety at Sports Grounds." (Taylor, 1989, p11)

Outside the ground , as kick off approached, the crowd became more anxious to ensure quick access. Given the numbers of turnstiles, progress was likely to be slow. Progress was further slowed by the rising pressure, pushing and shoving. It was clear that the crowd would be unable to enter the ground by 3.00 p.m. A request, from a police officer, for kick-off to be postponed was rejected by the South Yorkshire Constabulary Match Commander. Technical problems affecting communication between officers outside the ground and the control room were also reported at this time. Superintendent Marshall, officer in charge outside the Leppings Lane, fearful of

fatalities occurring outside the ground requested permission (at 2.47 p.m.) to open the exit gates, adjacent to the turnstiles, to relieve the crowd pressure outside the ground. At 2.52 p.m. authorisation to open an exit gate was given. The largest entry was through gate C which opened into the area directly behind the terraces. The most obvious route to the terraces, as described, was through the tunnel to pens 3 and 4 which were already overcrowded.

Intense pressure built up in the tunnel, pressure which took advantage of any movement forward in the pens ahead, thereby increasing the pressure on the fans trapped inside the pens. Against a background of noise within the stadium the police officers in front of the pens did not immediately notice what was wrong. The narrow exit gates to the front of pens 3 and 4 sprang open due to the pressure. Police officers sought to close them and either to push back fans spilling out of them or to redirect them to the wing pens. As awareness of the problem grew further problems of communication were evident:

"At gate 3, a constable, now alive to the crisis, followed strictly his written orders and radioed for permission to open that gate. Receiving no reply, he took it upon himself to open it."(Taylor, 1989, p13)

Prior to the incident, at the pre match briefing police officers had been instructed not to open the gate under any circumstances, and had been given clear instructions that they were to accept 'no trouble from the scouse hooligans' [Private Communication, various anonymous members of the South Yorkshire Constabulary]. One officer is identified by Taylor (1989) as actually pushing the gate to pen 3 shut after it had sprung open under the pressure of the crowd crush. The officer could see the distress of spectators but remembered his instructions not to allow fans onto the pitch. A few minutes later, thinking to himself that "I'll get a real bollocking for this" he opened the gate and assisted in the rescue of the injured and dying.

Whilst some fans sought to escape through the gates, others tried to climb the perimeter fence. These were pushed back at first by police who suspected a pitch invasion. The overcrowding remained un-noticed by the control rooms, they assumed that the fans spilling onto the pitch were involved in an attempted pitch invasion. Photographic evidence also shows that before 3.00 p.m., spectators were being pulled out of the terrace by spectators sitting in the stand above. At some stage one of the crush barriers in pen 3 broke, providing an unbroken thrust of pressure from rear of the tunnel to front of the terrace.

"The crushing force was transmitted and dispersed so that all along the front of pen 3 fans were pressed hard up against the low wall and the wire of the fence above it...The pressure stayed and for those crushed breathless by it, standing or prone, life was ebbing away. If no relief came in four minutes there would be irreversible brain damage; if longer death."(p13)

The most noticeable thing about video evidence of the incident was the slowness with which the police appeared to comprehend what was going on. Even after officers closest to pens 3 and 4 "come alive to the situation" many other officers clearly believed it to be an case of crowd trouble. By 3.06 p.m. the police control room were aware of the seriousness of the problem and requested that the match be stopped. It was not until 3.12 p.m. however, that any attempt to seal off the entrance to the tunnel was made. Chief Superintendent Nesbit of the traffic police arrived on the pitch at about this time and set about organising the extraction of casualties from pen 3. At 3.13 p.m. a request from the police to the fire brigade for cutting equipment was made. The flow of communication from police at the ground to a central police control and subsequently, to the fire service indicate a lack of planning.

Moelwyn-Hughes' (1946) analysis of the causes of the Bolton tragedy might have been written for Hillsborough: a larger than expected crowd, too many admitted, defective method to count spectators into enclosures, slow remedial action and

unorganised, and unauthorised entry. Taylor (1989) as reported earlier stated that all the problems into which he was requested to inquire had been envisaged before. Indeed a similar accident had only been narrowly averted the preceding year. It is clear that as was the case with Ibrox and Bradford, warnings went unheeded, lessons from previous incidents had not been learnt. From the preceding analysis it seems clear that major cultural adjustment did not take place prior to the Hillsborough tragedy. The limited resources of football clubs, the wide span of responsibility of

Hillsborough Stadium Disaster: A Socio-Technical Systems Failure	
<b>Crisis of Management</b> Cultural Context  Configuration/Communication  Finance	Focus on hooliganism. Technical measures, no holistic redevelopment of Stadium Police ‘stirred up to take no nonsense from scouse troublemakers’[anon 1995] Crowd control not crowd safety. Focus upon playing success to detriment of safety management.  Failure to debrief from previous year means opportunity for learning lost. Rigid response, ignored evidence of own eyes. Piecemeal re-development of Stadium. Few poorly paid and trained stewards. Poor condition of ground.
<b>Operational Crisis</b> Communications  Coupling & Complexity  Configuration	Too few radio channels and communication overload.  Design of stand, signposting inside and outside, failure to monitor packing in pens, perception that problem one of hooligans, layout of pens, warm weather and roadworks lead to late arrivals of supporters.  Central co-ordinator freezes, leaves the police response without leadership for critical period Machine bureaucracy structure of police prevents quick and effective response
<b>Crisis of Legitimation</b>   Incident specific learning blocks learning	Attempt to scapegoat fans in first instance. Switch to blame police for operational mistakes on the day. It couldn’t happen here response of other clubs Ultimately the Scapegoating of the police diverted attention away from football clubs, reduces pressures for cultural re-adjustment and removes key pressure for internal change  Focus on FLA immediately upon introducing all seater stadia - a technical fix. Failure to learn from previous incidents or only in a specific way (erection of new fences with no thought of further problems)

Table 5.9: The Hillsborough Stadium Disaster: Three Stages of Crisis

key executives, a weak and largely ineffective regulatory regime combined to prevent the translation of acquired knowledge into active learning. Drawing upon Gouldner’s (1954) framework, it is clear that an indulgency pattern of behaviour persisted

throughout this period with an occasional flurry of punitive enforcement following high profile incidents. Given the lack of evidence of any major cultural readjustment in this period and the absence of extensive, active learning, a key question concerns the transfer of knowledge into action since 1989

## **5.12 Summary**

This Chapter focused upon the UK Football Industry 1946-89. The evidence indicates the persistence of an indulgency pattern of behaviour with periodic switches to a punishment centred bureaucracy following disaster incidents. On the basis of this evidence it can be conjectured that such switches are brief and a reversion to indulgency soon follows. No major or long term changes to culture are indicated, thus lending support to the principal hypothesis that no full cultural readjustment occurred in this period. The reluctance of government to introduce an effective regulatory framework mirrors the reluctance of many football clubs to develop safe crowd management systems through technical improvements or through stewarding and the education of spectators. The influence of the hooligan issue is also clear, most evident in the concluding remarks of Justice Popplewell's final Report (1986) cited above. However, the evidence does not support the explanation that hooligans acted as the primary instigators of the disasters examined. The hooliganism issue, however, did play an important role in creating a particular mindset that influenced stadia modifications and practice. There has been nothing eclectic in the selection of these focal incidents. They represented the worst disasters of their kind in the UK and register very highly on a world scale. The evidence supports the view that these were socio-technical failures that were caused in large part, by the actions and inactions of actors within the various agencies with responsibility for crowd safety inside stadia.

It had been hypothesised that following a disaster a full cultural re-adjustment would take place. (see Hypothesis 1, Turner 1976, 1978; Toft & Reynolds 1992). In the period 1946-89 there was little evidence in support of this contention. The reluctance of the Rangers' Board to redevelop the Ibrox stadium is one example of this. The focus upon hooliganism following the Bradford and Heysel disasters are further examples. As has been argued, the view that these tragedies were caused by hooligans or were acts of God remained pervasive, a fact reflected in the persistence of the indulgency pattern.

The evidence indicates that organisational learning was deficient in this period. It was argued in preceding chapters that factors such as organisational structure, culture and communications may act as the filters through which active learning can occur or be blocked. In the next Chapter, the post 1989 response of the Industry is considered. Particular attention is placed on the elements of culture, structure and communications discussed in Chapter 2. The purpose of Chapter 6 is not only to consider the evidence concerning the degree of cultural readjustment since Taylor's (1989, 1990) public inquiry into the Hillsborough tragedy, but also to determine the key factors that influenced the industry's learning in this period.

## **Chapter 6**

### **Organisational Learning from Crisis:**

### **An Examination of the Football Industry in the Post 1989**

### **Period**

## **6.1 Introduction**

Since the 1989 Hillsborough Tragedy there have not been any major tragedies inside UK football stadia. However, as table 1.1 indicated, there have been some minor incidents. This Chapter examines the football industry in the post 1989 period. It begins with a description and brief assessment of the regulatory response to the Hillsborough tragedy. The analysis draws extensively upon the data collected from semi-structured interviews with Club executives and 'Local Authority safety advisory group' chairmen. The discussion then examines the results of the survey of football Club safety officers. Five key factors emerged from the statistical analysis and these were used as the basis for assessing the levels of crisis proneness within the football industry. It has been argued that following the Bolton, Ibrox and Bradford (& Heysel) disasters no full cultural re-adjustment took place, reflected in the persistence of the mock bureaucracy in safety management. This Chapter examines the degree of cultural change in the post 1989 period and considers its effect upon organisational learning from crisis.

## **6.2 1989-97: The Regulatory Response to the Hillsborough Tragedy**

Included within Taylor's Report (1990) were recommendations to establish a national Football Licensing Authority (FLA) to promote and ensure the consistent application of legislation. The 1989 Football Spectators Act may be seen as an extension to the 1975 Safety in Sports Ground Act and conformed in large part to many of the recommendations made by Moelwyn-Hughes in 1946 (Taylor 1990). Within the regulatory framework each football stadium would be overseen by a Safety Advisory Group (SAG) which included representatives from each Club, Football Licensing Authority (FLA), Local Authority, St. John's Ambulance, the various emergency services, Fire, Police, Ambulance and other groups co-opted

onto it. For example, P4 indicated that a supporters' representative also attended meetings, although this proved to be exceptional. The function of the FLA was defined as being to:

“Keep under review the discharge by Local Authorities (certifying authorities) of their functions under the Safety at Sports Grounds Act (1975) in relation to sports grounds at which designated football matches are played. Specifically, the FLA may, after due consultation, require a certifying authority to include in any safety certificate such terms and conditions as the FLA may specify in writing. The FLA, however, wishes to use this power only in the last resort. It intends wherever possible to proceed by advice, persuasion and agreement. the FLA is aware of considerable variations between safety certificates issued by certifying authorities. Its aim is to bring about greater consistency and to promote best practice.” (FLA 1992, p3)

The FLA's stated approach fits within Gouldner's representative bureaucracy and the title 'Safety Advisory Council' (renamed committee or group) symbolises this approach. de Quidt (1997a, 1997b) reported that the FLA has never had to use its regulatory powers to coerce behaviour, although it has used the threat on a small number of occasions. However, the response of Clubs reflected different views and values.

Only two Club chairmen, from our sample of twenty, were reported to attend Safety Advisory Group meetings. In the majority of cases this task was delegated to an official with some budgetary control. The precise level of budgetary control was more difficult to discern, but, for the majority of Clubs the person with ultimate control was not present at meetings. The difficulties that this could cause were demonstrated during a visit to P3 where a number of stewards were ordered to 'keep out of the way of the chairman' who had been questioning whether so many were needed. A number of Clubs reported very positive relationships with the regulatory authorities. P3 described it as the "Safety Team..... and we work as a unit".

For P4 the main use of the Safety Committee was:

‘That they make you follow it to the letter... now whether the Club would do that I don’t know’.

This emphasis was found in a number of other Clubs, F3 stated that the “FLA man sticks rigidly to his terms of reference’, P1 and F4 identified that the Local Authority used the Green Guide as a ‘bible or gospel’. T2 suggested that the FLA prevented the Local Authority from being flexible because the its officers were very conscious of being criticised by the FLA. Others were less positive; P2 for example:

“It’s surprising how the advisory committee, they don’t do anything really, but they want to come along and sit in the directors box and watch the match..... but if they weren’t there they wouldn’t be missed really.”

In the two lower Divisions more negative views were expressed; S2 spoke of the ‘daft documents emanating from everyone’ and the false wisdom of the Local Authority. S4 told of a recent ‘set to’ with the FLA man:

“I think to be honest, that they nit-pick, to justify their existence, its jobs for the boys.”

T1 was required by the FLA to prepare a report on a three year strategy for ground improvement:

“We didn’t do it because it would either have been a blank piece of paper or all fiction so what was the point. Last year I didn’t know where I’d be next week let alone next year or three years time.”

It is important to note that the SAG is comprised of members from very different types of organisation. Local Authorities, Police, Fire and Ambulance are all public bureaucracies and are characterised by a clear definition of roles and responsibilities. The regular procedures that characterise these organisations contrast sharply with the entrepreneurial football Club with its centralised control and general lack, as argued in Chapter 4, of regular routines and procedures. The

FLA is a relatively new organisation with eleven inspectors nationally. Each has responsibility for a number of Clubs within a particular region. The majority of FLA inspectors have been recruited from retired police and fire officers from which it may be inferred they have a greater sympathy and understanding of public service operating norms and procedures. The clash of cultures identified above is not surprising given the very different configurations of the agencies involved in the SAG.

A further observation from these statements concerned the use of the Green Guide as 'gospel' or 'bible,' indicated that guidelines had been enforced and implemented rigidly; despite de Quidt's (1997) expressed view that they be used to promote consistency rather than uniformity. The reliance upon the Green Guide is indicative of a technical response rather than a cultural response. Indeed the comments are also indicative of the use of a punishment-centred bureaucracy. This lends support to our hypothesis that no significant cultural changes have occurred within the industry and that the problems of crowd safety are still being approached from a technical perspective. As identified previously, a large proportion of 'technical' improvements were subsidised through a Pools levy administered by the Football Trust.

Although the discussion above suggests that the 'representative pattern of behaviour' has not developed as fully as de Quidt (1997) had hoped, there was some evidence of a cultural change. The Taylor Report and the Hillsborough Tragedy were identified by many respondents as a key turning point, a point made in a number of contexts. P4 suggested that before Hillsborough :

"Stewards were for stopping people from getting in illegally."

for T3:

“Pre Hillsborough, there wasn’t the emphasis on making sure that the stewards were there. If one didn’t turn up then you’d saved yourself a few bob, there wasn’t the safety concerns before Hillsborough even though Bradford had happened.”

P3, F3 and S4 all identified that the high profile of the Taylor Report had made the task of justifying ground improvement expenditure easier to justify to their Directors.

As table 6.1 indicates, the post Hillsborough period has seen the development of a representative bureaucracy in some cases. However, the persistence of the mock and punishment-centred bureaucracies is an indicator of the absence of

Indulgency Pattern	
Mock Bureaucracy	<p>P2 “the advisory committee don’t do anything really, they want to come along and sit in the director’s box and watch the match.”</p> <p>S2 “there are some daft documents that come out of the health and safety and FLA.”</p> <p>S4 “I think, I feel at times they nit-pick to be honest”(the FLA)</p> <p>T1 “we didn’t prepare a plan for the FLA, it would have been either a blank piece of paper or fiction.”</p>
Punishment-centred Bureaucracy	<p>P4 “We do feel that at times we’re being dictated to, but it has been necessary.”</p> <p>F3 - “the FLA sticks rigidly to his guidelines and if you don’t comply they can reduce your capacity... so we have always done exactly what was required, before the Taylor Report there was leeway with all Local Authorities but the Green Guide was re written and you then had hardly any leeway, so Local Authorities went in with a big stick and said that they would not relicense you.”</p> <p>T1 “the Green Guide, this is the problem, is the bible or gospel.”</p> <p>T2 “safety team meeting, everyone is so nervous that they’re just trying to ensure that if the shit hits the fan they are not brought to account.”</p>
Representative Bureaucracy	<p>P3 “I’m a member of the safety team, if something goes wrong we are all losers.”</p> <p>F3 “as far as our safety committee is concerned there is lots of dialogue.”</p>

Table 6.1: Patterns of Behaviour 1989 - 97

significant cultural changes within the industry. Whilst the logic of the FLA’s strategy or persuasion rather than coercion, makes some sense, given the demonstrated reluctance of football Clubs to change, such an approach must be questioned. It should be noted that the FLA has no jurisdiction in Scotland

although Local Authorities play a key role in licensing sports stadia. This explains the absence of comments from Scotland in table 6.1.

Although two Scottish respondents referred to their Local Authorities, the data suggested that stadia safety was left to the Club and the police to organise. SC1 reported that during an event:

“A police officer will be match commander. The police want to have the final say.”

SC2 described the match control room as the ‘police control room’ suggesting that whilst the Club and police work together the latter agency takes the lead. As table 6.2 illustrates, the police are still responsible for the control of public events at football stadia in Scotland, in marked contrast to developments within England and Wales. Indeed for England and Wales the transfer of responsibility for matchday control has passed towards the Club’s own safety officers, whether individually or in partnership with the police. The high proportion of safety officers given matchday control in the Premiership, indicates the ability of these Clubs to employ full time

	Police	Safety Officer	Joint Effort
Premier	2	10	5
First	7	1	10
Second	2	3	7
Third	2	9	1
Scottish	14	0	0
Total	27	23	23
%			

Table 6.2: *Who is in Charge of Matchday Operations?*

officials who enjoy the confidence of the police. The high figure for the Third Division may be indicative of the perception that there is a lower risk of problems with a smaller crowd; a dangerous assumption as this thesis has demonstrated.

In summary, the post Hillsborough period has elements of the various patterns identified by Gouldner (1954). There is evidence to suggest that there has been a switch from the indulgency pattern, although our own observations of operational practices and those included in a recent documentary (Laybrun 1994) indicated that this pattern has not been eradicated. There is real evidence that a punishment-centred approach is forcing changes, although there have been concerns expressed that fear has led to a literal interpretation of the rules and regulations. P4's comments suggested conflict with the regulators but an acceptance that their actions had been necessary. There is less evidence in support of the development of a representative bureaucracy whereby all parties see the benefits of the rules. The link between these two approaches may provide a key influence on organisational behaviour. For example, punishment-centred bureaucracies appeared exclusively where the task for liaison with the safety committee was delegated to an individual without board status. In these instances, the role of the Club representative might be seen as to ensure minimum expenditure and to comply with the minimum standards required. Even P3 reported that the chairman quibbled over the requests or decision of the safety committee. Where the chairman or other board member was involved with the safety committee there appeared to be a greater chance of dialogue.

### **6.2.1 Relations Between Football Clubs And Regulatory Bodies**

The development of relations between football Clubs and regulatory authorities has passed through a number of distinct phases. Most significant has been the persistence of the 'indulgency pattern' in which there appears to have been little effective regulation and little action on the part of Clubs. The 1975 Act provided a framework for regulation and appears to have had some limited

influence on those designated Clubs, but the fact that some twenty seven Clubs were subjected to closures following the Bradford Fire suggests that neither regulators nor regulated had worked as required. The Hillsborough Disaster and subsequent Taylor report appear to have acted as catalysts to a more structured response on the part of regulators and regulated, and the development from an indulgency pattern and mock bureaucratic approach to a punishment-centred modus operandi. The development of a representative bureaucracy suggested by some respondents, indicates that cultural change is partially underway.

The analysis of regulation in the football industry since 1945 indicates the failure of legislators to change attitudes and behaviour. The persistence of the indulgency pattern reflects the lack of resources and 'clout' of regulators. Smith & Tombs' (1995) observations of the chemical industry suggest that this problem is not confined to the football industry alone. Since 1989 there has been some evidence of a developing representative bureaucracy. The negative attitude of many Clubs towards their supporters, however, indicates that they are unlikely to be invited to participate in decision making concerning hazards which Smith & Tombs (1995) identified as the fourth strand of a strategy to improve regulatory compliance.

There is an important link between the response of the industry to regulation and the nature of regulation. Many Clubs identified compliance as an end in itself. Describing the Green Guide as 'bible or gospel' indicates that those Clubs are focused upon incident specific learning rather than seeking for isomorphic lessons (Toft & Reynolds 1992). Legislation has been criticised (see for example Mintzberg 1983) for setting a lowest common denominator standard of behaviour rather than promoting excellent standards. Within such a context regulation may

actually stifle organisational learning and legitimise efforts that fall well below that which is required, a case of always shutting ‘the stable door after the horse has bolted.’

In all four cases there was evidence of crisis incubation with failures of hindsight, and a failure to consider the possibility of crisis amplification by those who were responsible for managing the stadia (see table 6.3).. There were a number of common features if the incidents and the period preceding them are examined at an appropriate systems level. Table 6.3 highlights the failures of hindsight pertaining to each incident.

Tragedy:	Failures of Hindsight
Ibrox (1971)	3 serious incidents on stairway 13 in preceding 10 years.
Bradford (1985)	FPA Journal Report 1969, Warnings from Fire Brigade, HSE.
Heysel (1985)	Poor state of ground.
Hillsborough (1989)	Crushing in 1981 semi-final and 1988 overcrowding

Table 6.3: Football Stadium Disasters and Failures of Hindsight

Are warning signs being missed now? The evidence of the continuation of smaller incidents suggests that this may be the case. However, are these incidents merely the tailing off of a phenomenon that is now largely under control? Are the cultures of individual Clubs within the industry now crisis prepared? The thesis now moves onto an analysis of the culture of the industry, beginning with the nature of Local Authority regulation in the post Hillsborough period.

### 6.3 Local Authority Regulatory Patterns 1989-97

From the data collected concerning Local Authorities with responsibility for regulating safety management inside designated stadia, two basic patterns of behaviour emerged. First, one group of Local Authorities described a confrontational, punishment-centred approach with the Club officials with whom they dealt. The second pattern indicated a more consensual or representative

approach between the various agencies on the Safety Advisory Group (SAG) and Club officials.

### **6.3.1 Punishment-centred Local Authorities**

This pattern was characterised by the use of punitive measures in the form of enforcement or prohibition notices to ensure conformity with the Green Guide. For example, LA 3, an Environmental Health Department, stated that they avoided consensus on the Safety Advisory Group (SAG) because: “We didn’t want the group to think that it was a voting group” (LA 3). LA 3 also reported that the approach adopted, was based upon the system used for Environmental Health’s inspection processes for health and safety and food hygiene. Other Local Authorities that had delegated responsibility for stadium safety to an enforcement department (LA 5, LA 10, LA 13) also identified the use of coercive methods as a key means of achieving conformity with the Green Guide. In the cases of LA’s 3, 5 and 10 a number of examples were given where enforcement notices had actually been served or a written final warning issued, demonstrating the representativeness of these anecdotes to the full interviews. Additionally, the tone of these interviews indicated an adversarial character in the relationship between Clubs and Local Authorities. Of these four respondents only one (LA 13), suggested that they attempted to reach consensus in the first instance. The response of the Clubs in two cases appears to have been very negative, with LA’s 3 and 10 reporting that the Club’s did not attend SAG meetings. For LA 5 there were only two SAG meetings per year. This first pattern of behaviour appears to fit closely with the routine enforcement work of the host departments. An explanation supported by LA 3 who observed:

“We’ve had to resort to prohibition notices on three occasions, a style that we’ve adopted from our Environmental Health work.” (LA 3)

and LA 10

“We try to persuade but with our background in prosecution we will take them to court if necessary.” (LA 10)

Whilst enforcement is likely to achieve conformity with written standards it is less likely to achieve cultural change. The lack of participation of the Clubs in discussing safety matters will also provide a block on the transfer of relevant knowledge, making cultural change and organisational learning less likely.

### **6.3.2 Consensual Approach: Local Authorities**

The second pattern that emerged was more consensual in approach. This does not necessarily mean that coercion was not used, as the following comment by LA 1 suggests ( the only respondent from an ‘enforcement department in this group):

“I aim to use goodwill and I try to avoid laying the law down but the Club has to know that if necessary these rules will be imposed” (LA 1)

LA 6 referred to the SAG as the team stating that

“The team works well. From time to time it raises the hackles of some people but it is a very useful way of bringing safety issues to the Club’s attention - the Club are very responsible and genuinely want to get it right” (LA 6)

Other respondents in this group also used the word team to describe the SAG, (LA 2, LA 6, LA 8, LA 9, LA 12, LA 13) indicating a positive working relationship between the various agencies and Clubs that belong to it. Five of the respondents were keen to emphasise that despite the team relationship there were no cosy arrangements and there had been heated debates and disagreements as LA 6’s ‘raising the hackles’ suggests. The favoured means of compelling action was through manipulation of the so called ‘S’ or Safety factor. Briefly the S factor is produced by the regulatory agency as an assessment of safety management practice.

It is used to weight the technically derived stand or terrace capacity, from 100% to zero. Thus the Local Authority can determine the safe, maximum capacity of any part of a stadium, taking into consideration the quality of safety management practices<sup>1</sup>. It is less confrontational than enforcement notices because it is derived from a recommendation of the Local Authority that is discussed at SAG where it can be explained in detail to the relevant Club. LA 2 identified that they aimed to develop the safety management side through the application of the S multiplier, to draw to the attention of Club directors the importance of a safety culture.

The consensual approach is founded on the operation of the SAG as a team. However, bearing in mind the reluctance of Clubs to invest in physical infrastructure and safety management, it is not without teeth. It differs from the punishment-centred approach in its emphasis upon discussion and persuasion. The regular attendance of all Clubs to these SAG meetings provides an indication of its greater success in maintaining the awareness of Club executives with regard to safety management.

In summary, it is difficult to be certain whether the intransigence of the Club or punishment-centred approach comes first. However, the correlation between the types of department (Environmental Health, Legal Services and Trading Standards) and their routine practices and procedures suggests that an adversarial approach is not as successful as a consensual approach in achieving change. Analysis of the Clubs did not provide any evidence that the four punishment-centred Local Authorities had to deal with particularly poor safety practice.

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<sup>1</sup> Safety Management practices refer to elements including the quality of stewards recruited, their training, the attitudes of the Club towards equipping them, etc.

The obvious commitment of the Local Authorities to the promotion of higher standards, despite their different methods, does represent a significant change from the pre 1989 period in which regulatory action appears to have been the exception rather than the norm. The reference to manipulation of the S factor, (to encourage higher standards in areas such as the quality of stewarding), is evidence of a shift from a purely technically focused approach to improving stadium safety and is thus indicative of a significant cultural change. However, one weakness identified by seven respondents concerned their lack of expertise in all the areas relevant to stadium safety management. A lack of relevant training or other support facility was identified as the major cause of this weakness. This raises questions about the 'pigeon holing' of responsibility for stadium safety with one group of 'experts' ignoring the necessity for input from a variety of disciplines.

In conclusion, the activities of Local Authorities appear to provide a powerful push on football Clubs to raise standards. This thesis now turns to an analysis of a survey of football Club safety officers.

### **6.3 Statistical Data Analysis Methodology**

The purpose of the survey of football safety officers was twofold. First, it sought to elicit specific information regarding safety management systems before and after the Taylor Report. Second, it aimed to identify the levels of crisis preparedness within the football industry by examining the attitudes of respondents to a number of statements. The primary source for the second part of the Football Safety Officers' questionnaire was Pauchant & Mitroff's (1992a) interview survey of 410 companies in the United States, Canada and France. The results of this analysis were used to formulate a diagnostic questionnaire to be used to help assess the proneness of organisations to crisis. That is, the questions included within the

diagnostic tool were derived directly from the responses of interviewees. Pauchant & Mitroff (1988, 1992a) reported that the diagnostic questionnaire was developed to provide indicators of the seven defence mechanisms and groups of rationalisations in a format relevant to crisis management. This diagnostic tool was, therefore, well grounded empirically. Fifteen statements (see table 6.4) were selected and reworded for a UK, football industry audience. These fifteen statements were selected to provide coverage of the seven defence mechanisms and the four groups of faulty rationalisations identified in the source questionnaire. Four additional variables were added as indicators of the eighth defence mechanism identified in this study (i.e. displacement).

The selection of individual variables was constrained by the need to cover the 'dimensions' identified by Pauchant & Mitroff (1988, 1992a) and the ratio of five cases to each variable recommended by Gorsuch 1983 and Hair et al 1984. Bryman (1997) observed that as a minimum there should be more cases than variables but that the lower the ratio between the two, the lower the confidence in the results. With a total target population of 113 (112 soon after dissemination of the survey) even a very high response rate would only just meet this particular criteria. However, this sample represents 65.5% of the total population of professional football Clubs, providing greater confidence in replicating the study and results than if it represented a smaller proportion of the total population as so many samples do. Hair et al (1984) suggest a stricter interpretation of results when smaller samples are employed, illustrating that despite the usual advice, that factor analysis can be used on smaller samples. Given these observations and potential weaknesses of this study, more stringent criteria were used for the selection of factors to be further examined.

There have been some criticisms of the 'simplistic' use of factor analysis. Gould (1988) argued that even positive correlations and a strong first principal component can not be reified as a 'thing' without convincing, independent information beyond the fact of the correlations themselves. Bearing this criticism in mind, the context for the use of factor analysis in this study was to triangulate the data within an essentially qualitative methodology. Although superficially the use of qualitative and quantitative data collection and analysis techniques differ, grounded theory and factor analysis have much in common. Both are a means of data reduction. In both instances the design of the instruments to collect the data plays an important role in determining the final factors or categories identified. The design of this whole research project played a vital role here in counteracting the potential for the final results to be simply fitted around the analytical framework. Grounded theory, as explained in Chapter 3, was deliberately used in a creative way to avoid reaching conclusions prematurely. Additionally, the combination of elements of Pauchant & Mitroff's (1992a) questionnaire with elements emerging from the semi structured interview data was used to ensure that this study drew not only upon the available literature but from material collected within the industry.

A pilot of the questionnaire with five Club executives indicated that a full version of the questionnaire (100 questions) would be unacceptable and unlikely to be returned by safety officers. A further difference from Pauchant & Mitroff (1988,1992a) was that their questionnaire dealt with all types of crises whereas the context for this study was 'safety management,' and inevitably respondents focused upon their efforts to prevent crowd disasters. The evidence of this survey questions Pauchant & Mitroff's (1992a) implicit hypothesis regarding the structure of

	Football Safety Officers Questionnaire	Pauchant & Mitroff (1992a)	Onion Model
Q45	We can handle any crowd incident	We can handle any crisis	Level 1 (grandiosity)
Q46	A major tragedy cannot happen in our ground	This will not happen to us	Level 1 (denial)
Q47	We now do enough in safety management	We do enough already	Level 1 (disavowal)
Q48	Disasters just happen we cannot prepare for them	Crises happen by fatality; we cannot prepare for them	Level 1 (Fate)
Q49	Only badly managed Clubs have crises	Only bad companies have crises	Level 1 (intellectualisation)
Q50	Crises are usually caused by the mistakes of a few people	Crises happen by the wrongdoing of a few rotten apples	Level 1 (splitting)
Q51	A crisis has one or two main causes	A crisis always has one or two major causes	Level 1 (splitting)
Q52	We do not have time to fully prepare for crises	We do not have the time	Level 2, Group 3.
Q53	Well managed Clubs do not have crises	Excellent, well managed companies do not have crises	Level 2, Group 1
Q54	Extensive Crisis Management is a luxury	Crisis management or crisis prevention is a luxury	Level 2, Group 1
Q55	If a major crisis happens someone else will rescue us	If a crisis happens, someone else will rescue us.	Level 2, Group 2
Q56	Every disaster is so different that it is impossible to prepare for it	Each crisis is so unique that it is impossible to prepare for	Level 2, Group 3.
Q57	In a crisis our contingency plans will see us through	In a crisis situation we just need to refer to the emergency procedures we've laid down	Level 2, Group 4.
Q58	We will be able to react to a crisis in a calm and positive manner	We are tough enough to be able to react in an objective and rational manner	Level 2, Group 4.
Q59	Our communications systems are sufficient to deal with a major incident	We are a team that will function well in a crisis	Level 2, Group 4
Q60	The police are responsible for public safety.		Level 1 (displacement)
Q61	The police should, normally, have no role within a football ground.		Level 1 (non-displacement)
Q62	Hillsborough was terrible but current regulations are too much of a burden.	Displacement	Level 1 (displacement)
Q66	The enforcement bodies expect too much from football Clubs	Displacement	Level 1 (displacement)

Key: Table 6.4 Football Safety Officers' Attitudinal Questions

Level 2, Group 1 Properties of the Organisation

Level 2, Group 2 Properties of the Environment

Level 2, Group 3 Properties of Crises themselves

Level 2, Group 4 Properties of prior crisis management efforts themselves

organisational culture and the variables which underpin it. Table 6.4 identifies the questions that were included in our survey and includes the Pauchant & Mitroff statement upon which each was modelled.

When responses were received they were coded and entered onto the statistical package SPSS for Windows 95. Initially 1 was entered for strongly agree, 2 for

	Level 1	Level 2	Eigenvalue	% Variance explained
Pre-Factor 1	Q48, Q49, Q52,	Q53, Q54, Q55, Q56	3.43	18%
Pre-Factor 2	Q45, Q46,	Q57, Q58, Q59,	2.93	15.4%
Pre-Factor 3	Q50, Q51, (Q66)		1.93	10.2%
Pre-Factor 4		Q61, Q62,	1.46	7.7%
Pre-Factor 5	Q60		1.32	7.0%
Pre-Factor 6		Q58	1.08	5.7%
Pre-Factor 7	Q47		1.01	5.3%

Table 6.5 Preliminary Factors (variables in brackets indicate negative loadings)

agree, 3 for don't know, 4 for strongly disagree and 5 for strongly disagree. This was reversed for q48 which was set up differently from the other variables. R factor analysis was used to identify the latent factors within the data set. Seven factors had eigen values > 1.0., indicating that each explained more of the variance in the data than an individual variable (see table 6.5). Three factors explained more than 10 percent, each, of the variance. The other four explained more than 5 percent of the variance. These pre-factors are shown in table 6.5.

As a second stage, and in order to increase their 'interpretability', the factors were rotated orthogonally. The purpose of orthogonal rotation is to maximise the heterogeneity of factors whilst maximising homogeneity of variables within each factor (Hair et al 1984, Bryman 1997), rather like the process of market segmentation. The particular method adopted was a varimax rotation.

Given the ratio of 73 responses to 19 variables it was decided to exclude from the rotation those factors which had an eigen value below 1.25, given the earlier comments regarding the sample size and ratio of cases to variables. Within the factor analysis dialogue boxes of SPSS these parameters were set and varimax rotation undertaken. The factor-variable loadings are shown in table 6.6.

Given the small sample size and the exploratory nature of this research the guidelines for significant factor loadings at a 0.05 significance level, based upon sample sizes were used as guidance. With a sample size of 74 a factor loading of .65 is deemed to be significant (Hair et al 1984). Koutsoyiannis (1983) using the Burt-Banks test reported that loadings in excess of .302 (1% level, two tailed) should be deemed significant, taking into account the sample size and the number of variables. Accordingly, variables above and approaching 0.5 were included in the identification of factors suggesting a more rigorous standard than that suggested by Koutsoyiannis (1983) and approaching that recommended by Hair et al (1984).

Variable	Factor 1	Factor 2	Factor 3	Factor 4	Factor 5
Q45	.01783	<b>.78545</b>	.11535	.09184	.08579
Q46	.40399	<b>.53879</b>	-.01511	.26286	-.13240
Q47	-.11232	<b>-.40660</b>	.27547	-.32699	-.00274
Q48	<b>.54830</b>	.17444	.27053	.01453	-.08639
Q49	.11537	.13840	<b>.75596</b>	.15787	-.15976
Q50	-.00446	.07204	.20760	<b>.70871</b>	.11250
Q51	-.08521	.25039	.20089	<b>.68423</b>	.30873
Q52	<b>.54322</b>	-.40356	.25091	.01861	.11986
Q53	.10910	.04074	<b>.78640</b>	.07218	-.05179
Q54	.31337	-.30056	<b>.51612</b>	.27060	.07492
Q55	<b>.56223</b>	-.34208	.46220	.09522	-.13205
Q56	<b>.75506</b>	-.03229	.23645	-.01899	.24172
Q57	-.04756	<b>.75719</b>	.07283	-.07250	.16917
Q58	-.23100	.37838	-.21136	.00337	<b>.45811</b>
Q59	.10655	.40147	-.32474	.08002	<b>.59923</b>
Q60	.13110	-.07933	.00528	.07698	<b>.78563</b>
Q61	.11290	-.15113	.00685	<b>.66587</b>	-.43826
Q62	<b>.72316</b>	-.06752	-.22901	.25928	-.19947
Q66	<b>.71053</b>	.24497	.01022	-.18363	.13066

Table 6.6 Rotated Factors (Varimax)

Given the concerns of some authors (see Hair et al 1984, Rendall 1997) regarding the use of factor analysis with ordinal (as opposed to interval) data two procedures were used to check that the results shared some of the properties of interval data. First, the original scores of 1,2,3,4, and 5 were replaced with +2,+1,0,-1,-2 to check that an alternative, consistent, numbering system did not alter the factors identified. Although specific loadings altered slightly the same seven factors were identified with the same contributory variables. Second, the scores were reversed (1 to 5, 2 to 4 and vice versa). Although the resulting matrix and loadings differed in the specific detail, the same factors emerged providing greater confidence in the suitability of this approach for this study. It should be noted that the use of factor analysis was pioneered in the social sciences, particularly by psychologists in the early Twentieth Century (Gould 1988). There is therefore, a long tradition of the use of the technique with ordinal data. Additionally, the use of factor analysis in this study has complemented the extensive qualitative data collection. Factor analysis offers an opportunity for triangulation. This thesis now turns to a discussion of each of the five factors drawing upon data collected from the interviews, participant observation and documentary sources, to ensure that they are interpreted within a context of rich data.

#### **6.4 The Five Factors**

The discussion of organisational culture in Chapter 2 highlighted the consensus amongst many researchers that it is a complex, multi-level phenomenon. The crisis management and high reliability organisation literatures emphasise culture's key role in binding together the other elements of organisation. In the analytical framework (figure 2.1) it stands alongside communications, structure and

technical system elements. Pauchant & Mitroff's (1988, 1992a) Onion Model shares many features with the most influential models of organisational culture and behaviour (see Schein 1985, Hofstede 1990, Trompenaars 1993 and Hampden-Turner 1990 for example).

The five factors identified from this study suggest that the distinction between the levels of culture (or factors as Pauchant & Mitroff describe them) are not as they hypothesised. Pauchant and Mitroff (1988) and Mitroff et al (1989) have emphasised the importance of culture in determining the proneness of organisations to crisis illustrated by their Onion Model of Crisis Management (see Chapter 2), which shows the relationships between organisational culture, managerial beliefs and structure and behaviour (realised strategy):

"In actuality, there is an extreme overlap and interpenetration between the various factors that compose the levels such that it is extremely difficult to say precisely which circles ... are true subsets of which." (p273)

At the innermost, core level, are the fundamental beliefs that influence the way in which organisation or individuals process information collected for the decision making process. Four of the five factors from this study incorporated variable statements from both levels 1 and 2. Only factor 5 consists solely of level 1 variable statements. A model depicting concentric circles does not appear to reflect the complexity of the phenomenon observed. A net may better depict the relationships between these two levels. This is an area for further research and beyond the scope of this thesis which now turns to a consideration of the three main factors identified.

#### **6.4.1 Factor 1: Fatalism: Nothing We Do Will Matter!**

It should be emphasised that this was the most important factor to emerge from the analysis. The highest loading for this factor was the variable-statement,

“Every disaster is so different that it is impossible to prepare for”. The other statements that loaded on this factor concerned the attitudes concerning the nature of crises and the value of making preparations for them. The uniqueness of each crisis incident, their randomness or fate were key variable-statements. Additionally, two variable statements linked to displacement and concerning specifically the extent of regulation were linked, reflecting the view that fate cannot be legislated away. If it is going to happen then there is nothing we can do to prevent it. As P3 stated:

“That’s what disasters are, that’s what accidents are, the unknown happening without warning.”

Suffering a disaster may be a lottery no Club wants to win but is entered for automatically. The basic defence mechanism is fate leading to the faulty rationalisations that given the uniqueness of crises, we cannot prepare for them.

In the earlier discussion concerning the nature of the stadia disasters it was argued that they resulted from socio-technical failures. If this is the case then there

		Level	Rotated Loading	
Q48	Disasters just happen we cannot prepare for them	Level 1 Fate	.54830	
Q52	We do not have time to fully prepare for crises	Level 1 Time	.54322	
Q55	If a major crisis happens someone else will rescue us	Level 2 Group 2.	.56223	
Q56	Every disaster is so different that it is impossible to prepare for it	Level 2 Group 3.	.75506	
Q62	Hillsborough was terrible but current regulations are too much of a burden	Level 1 displacement	.72316	
Q66	The enforcement bodies expect too much from Clubs	Level 1 displacement	.71503	

Table 6.7 Factor 1: Variable Loadings

is a real opportunity for learning from them, at an appropriate level. Real learning requires individuals to rise above the specific detail and identify lessons at an

appropriate level of generality, as Toft & Reynold's (1992) isomorphic learning suggests. This factor is a vital indicator of the culture in which organisational learning takes place. First, a fatalistic view of the world undermines the practice of safety management. 'If it is going to happen, it is going to happen, there is nothing we can do. Second, the belief that each crisis is unique questions the value of analysing such failures, as it suggests that nothing of value can be learnt. A high score on this factor reflects the presence of powerful restraints upon organisational learning from crisis. An example of this 'fatalistic view' and a concern regarding regulation emerged from the interview data.

The capacities of football stadia has been significantly reduced during the last twenty years, well within the memory of many spectators and administrators. Memories of large, well behaved crowds were identified by a number of interview-respondents. These examples were used to indicate that current arrangements were too strict. S3 for example observed :

"We would all love to see the days when you look back, say at Wembley when they used to have those vast crowds, when there were no restrictions and everyone was good and sat quietly at the edge of the pitch and crossed legs, and kids at the front and no cages, no barriers, no anything."

Implicit in this statement is that 'if everyone were good;' then there would be no need for barriers and fences. F2 looked back to when the Kop held some 22,000 'safely' compared to only 6,000 in 1994, implying that current restrictions were too severe. S2 spoke of pressure from the directors who could remember a crowd of 50,000 without any problems and questioned the need to reduce the stadium capacity to below 20,000. P4 remembered a crowd of 51,000 (with 30,000 the current capacity of the whole ground) on one terrace, but of course 'They were better behaved then', repeating the perceived link between behaviour and current

'safety measures'. These rosy reminiscences highlighted an overriding view that much of the blame for stadium incidents could be placed on poor crowd behaviour. It is worth repeating that there was no suggestion of poor behaviour as contributory causes of either the Ibrox or Bradford disasters and its role in the Hillsborough disaster has been considered at length in Chapter 5.

If thousands of spectators could crowd onto a terrace, with minimal supervision and protection quite safely for many years then it follows that many incidents were random happenings. A concentration of incidents in the 1980s led to a search for a scapegoat, the poorly behaved spectator. The illusion of large crowds spectating safely in the first three quarters of this century is however, a fallacy. The evidence in support of this statement comes from the catalogue of incidents identified in table 1.1 and from a variety of anecdotal sources. The failure to routinely collect accident statistics from football matches means that a full picture can never be portrayed. Bale (1993) reported on the regular injuries to Liverpool spectators in the swaying and pushing on the Kop.

As table 6.8 illustrates, safety officer responses were predominantly in the safety and question mark zones, with 2 in the danger zone. These scores were computed by adding up respondents' scores on a 1 to 5 scale from strongly disagree to strongly agree. The safety zone includes those respondents with a total score for the six variable-statements of between 6 and 12. That is, they indicated disagreement with the statements. The question mark zone consisted of scores that indicated some element of uncertainty or agreement with the six statements. The danger zone indicated agreement and strong agreement with the statements. This method was used in our analysis of each of the five factors.

	Safety Zone (6 - 12)	Question Mark (13 - 20)	Danger Zone (21 - 30)
Premier Division	14	3	0
First Division	11	7	1
Second Division	7	5	0
Third Division	5	7	0
Scottish Premier & First Division	7	5	2
Total	44 (59.5%)	27 (36.5%)	3 (4.1%)

Table 6.8: Factor 1: Nature of Crises and Crisis Preparations

The results of the questionnaire data provided a contrast with the interview data. A seemingly interesting anomaly was ‘thrown up’ by the triangulated data. Table 6.8 indicates a less crisis prone profile than had been expected from the interview data. A plausible explanation for this is that the questionnaire data reports the attitudes of safety officers, a large percentage of whom were former police and fire officers. The interviews were conducted with Club executives, who combined a general responsibility for safety with many other administrative tasks.

This contrast suggests that there may be conflict within football Clubs regarding safety management. It indicates that those charged with the task of safety management are faced with some resistance to the introduction of new measures. Our earlier report of comments regarding the numbers of stewards and payment of travel costs lend support to this argument. Given this conflict within Clubs the presence of forty percent of respondents with scores placed in the question mark or danger zones demonstrates that a full cultural readjustment has not yet taken place amongst those charged with the task of championing safety management. It suggests that little cultural readjustment with regard to factor 1; if the Club as an organisation is the level of analysis (as opposed to the safety officer) then the figure of 60% represents an optimistic assessment.

This view is supported by the interview data in which a marked inability to consider alternative forms of crises was noted. One exception stood out. P3 commented:

“I’d hate to think that there is any Club in the country who will now say, well we’ve done everything Justice Taylor has recommended and we’re OK now, because I don’t think you can ever be in that situation... I mean I don’t know at three o’clock or quarter past three on a Saturday afternoon whether a tanker is suddenly going to come along \*\*\*\* Road and suddenly go through the boundary wall and explode, there are so many outside influences .”

continuing:

“all I can do is to try and train everybody, including myself that the majority of things we can do in a major incident scenario would be instinctive”

A prevailing view within the industry, expressed in the interview data, was that crises were unique incidents, thereby denying the underlying importance of systemic factors which have been identified as key within the crisis management literature (See for example, Perrow 1984, Shrivastava 1987, Pauchant & Mitroff 1989, Smith 1990a). Instead there has been a focus upon incident specific learning, based in part as we have seen upon the official regulatory response to issues. Thus, despite citing personal experiences of previous stadium fires F4 and S1 described the Bradford Fire as a freak accident. Explanations offered for the Bradford and Hillsborough disasters frequently revolved around simple cause and effect with a particular focus on the problems on the day, rather than a consideration of how the potential for crisis had developed over a long period before the incidents (See table 5.6, 6.9).

Table 6.9 summarises interview-respondents’ views concerning the main causes of the Hillsborough tragedy and of those groups held to have primary responsibility. The decision rules used to categorise the responses were based on the assessment offered by respondents. Clearly, much of the richness of the data is lost

in such a table. The problem is to balance the need for summary with the need to reflect the views of respondents. There are clear dangers of including only 'selective' statements that reflect the researcher's bias rather than the respondents' perceptions. To reduce such bias once the table had been first drafted interview data were re-examined to identify evidence contrary to that included within the table. Few revisions were necessary given the firm, and apparently fixed views of respondents.

A number of key themes from the data emerged. First respondents differed in their view of the causes of the Hillsborough tragedy with regard to whether they were complex or simple (see factor 5). For example P4 and S4 were unequivocal in their identification of supporter behaviour as the primary cause. Hooliganism was identified as one of the three basic explanations for the stadia disasters despite the evidence to the contrary. Similarly F3 accused the police of breaking the 'cardinal rule' and thus identified a simple explanation for the tragedy. Other respondents cited more complex causes, P3, F4, and T 4 for example. Typically, where complex causes were identified less equivocal responses were made. P3 uses 'perhaps', F4 and T3 begin their statements with 'I think'. Linked to their identification of causes were the allocation of responsibility. For P4 and S4 supporters were to blame, for F3 the police were held to be responsible. P1 placed responsibility with the Local Authority for not identifying the problem, providing further evidence of 'displacement'. Contrastingly, where respondents identified complex causes, responsibility was deemed to be shared between the various agencies and stakeholder groups involved. However, there was one notable omission from all responses. No one indicated that the owners of the ground,

Club	Primary Cause				Primary Responsibility			
	Ground Layout	Hooligans	Operational failures	Ill luck	Local Authority	Police	All agencies involved	Supporters
P1	***				***			
P2			***					
P3	**		**				***	
P4		***						***
F1		***	*					***
F2		***	*			*		***
F3			***			***		
F4		**	**	**		**		**
S1	**	**	**			**	**	**
S2		***						***
S3	-	-	-	-	-	-	-	-
S4		***						***
T1		**	**			**		**
T2	-	-	-	-	-	-	-	-
T3	*		**			**	**	
T4		**	**			**		**

Table 6.9 : Summary of views of respondents on causes and responsibility for Hillsborough tragedy

- |     |  |     |                                     |
|-----|--|-----|-------------------------------------|
| *** | Sole or primary cause                    | *** | One group with prime responsibility |
| **  | Secondary or one of a no. of key factors | **  | Balance of responsibility           |
| *   | Contributory                             | *   | Contributory (fleeting mention)     |

Sheffield Wednesday, contributed to the causes of the disaster or that they had any responsibility for the incident. In June 1996 the Sheffield Wednesday Football Club, its structural engineers and the South Yorkshire Police settled out of court claims made by police officers who had been at the Hillsborough Tragedy (Guardian 5/6/96). Even where complex causes were identified, responsibility was placed with a combination of police, government, Local Authority and supporters. Only T3's general statement about the failures of everybody concerned with the match organisation might be interpreted as placing some of the responsibility with the stadium owners.

This evidence supports the view that many key executives within the industry persist in the view that crises are simply 'acts of God' or that they have simple causes. Within the literature it has been suggested that such views will lead to a focus on technical solutions to problems (Canter et al 1989, Smith 1990a, Pauchant

& Mitroff 1992a, Toft & Reynolds 1992) rather than a system wide review. This view may be reinforced by the Local Authorities which have responsibility for ensuring conformity with the Green Guide. Data collected from thirteen Local Authority respondents indicated an ongoing emphasis upon technical issues. Only one Local Authority questioned the status of the Green Guide stating:

“Its just a guide. It recommends that an 1100mm barrier be erected around vomitories. We had one that was in the middle of a seating area and if we’d gone by the guide we’d have obscured the view of spectators. So we reclassified it as a stairway and had it at 900mm so that sitting spectators can see over it.(LA 2)

Although many identified the importance of developing a safety culture there was an acknowledgement that this would be difficult to achieve. Therefore, the first objective for many Local Authorities was to ensure that football stadia met the standards identified in the Green Guide.

#### **6.4.2 Factor 2: Complacency: Self Inflated Organisations**

Where factor 1 indicated the helplessness of Clubs in the face of disasters, factor 2 indicates a more optimistic assessment of a Club’s ability to deal with crisis incidents. This ‘optimism’ has been labelled ‘complacency’ because it reflects a high degree of self satisfaction, even smugness (q45, q46, q47). Variable-statement 57 suggests a high confidence in the value of contingency plans at times of crisis.

The variables that load upon this factor concern an assessment of how well respondents believed their efforts have either reduced the risk of crisis incidents occurring or enhanced their ability to deal with them. At level 1 the beliefs that any crowd incident can be dealt with (q45) and a major tragedy cannot happen here (q46) reflect the grandiosity and denial defence mechanisms respectively.

		Level		
Q45	We can handle any crowd incident	1 grandiosity	.78545	
Q46	A major tragedy cannot happen in our ground	1 denial	.53879	
Q47	We now do enough in safety management	1 disavowal	-.40660	
Q57	In a crisis our contingency plans will see us through	2 properties of cm efforts	.75719	

Table 6.10 Factor 2: Variable Loadings

As F1 stated:

“I suppose that when you assess the odds then it won’t happen, you know the number of disasters when you consider the number of football matches, its one of the safest past times isn’t it, it really is low low odds”

These beliefs are closely correlated with the rationalisation that the organisations have made adequate preparations (through contingency plans) to deal with any incident.

Each variable-statement provided an indicator of a mindset of complacency, which Taylor (1990) described as the ‘enemy of safety’. This "mindset" will determine the range of policy options considered. For example, Taylor (1990) reported:

"Amazingly, complacency was still to be found after Hillsborough. It was chilling to hear the same refrain from directors at several Clubs I visited:-

"Hillsborough was horrible - but, of course, it couldn't have happened here."

Couldn't it? The Hillsborough ground was regarded by many as one of the best in the country." (p4)

This complacent assumption indicates a mindset that will not place importance on Clubs financing improvements to the layout of their stadia. At times of financial hardship, available moneys are more likely to be spent on team improvements, given this key assumption and the finding by Arnold and Benveniste (1988) that playing success is the most important objective for Clubs. The continued use of stairway 13 at Ibrox despite three serious incidents, the poor housekeeping at Bradford despite

warnings over a period of at least five years are both indicators of the low priority given to ground improvements and accordingly to crowd safety. Both suggest 'denial' argued to lie at the core of the Onion Model (Pauchant & Mitroff 1992a). That ground safety is viewed by Clubs as simply a question of fulfilling legislative requirements is demonstrated by Popplewell (1985) :

"There seems to be a general view that the Green Guide has no application unless the ground is designated. Nothing could be more misconceived. I recommend that the next edition of the Green Guide should make it clear that it applies to all sports grounds, not simply those designated." (p30)

The football industry, based upon the evidence from the official inquiries, has a tendency towards complacency, which has acted as a constraint upon active learning. With regard to organisational learning a high scoring on this factor indicates that the organisation has already reached an endpoint. It has the skills and resources to deal with anything and this may act as a justification for looking no further at possible improvements. Examples of elements of this factor can be found throughout our analysis in Chapter 5. Disavowal (q47), the downplaying of the importance of a recognised threat, can be seen in the persistent reluctance of football Clubs to invest in new stadia and safety stewards. The outright denial (q46) that a tragedy might occur, as expressed in the comment 'it couldn't happen here' and feelings of grandiosity (q45), 'we can deal with anything' was noted during observations of stewards at P2, F1, F3 and S3.

A high score in this factor indicates assumptions about the value of crisis preparations that is at odds with the evidence presented in Chapter 5. Communication systems, technical and social, were inappropriate in each crisis incident. Confidence in contingency plans is also misplaced as is the assumption that they will be able to respond in a calm and confident manner. Questions, 45, 46

and 47 all correspond to complacency, a high score on these variables indicates a high degree of complacency and a misplaced confidence in the value of pre-crisis preparations. Table 6.11 indicates that all respondents, with one exception, lie in either the question mark or danger zone.

As table 6.11 shows only one respondent scored within the safety zone. The remaining seventy two Clubs were split between the question mark and danger zones by a ratio of 2:1. This indicates that the football safety officers, champions for safety management practice, have not undergone a major cultural readjustment.

	Safety Zone (4 - 8)	Question Mark (9 - 13)	Danger Zone (14 - 20)
Premier Division	1	12	4
First Division		11	8
Second Division		12	0
Third Division		7	5
Scottish Premier & First Division		7	7
Total	1 (1.4%)	49 (66.2%)	24 (32.4%)

Table 6.11: Factor 2 Assessment of Crisis Preparedness

Given the recent history of high profile disasters it begs the question, what will cause a full cultural adjustment.

An incident that occurred in the course of this study reveals the fallacy of this attitude. The scenario concerned direct observations of crowd management during an FA Cup tie between a Premier and a Second Division Club. As a relatively unattractive tie parts of the ground were empty. With two minutes of the match remaining the home (premier) team were losing 0 - 2. Many spectators left early. Two late goals however, took the tie into extra time. The cheers that greeted the two late goals attracted many spectators to attempt to get back into the ground. The gates were locked and a crush ensued. The chief steward, who despite wearing a radio head set, was unable to hear clearly the Safety Officer who was trying to alleviate the problem. He ran from one side of the ground to the other and managed

to get outside where the crush was developing. He kept having to move so that the he could use his head set, which because of a combination of poor signal and background noise was hardly audible. He was also threatened by some of the supporters who recognised the insignia on his stewards jacket. He was unable to deal with the problem. Only quick thinking by a small group of private security guards, acting on their own authority, who opened access to an empty part of the ground, avoided the real threat of serious injuries. If the ground had been full that night this action would not have been possible. The communication systems were not adequate that night and they were amongst the most reliable observed in the course of this study. The contingency planning process had not considered the possibility of thousands of spectators trying to get back into a ground to watch the end of a match for which they had paid. The external Tannoy system was not loud or clear enough to communicate with the returning fans. As a low risk fixture there were few police officers present. This incident was a near miss. Occurring as it did outside the ground none of the media were aware of the incident, nor were the relevant safety advisory group.

The high levels of complacency identified in table 6.11 support our hypothesis that no major cultural readjustment has taken place. The high percentage in the questionmark zone may reflect improvement since the pre-1989 period. However, the uncertainty that it indicates and the usually part time role of the football safety officer is indicative of higher levels of complacency within the administrative and board structures of football Clubs.

#### **6.4.3 Factor 3: Who suffers crises**

The variable-statements which load highly upon this factor relate to the link between the properties of organisations and their propensity to crisis. A high score

indicated an attitude that only badly managed Clubs had crises. Well managed Clubs, this factor suggests, do not need to invest in crisis management efforts. Within the football industry many Clubs indicated that they had exceeded their licensed capacity on terracing, due to particular problems.

Q49	Only badly managed Clubs have crises	.75596
Q53	Well managed Clubs do not have crises	.78640
Q54	Extensive Crisis Management is a luxury	.51612

Table 6.12 : Factor 3 : Variable Loadings

Three quarters of respondents scored within the safety zone, with a further 22% scoring in the question mark zone. This indicates that the majority accept that crises can happen to anyone and that therefore crisis management is not a luxury. This is an important finding because as the various tragedies have shown it is not the Clubs alone that create the potential for crises. Many agencies and bodies may be involved.

	Safety Zone (3 - 6)	Question Mark (7 - 10)	Danger Zone (11 - 15)
Premier Division	13	4	0
First Division	15	4	0
Second Division	10	1	1
Third Division	8	3	1
Scottish Premier & First Division	8	4	2
Total	54 (73%)	16 (21.6%)	4 (5.4%)

Table 6.13: Factor 3 : Assessment of Crisis Preparedness

Much of the focus so far has been on the stadia and the Clubs themselves that hosted the disasters. The involvement of other parties, however, must not be overlooked. The failure of the various inspection bodies to follow up expressed concern prior to the Bradford fire or the allegedly lax inspection of Heysel by UEFA officials are examples of a 'crisis of management' that goes beyond stadia managers themselves. Problems of communication may be relevant here, for example the failure of the HSE to communicate their worries about the Bradford Stadium to the fire brigade. The different configurations or structures of these organisations may also

impede communication between them and their ability to act. Thus because the Green Guide stated that a fire hazard was a matter for the fire brigade, officials from the HSE did not feel it necessary for them to take responsibility for a problem which they had identified. This might be viewed as the actions of a bureaucracy which does not encourage its officers to use their initiative but rather encourages them to follow the prescribed procedures. This problem may be further exacerbated by the existence of dual responsibility for ground safety:

“It is clear from the foregoing that Mr. Laird (HSE) was doing no more than following the directive from his department. It does however, highlight the problem of dual responsibility. There is a serious risk of duplication of work, resulting in a waste of resources. There is also a risk that information available to one Authority responsible for safety will not reach another Authority” (Popplewell 1985, p24)

Sheffield Wednesday was considered to be an example of good management practice prior to the Hillsborough stadium (Inglis 1996).

#### **6.4.4 Factor 4 : Confidence regarding our Crisis response**

The variable-statements that loaded highly upon this factor reflect the confidence a respondent has regarding the ability of their Club to cope with crisis incidents. The evidence presented in Chapter 5 regarding the aetiology of each of the crisis incidents highlights that it is unlikely that any response will be cool, calm and confident. Nor does it appear likely that communication systems will be adequate to meet the needs of a major incident. The inclusion of q60 (displacement) with a high loading on this factor suggests that at times of crises it is expected that the police will assume control. Note that the George (ACPO, 1993) report has emphasised an advisory role only for the police inside football stadia with the ultimate decisions to be made by a Club representative in England and Wales.

Q58	We will be able to react to a crisis in a calm and positive manner	.45811
Q59	Our communications systems are sufficient to deal with a major incident	.59923
Q60	The police are responsible for public safety.	.78563

Table 6.14 Factor 4: Variable Loadings

A high score on this factor indicates a misplaced confidence in the ability of many organisations to deal with crises, an argument reinforced by the analysis of Chapter 5. Table 6.15 illustrates that only two respondents fell within the safety zone with the remainder in the question mark and danger zones. The scores for Scottish respondents were the highest, an observation in part explained by the leading role of the police force in Scottish stadia.

	Safety Zone (3 - 6)	Question Mark (7 - 10)	Danger Zone (11 - 15)
Premier Division	1	13	3
First Division	0	15	4
Second Division	0	11	1
Third Division	1	10	1
Scottish Premier & First Division	1	3	10
Total	3 (4.1%)	52 (70.3%)	19 (25.6%)

Table 6.15: Factor 4 Assessment of Crisis Preparedness

Some 97% of respondents scored within the question mark and danger zones reflecting a high degree of 'crisis proneness'. As for factor 2 these scores are all the more alarming because they suggest a high degree of optimism in the ability of Clubs to deal with crisis incidents. An optimism which is refuted by the evidence collected regarding the four main stadia tragedies. Additionally the response of Local Authorities indicated that whilst there have been many technical improvements to stadia there is still much room for improvement to safety management practices such as stewarding. Eight Local Authority respondents reported examples of malpractice during matches ranging from too few or untrained stewards [LA 2, LA 3, LA 5, LA 7, LA 10, LA 11,], no emergency lighting [LA1,],

and lack of emergency exits [LA 6, LA 7]. Most notable are the concerns regarding the quality of stewards. This contrasts sharply with the views of Safety Officers whom indicated a high level of satisfaction with their stewarding arrangements.

Table 6.1 indicates that the Premier and First Divisions are more satisfied with the quality of stewarding, although there is virtual consensus that all stewarding is at least adequate. A survey of police match commanders (Middleham 1993) reported that almost a quarter of Clubs had stewarding that was less than satisfactory (see table 6.17). A different perception can be identified with

	Very Poor	Poor	Just Adequate	Adequate	Excellent
Premier			0	8	9
First			1	13	5
Second			0	8	3
Third			2	7	3
Scottish			2	10	2
Total			5	46	22

Table 6.16: How would you define the quality of your stewards now: Perceptions of Safety Officers on Stewarding Quality

Safety Officers expressing greater confidence in the ability of stewards than police observers, suggesting some complacency .

	Police Commanders	Safety Officers
Very Good	7.8%	29.7%
Good	31.1%	62.2%
Satisfactory	37.8%	6.8%
Not Good	20.0%	0.0%
Poor	3.3%	0.0%

Table 6.17 : Perceptions of the Quality of Stewarding in the post Hillsborough Period  
Source Middleham (1993), Survey Data (1994-6)

Notwithstanding this criticism it is apparent that there was wide agreement that the quality of stewarding had improved since 1989, with 95% of Police Commanders indicating significant changes. Also 67% of Safety Officers reported that pre Hillsborough stewarding was poor.

Complacency is however, one of a number of factors (Turner 1976, 1978; Smith 1992a), although it is argued that it plays an influential role in determining a range of

behaviours. Bradford City AFC was faced with bankruptcy twice in the twenty years prior to the tragedy. The cost of improvements, given the limited financial resources and priorities of the Club, meant limited maintenance of and improvement to the ground. The dilapidation of the Heysel stadium reflected many years neglect. At Ibrox, replacement of stairway 13 required significant investment. The deaths of sixty six spectators must have helped increase the priority of such investment, although not for some six years. Piecemeal improvements to the Leppings Lane end of the Hillsborough stadium must also be in part attributable to the shortage of financial resources. The cost of redesigning the entrances to allow turnstiles to service specific pens was no doubt considered to be prohibitive before the tragedy. The effects of tragedy may be to challenge some of the key assumptions which, subconsciously perhaps, underpin all management decisions. Finances for new stands and layout improvements may suddenly be available as their priority becomes only too evident.

From the evidence included, it is clear that the potential for crisis existed for a number of years prior to each incident. In particular the incidents on stairway 13 between 1961-9, the warnings to Bradford AFC 1980-5 and the 1981 near miss at Hillsborough provide evidence of warnings up to ten years before the major accidents.

Problems of communication tend to come to the forefront during disasters. The configuration or structure, determining how work is co-ordinated is critical here. Where organisations co-ordinate by contingency plan, communication needs are determined by two key factors. First, the relevance of the original plan to the crisis circumstances and second, the familiarity of individual operatives with the plan. Assuming a close correlation, communication between individuals and central control may be minimised leaving the central co-ordinator time to devote to management of the whole incident, liaising with other agencies rather than management of the small

parts. Contingency plans may be seen as the product of organisations used to a fairly simple and stable environment trying to make sense of the unknown. Individuals are expected to carry out duties in accordance with the plan. As the lives of others may depend on each person undertaking his assignment in a prescribed way, as is the case with the Fire Service, little scope for the use of initiative is allowed. Organisational structure and culture will reinforce this creating environments which do not reward such behaviour. Clearly such organisations are likely to face serious difficulties at times of crisis which do not correlate closely to the contingency plan. This contrasts sharply with a training scheme organised by the Scottish Police Service which has created a simulation scheme which enables officers to develop a wide range of skills which may be applied in a range of situations rather than confine them to strict contingency plans.

At Hillsborough, permission to open gates to the pitch was required from the central control. It is difficult to determine how long a PC waited for authorisation before opening the gate to pen 3 on his own initiative. A reliance on control and co-ordination through a central point of authority, requires excellent communications which often are not available for the duration of a crisis incident. Otherwise there is a danger of information overload meaning that the central control fails. This problem will often be exacerbated by communications failures:

"Mr. Greenwood's request for the match to be stopped and various messages from Constables reporting the distress in the pens did not register. Likewise, communication from Leppings Lane to control was unreliable. Undoubtedly these breakdowns made it more difficult for those in command to make proper assessments and exercise effective command." Taylor, 1989, p54)

The failure of Mr. Duckenfield to take control of the co-ordination of the rescue from the pens suggests the serious problems within the control room.

The limitations of police radios, the level of background noise and finally an attempt to use hand signals indicate the difficulties of communicating in circumstances such as these. The need, however, for central co-ordination is displayed, by the request of the Officer outside the ground to open the gates. Someone with a knowledge of circumstances inside and outside was needed to make an effective decision.

The issue of communication may also refer to the crowds themselves in situations such as these. All four disasters occurred with crowds in what might be described as complex spaces. Canter (1989) argues that it is not simply the weight of these crowds that causes crushes but:

" The communicative and behavioural inertia, which means that once a crowd starts on one course of action it is slow to react to circumstances, partly because of difficulty in passing information all the way from the site of the danger to the fringes. Typically, those at the back of such a crowd never realise how dangerous conditions have become at the front." (p88)

The need for excellent monitoring of such crowds and the need to ensure effective communication to them is clear. The need for good quality public address systems which can be accessed by those co-ordinating either the control or the rescue function is imperative. At Ibrox and Hillsborough the predicament of those caught up in the middle of the crush is clearly not comprehended by those on the edge of it. Quick communication might have played a part in reducing the number of casualties. At Bradford effective use of a PA system might have marshalled people more quickly and encouraged them to find proper exits. However, the effectiveness of the communication lies in part, in the ability for spectators to hear the message and the ability of the co-ordinator to give meaningful direction.

Correlational analysis indicated a positive correlation between country and factor 4 (.577, significant at the 0.000 level, 2-tailed test). This finding was

supported by the interview data. SC1 suggested that Scottish Clubs had traditionally managed their resources better than their English counterparts, largely owing to the perceived dominance of the two Glasgow Clubs and the futility of attempting to match them. SC2 and SC3 both reported that they did not have to undertake any work following Hillsborough because they already conformed to their safety certificate. SC3 however, reported that the executive with responsibility for safety had had to threaten resignation in order to get adequate support from the Club.

#### 6.4.5 Factor 5: Causes of crisis

This factor can be interpreted as relating to ‘the causes of crisis,’ with the statement “crises are usually caused by one or two people’ and ‘a crisis has one or two main causes’ loading highly (see table 6.18). This factor corresponded closely with Pauchant & Mitroff’s (1992a) ‘Splitting Defence Mechanism’.

It has been argued that the disasters represented socio-technical failures, a focus upon either simple causes or upon scapegoats is likely to reduce the scope for active learning from disasters. The evidence collected from respondents regarding the causes of the Bradford and Hillsborough tragedies suggests that football Club executives frequently focus upon simple causes.

		Level		
Q50	crises are usually caused by the mistakes of a few people	1 splitting	.70871	
Q51	a crisis has one or two main causes	1 splitting	.68423	
Q61	The police should normally have no role inside a football ground		.66587	

Table 6.18 Factor 5: Variable Loadings

The negative loading of q66 on this factor indicates that the more a respondent focuses upon simple causes, the less agreement there is that current regulation and

enforcement are adequate. A plausible explanation of this is that a belief in simple causes is linked to a belief that crises can be regulated away. Rotating this argument, where the causes of crises are perceived to be complex there is a perception that too much is expected of football Clubs who are only in control of one group of causal factors. Alternative explanations including the age and previous employment of respondents were also examined but no significant relationships could be identified.

	Safety Zone (3 -6)	Question Mark (7 -10)	Danger Zone (11 - 15)
Premier Division	4	11	2
First Division	7	11	1
Second Division	3	9	0
Third Division	1	9	2
Scottish Premier & First Division	5	9	0
Total	20 (27.0%)	49 (66.2%)	5 (6.8%)

Table 6.19: Factor 5: Assessment of Crisis Preparedness

Table 6.19 reveals the persistence of simplistic views of the causes of crises. Nearly 73% of respondents scored within the question mark and danger zones for this factor. This indicates that many respondents believe that crises have simple causes. With regard to our discussion of organisational learning this suggests that the football industry is not a fertile ground for isomorphic learning. In Chapter 1 the basis for an explanation of the stadia tragedies within a socio-technical framework was established. Smith & Sipika (1993) for example, argued that

"In a related process, culture and configuration combine to affect the decision and communication functions of an organisation and these factors interact with an organisation's history to provide a climate within which a trigger event can precipitate a major incident." (Smith & Sipika 1991, p8)

The crisis incident is child to the preceding crisis of management. Just as children are shaped by their parents, the crisis of management will influence the ability of the organisations involved to cope with the demands of the crisis event. The absence of

the Officer In Charge of the Gendarmerie at Heysel from pre-match briefings limited the effectiveness of his response during the crisis. Greater concern for security at the expense of safety, led to the locking of exits and removal of fire fighting equipment from the Bradford Stadium. The assumptions of management, a denial of risk (It can't happen here assumption) underpin these decisions.

While examples of the various 7C's may be found having effect during the crisis, certain of them are regularly more critical. The coupling of events is often visible in crises: at Hillsborough, the poor layout at the Leppings Lane, the signs focused on the tunnel to pens 3 and 4, overcrowding aggravated by a further influx of fans through the open gate. Failure, at the time, to appreciate the links between the gate, tunnel and overcrowded pens was in one sense the cause of the tragedy. Poor co-ordination from the control room by failing to communicate the effects of opening the gate was also evident. Crises have complex, systemic causes. An attitude that they have few and simple causes will determine that a simplistic approach to prevention (if any) will be undertaken.

### 6.5 Crisis Prone or Crisis Prepared

A profile for the football industry as a whole on these five factors is shown in table 6.20. The table highlights that respondents scored lowest in the two factors that related to 'complacency' (factors 2 and 4). Analysis indicated the failure of

	Safety Zone	Question mark zone	Danger zone
Factor 1	44 (56.5%)	27 (36.5%)	3 ( 4.1%)
Factor 2	1 (1.4%)	49 (66.2%)	24 (32.4%)
Factor 3	54 (73.0%)	16 (21.6%)	4 ( 5.4%)
Factor 4	3 (4.1%)	52 (70.3%)	19 (25.6%)
Factor 5	20 (27%)	49 (66.2%)	5 ( 6.8%)

Table 6.20: All Factors : Assessment of Crisis Preparedness

regulation to promote high standards of safety in football stadia. Despite increased regulation, the industry appears to have remained prone to crisis. The factors

derived from our analysis have provided substantial evidence to support the hypothesis that no major cultural readjustment has occurred since 1989. There may have been some shift, but in the wake of four high profile disasters the industry can not be placed in the crisis prepared category.

Chapter 5 indicated a long tradition of self-centredness within the football industry that included: a refusal to contribute to earlier reports; a reluctance to consult with their spectators; the negative views expressed by respondents regarding outside agencies. This Chapter has provided evidence of a fatalistic view of the world as well as the ongoing use of a variety of defence mechanisms. The evidence presented above indicates that levels 1 and 2 of Pauchant & Mitroff's Onion Model are closely linked, with our factors reflecting elements of both. The high levels of complacency are perhaps the most worrying. Although much has been done with regard to investment in new stadia build it is clear that the promotion of crowd safety still requires much attention.

#### **6.6 Levels 3 and 4: Organisational Structure and Strategies**

Although Pauchant & Mitroff (1992a) relate the outer skin of their onion model to plans, mechanisms and procedures for crisis management, the routine administration and management of the Clubs shall be considered here alongside the results of the direct observation of the management of a number of events. The context in which safety management decisions are taken cannot be separated from the day to day management of the Clubs. As Chapter 4 argued, Clubs do not squander resources on administration and support services. As many safety officers are part time or combine this role with duties, a part of the safety management task will often fall to the senior administrator. The analysis and discussion of factors

suggests that there is some conflict between safety officers and their Club executives.

#### **6.6.1 Scope of Responsibility of Club Secretaries and Planning**

Two key themes emerged in the course of the interviews concerning business practices. The first concerned the range of tasks with which the Club secretary had to deal with. The second concerned planning. These two themes proved to be closely related as respondents indicated that a heavy workload with wide ranging responsibilities prevented them from considering the future adequately. This view was supported by the findings of the 1966 PEP Report which identified that the key performance indicators used to assess managerial performance in football were short term focusing on immediate playing success:

“The manager’s position is thus perilous as long term policies, in particular team building and ground improvement may be sacrificed in favour of the team’s current performance”[p123]

Such a view was supported by our respondents, P1 for example, commented that the Club was:

“Better managed now, but before, I didn’t have enough time to concentrate on the issues that really mattered because you’re bogged down with the day to day issues”

The other Premier League Clubs also indicated significant changes including the appointment of more administrative and support staff and a redistribution of responsibilities allowing the secretary (or chief executive) to devote more time to planning issues. One result of this was that now budgets were prepared on a variety of scenarios from good to bad. For example, P4 reported:

“We have three lots of cashflow each year, and you’ve got to base scenarios on the worst.”

P3 indicated that increasingly those who had the title 'Club Secretary' were legal officers and that many of the duties associated with that post had been re-allocated to 'Chief Executives'.

The picture that emerged from the lowest two divisions, as described in Chapter 4, was very different. Responsibility for safety management lay with the Club Secretary or Chief Executive for whom it was one amongst a number of responsibilities. Comments, already reported, depict these individuals as continually striving to balance competing, and sometimes conflicting, demands upon them. At one Club, LA3 reported that the Safety Officer was also the Club's odd job man and was usually to be found in his overalls. LA3 concluded that his dual role did little to enhance the status of the Safety Officer in the eyes of the Board of Directors. For T3, planning was limited to the re-signing of their best player to ensure that he could be sold for more at the end of the season. T4's prioritisation consisted of:

“Whoever shouts the loudest you do that next, there is no other more methodical way of doing it, you learn as you go on and if you're lucky you don't learn too often by your mistakes.”

The reluctance of Directors to invest more resources in administration and support was noted by two interviewees. S2 indicated a desire to appoint staff in preparation for promotion, directors wanted to wait until they achieved it before committing any resources. Five interviewees used the term 'jack of all trades' to describe their current role.

The explanation of the reluctance of football Clubs to respond to regulation and the problems posed to safety have hitherto focused on a 'crisis prone safety culture'. The study's findings indicate another factor, namely the time pressures upon administrators. Given the lack of resources and the immediacy of problems ranging from preparing for forthcoming events, contractual problems, lotteries,

responding to requests for information, dealing with financial matters, the Inland Revenue, ticket sales etc., it can be seen that unless rigidly enforced, regulations may be overlooked. Club Secretaries reported a lack of a proper job definition, (in practice even if they existed on paper), which mean that 'non-urgent' tasks, however important, were frequently 'forgotten'. In Popplewell's (1985) analysis of the causes of the Bradford fire the dire financial circumstances of that Club are posited as key. However, his analysis also shows how the Club had received a number of warnings concerning the build up of combustible waste beneath the main stand. Lack of finances certainly played a part but ironically the replacement of that stand would have begun the following Monday in preparation for the Club's newly acquired designated status. The greater division of labour, facilitated by investment in administrative and commercial staff, was identified as an important development by all Premier and First Division respondents. In the lower divisions, it was clear from responses, as well as from personal observations in the course of the interviews, that this greater task specialisation was not possible. For example, although interviews lasted for in excess of two hours, no interview with a Premier or First Division Club was interrupted by a telephone call. In contrast, with the exception of S1, interviews were interrupted an average of seven times and a number of other personal callers were either put off or the interview was halted for a few minutes.

Routine business planning also differed between the divisions. Seven of the eight senior Clubs identified that they planned between three and five years ahead with projections based on at least three separate scenarios. Only one of the lower division Clubs (S1) identified any such planning practice. S3's experience provides a clear example of the perceived problems of the lower division Clubs:

“No plans for next season because we might get relegated, so do we do something or don’t we and we can’t afford to redevelop the main stand because we don’t get the crowds, we don’t have the money. But obviously when we are forced to make a decision we will do.”

Despite the uncertainty of either relegation or promotion there can be few industries faced with the certainty of a minimum number of key income generating events. Fixed income from the league could form a part of any projection and the estimation of likely attendances following promotion or relegation could be estimated relatively easily, given the vast quantities of data concerning attendance.

### **6.6.2 Direct Observation Findings**

A key element of the research methodology was the use of mixed methods. As discussed in Chapter 3 a deliberate choice was made to focus upon a wide sample of football clubs rather than to produce a very detailed analysis of a smaller number of case studies. This trade off, inevitable in this research given constraints of time, was calculated in order to maximise an understanding of the industry as a whole. A case study approach may have allowed for greater understanding of a small number of cases but would have had limited generalisability. Direct observation provided a real opportunity to build upon the lengthy interviews and create a real picture of organisational behaviour. Where the use of interviews and questionnaires provided an opportunity to study individual perceptions of safety management and its practice, direct observation presented an opportunity to witness safety management in practice. As Denzin (1979) and Jick (1979) have argued, multiple methods, if reaching the same conclusions should offer greater validity. Hammersley & Atkinson (1983) suggest a more limited role for triangulation, that it may strengthen qualitative research findings by combining observation, interviewing and documentary analysis.

In all but two cases the observations took place between two and four weeks of the respective semi structured interview. In one case the observation occurred the evening before the interview (T1) without the invitation of the club; and in another case the observation occurred the evening following the interview (P3). With the exception of T1 (where I was not invited to the briefings) the observation followed a similar format. I arrived at the ground three hours before a match and met with the club secretary or chief executive. I was then introduced to the club safety officer or chief steward and to the Silver Command Police Officer. I attended the pre match briefings for both stewards and police and was provided with access to all parts of the ground including all spectator areas, match control room and back room areas. A typical visit provided an opportunity to listen to safety officer, chief steward and individual stewards describe their work, training and perceptions of their role. I was able to listen to police officers, from the most senior present to the constable stood on the edge of the pitch, describe their work and how things had changed post 1989. In a number of cases the local authority SAG chairman was present and I was able to listen to their description of their role and history of relations between themselves and the relevant club. When a match started I was typically assigned to a senior steward although I had freedom to wander around the ground observing practice. I made a point of walking around each ground checking upon the location of stewards, noting locked gates left unattended. In addition to these formal visits to clubs I made a number of informal visits as a member of the public and worked as a steward for two matches. These latter 'visits' might be described as full participant observation as I was to all intents and purposes a paid employee carrying out a covert investigation. For the other visits as a researcher I was on the periphery of interaction, a 'complete

observer' to use Junker's (1960) taxonomy (cited in Gill & Johnson 1992). For comparative purposes I also visited other sports stadia as a guest of the relevant body, the format for which were similar to those described above.

As discussed in Chapter 3 direct observation played a key role in examining the extent of cultural readjustment within the football industry. This presented an opportunity to witness actual behaviour and thereby complement the data collected in other ways.

A number of key findings emerged from the observations which supported the findings using other methods, thus enhancing confidence in the findings of this study. Attempts were made to look for evidence of cultural change in the behaviour of those with responsibility for safety management, behaviour identified as the outer layer of Pauchant & Mitroff's (1992) Onion Model. It should be noted that an attempt was made to get an overall sense of behaviour and the assumptions that underpinned it. However, in any organisation employing many people there will be a range of behaviours reflecting different values and beliefs. Individuals bring these to their work and organisations only in part shape the attitudes and behaviour of employees. This posed a particular problem illustrated by the inclusion of examples of bad practice below. A key question concerns the extent to which these examples accurately reflect the standard of management at the various clubs. The examples shown in this analysis, it is argued, are reflective of the general state of affairs. However, as already stated, organisations provide the focus for a wide range of individual and collective behaviours, the examples listed here are intended to illustrate some of the key characteristics, not to provide a comprehensive picture of each organisation which would be beyond the scope of a thesis such as this.

### 6.6.2.1 Covert Observation

Reflecting the opportunism that is vital to organisational research (Buchanan et al 1988) a chance remark from a student, who was casually employed as a private security steward at a football club, led to my applying to work as a steward for \*\*\*\* club. I arrived at the assembly point for this private security firm at 12.30pm one Saturday. I informed the relevant member of staff that I was at De Montfort University and wished to work as a steward. "No problem" was the reply and I was assigned to a unit of five staff which I later found to be responsible for monitoring and checking incoming spectators. I was issued with a high visibility jacket, received no pre match briefing apart from a few informal words from my supervisor and was told to stand in front of three turnstiles and to check that spectators had valid tickets. Ten minutes after the match kicked off I was sent inside the ground where I stood with ten other stewards between the home and away supporters. Of the eleven stewards I found through conversation that three had received some basic training (fire extinguishers and a video of Bradford) and that only one had been to the three two hour training sessions required by the Club. Many of these had worked for the security firm at this and other football grounds since the previous August (my observations occurred in March and April). My second visit, two weeks later, followed a similar format except that I spent most of the match alongside two other stewards where we had responsibility for monitoring a gangway and stairway amongst away supporters. From conversation it became evident that whilst training was available there was little encouragement for 'stewards' to take part; a situation they believed unlikely to change given the casual nature of employment and the shortage of individuals willing to work as stewards. From previous investigations I was aware that the club claimed to monitor steward

training closely. The stewards that I spoke to, who had worked at other grounds, suggested that this was not the case and that this laxity was not confined to this particular club but to others where they had worked. Apart from the observations regarding training it was obvious that there was no strict dress code. A number of the female stewards wore high platform shoes or boots, sufficient to impede their quick movement. Those inappropriately dressed formed a small minority of stewards, however, it became apparent that the decision regarding what a steward should wear was left to the individual, despite the comment from the steward who had attended the three training sessions that guidelines for dress had been given. Random visits since the covert observation indicate that a minority continue to dress inappropriately (Observation April 1998).

These observations indicated that steward training was not considered a high priority. The requirement, in each venue's licence, that a specified minimum number of stewards be present at any event encourages this laxity for those clubs that find difficulty in recruiting a reliable and regular group of stewards. For private security firms too, supplying the requisite number of persons is the first priority. The lack of monitoring of steward dress provided an opportunity for staff to wear inappropriate clothing. A contrary example was noted at Rangers FC where a private security firm was employed. The Club Operations Executive followed a fixed route of inspection, around Ibrox, for each game. First, to ensure that sufficient stewards were in attendance; second to check on the appropriateness of their dress (a formal dress code applied); third to talk to spectators. No examples of inappropriate dress were observed at Rangers. Stewards who were not dressed appropriately were informed of this and warned that a recurrence would result in a

termination of their contract. This warning was communicated, where appropriate, to a representative of the private security company.

#### **6.6.2.2 Overt Observation**

As Gill & Johnson (1992) report a potential weakness of overt observation is that people may behave quite differently when aware that they are under observation. Further, perceptions of reality reported by respondents will no doubt be influenced by a desire to create a favourable image. In this case stewards and police officers were used to being observed by various agencies, be it each other, FLA, local authority, or an FA representative. The presence of another observer did not appear to arouse any interest.

##### **6.6.2.2.1 General Observations**

The noise at pitchside level at all clubs was surprising despite my regular attendance at football matches. This posed real communications difficulties as stewards, those issued with radios (often a ratio of 1 radio to 6 stewards) sought a sheltered spot from which to communicate. P2 and P3 alone had issued headsets for staff to help overcome the problem of background noise and thus facilitate communication. The limitations of these systems were indicated by the need for the chief steward at P3 to walk from one side of the ground to the other to speak face to face with the Club Safety officer 'to hear it from the horses mouth', because of the difficulties he had in hearing instructions over the radio. As events at Hillsborough, Bradford and Ibrox have illustrated failures may spread very quickly reinforcing the need for quick and effective communications. The poverty of communications hardware, justified in part by their relatively infrequent use, observed at many grounds is a serious potential weakness.

#### **6.6.2.2.2 Attitude of Clubs to Safety**

Following feedback from the Chairman of P3, stewards were requested to remain out of sight of the directors box because the Club's Chairman was concerned about the expense of so many stewards and their equipment. The safety officer was compelled to employ a certain number of stewards because they were specified in the ground's safety certificate.

'Strict' no smoking policies were clearly flouted in eleven venues, including senior staff, for example the Deputy Safety Officer at P3 and the senior steward at S3, who appeared to chain smoke during the match. At these eleven venues many spectators were observed smoking in wooden stands. I did not witness one occasion when a spectator was requested to stop smoking. The clear flouting of the no smoking policy is an example of Gouldner's (1954) mock bureaucracy illustrating the persistence of this form of behaviour in the post 1989 period.

#### **6.6.2.2.3 Police- Club Relations**

Despite the idiosyncrasies in the relations between each club and police service patterns did emerge. At one extreme the match control room was called the police control room (P1, F3, S3, T1, SC1, SC2, SC3, SC4) and admission was only permitted if accompanied by a police officer. In each case, apart from the Scottish clubs, this reflected an obvious dislike and distrust between the agencies. In Scotland it was assumed that the police would oversee the management of crowds. The police expressed a concern that P1 was keen for the hasty removal of police officers from match duties with their replacement, by stewards, as a means of reducing crowd management costs by 75%. In 1994-5 each police officer attending a match might cost the host club up to £130, depending upon the pricing structure of the local police service. Stewards pay at this time was a maximum of £15 and an

average of £8.42 across all venues, P1 tended to the higher figure.. It was rumoured that the club safety officer's pay package included a large performance related element and that this was the primary motive in the removal of police, rather than concern for crowd safety. The police officer in charge described P1 as 'possessing a spiv mentality, a really unethical business practice which its seems all football clubs accept'. In other cases P2 and S1 the police and club retained their own control rooms relying upon technical means of communication in order to co-ordinate their activities. In the case of Rangers FC the police and club control room were located beside each other, facilitating informal, face to face communication and the Police officer in charge worked alongside the club's safety officer. In all other cases one control room existed for both club and police with one agency taking the lead role in managing the event. T3's chief executive reported that the police played no role and attended no matches, despite my own observation that two police officers appeared to control matchday operations (no club representative was present in the match control room). T3 refused to accept that police officers had been present. T3 reported that the police had expressed serious concerns about the quality of stewarding at the club.

The P3 safety officer reported difficulties in recruiting a regular 350 stewards and was thus forced, to some extent, to employ those who turned up to meet the requirements of the safety certificate. A number of the stewards commented that for two years it had been a job, not like before which I interpreted as meaning that stewards just used to turn up to watch the match.. P3 police expressed concerns about the clubs use of private security firm stewards. Although training was not explicitly identified as a key issue a major concern was the

presence of new faces each week and that the perceived high turnover of staff prevented the development of expertise amongst the stewarding force.

It should be noted that the time when these observations took place were during a period of transition, albeit change that was more developed in some clubs than in others. The George Report (1993), prepared for the Association of Chief Police Officer's by the Deputy Chief Constable of Manchester, supported the withdrawal of the police service from ensuring crowd safety inside football grounds. George (1993) argued that this should rest with the clubs themselves. It was clear that there was some resistance to this from some police forces who were concerned about the quality of stewards replacing fully trained police officers and the concern (P1) that financial considerations would take precedence over crowd safety.

#### **6.6.2.2.4 Steward Training**

Many of the stewards with whom I spoke had received some training. The content of the training appeared to consist of watching videos of the Bradford and Hillsborough disasters, listening to police and fire officers, being given a tour of the ground and being informed of the location and idiosyncrasies of fire extinguishers. Stewards at every ground complained however, that the variety of fire extinguishers used made it difficult for them to be certain that they would know how to operate them should the need arise. Where stewards expressed greater confidence in their familiarity with equipment such as fire extinguishers it emerged that they had a regular area of the ground for which they were responsible. A number of clubs monitored the training of stewards including primary and refresher (i.e. annual retraining). Failure to attend training would mean termination of their contract (P3, P4, F1). However, the Chief Steward (P3) reported that despite the appearance of

rigorous checks he had not had to weed out any steward, perhaps reflecting the difficulties the club reported in recruiting the numbers of stewards required by the safety certificate (note the steward who was missing from the locked fire exit identified earlier). P3 had also devised a detailed questionnaire to test how stewards would respond to a number of scenarios. The questionnaire details scenarios that include issues related to both crowd safety and control. P3, in addition to its own stewards, employed the private security firm that I had worked for. A number of the faces I recognised suggesting that untrained staff were also present at P3. F2 had introduced a written exam following the identification that a number of stewards could not read. F2 expressed that a key motivation to weed out these stewards was the fear that an inquiry, should a failure occur, would highlight any such weakness immediately.

#### **6.6.2.2.5 Stewards**

Underlying many of the discussions was the view that the emphasis of police and stewards upon control was because of spectator misbehaviour which had created an environment in which control was paramount. This was reflected at P1, F1, F3 and S2 with the employment of a ‘hit squad’ of stewards whose job it was to ‘sort out troublemakers. In both cases the team included a number of ‘ex-military who could handle themselves,’ according to their fellow stewards.

At S3, with the exception of one senior steward, the senior stewarding staff were clear that their role was to ensure crowd safety. A number of these stewards were employed by the local authority building control service which had the task of inspecting the football ground on behalf of the local authority. At all other grounds the perceptions of senior stewards were mixed.

Although many stewards fitted the recommendations included in Taylor's Report concerning age, fitness etc. a small proportion, up to 25% in some instances (for example, S4, T3,) were clearly outside the remit or inappropriately attired. For example, at P1 a number of the female stewards wore high platform shoes; S4 and T3 employed a large number of frail and elderly gentlemen. F3 had discovered that a number of stewards could not read the briefing cards with which they were issued. At each ground apart from P3, F4, S2, T1, T2, T3 unattended locked gates were observed in the course of the match. At P3 a fire alarm went off in the main stand. I walked with the Chief steward and found our entry to that area blocked by a locked door, also a fire exit. We waited for four minutes until the return of the steward who had been assigned to that particular exit. The steward had 'nipped off to get a coffee'. The steward let us through and we found that it was a false alarm. This message was then communicated to the Control Room who were waiting for information before contacting the fire service. No record of the incident was made and no further action taken apart from a light reprimand that I felt occurred only because of my presence. This was the only incident that I believed to happen because of my presence.

At S3 a case of ticket forgeries came to light and an extra 450 spectators were allowed into a standing area because no decision was made to close entry gates when the designated maximum number of spectators had entered the ground. The problems of overcrowding in that area (licensed for 3,300 spectators) were made worse by the presence of a blocked drain that flooded part of the terracing. At many clubs the rate of admission to a given area is slowed (usually through the closure of some turnstiles) as the maximum capacity for a given area is reached. The case of S3, where no problem were expected, illustrates that clubs may become

complacent. The absence of the safety officer, who had authority to close all entrances, at a critical time meant that there was no one to take that decision, reflecting again the role of club structure.

A final observation that involved all clubs concerned the primacy given to protecting the pitch. I checked every fifteen minutes to see whether stewards were watching an event or the crowd. At these check points, in every case (with the exception of Rangers) 75% or more, of stewards observable at any time, were watching the event. This changed at the end of each half when stewards would (except S4, T1, T3, T4) move to pitchside. At this point the majority of stewards would be observing the crowd and protecting the pitch. There were as a consequence very few stewards allocated to the exit ways. The case at P3 illustrates the dangers of too great a focus upon the pitch. The demeanour of P3 stewards at the end of that game also highlights a weakness of employing fans as stewards.

At Rangers, stewards would walk down the gangway for which they were responsible every ten minutes. This provided an opportunity for the safety officer to monitor their state of alertness. Rangers indicated that it helped focus the minds of stewards and reminded spectators of the presence of their stewards. Although F3 and S1 had similar systems, observations indicated that these did not work well and that many stewards ignored the instruction that they walk down a gangway every ten minutes.

#### **6.6.2.2.6 Mechanisms for ongoing learning**

There is no central agency tasked with identifying common problems. For example Ranger's reported the abandoning of a match some fifteen minutes before kick off. This caused problems because many spectators, unaware of the postponement sought to enter the ground whilst those already present sought to

leave, posing an unusual problem. A similar case emerged at P3 when an unlikely two goals in the last two minutes of a cup tie led to extra time. Supporters who had been leaving for some 25 minutes heard the cheer and sought to regain entry to the ground by the nearest entry, there being no system to allow for their readmission to their paid for seats. Additionally concerns regarding a possible pitch invasion meant that stewards were concentrated near the pitch side and away from exit gates where no difficulties had been anticipated. Additionally, stewards were visibly elated at the comeback from their team and appeared to be more intent on celebrating than upon watching the crowd or listening to instructions. Both scenarios, although unusual, were not unique and illustrate the unexpected problems that can beset those with responsibility of ensuring crowd safety. A system that collated and investigated such issues might provide feedback that enables managers to anticipate and prepare for similar eventualities. The case at P3 illustrates again the primacy given to crowd control over safety as exit gates had been left unattended to ensure sufficient numbers of stewards in case of a pitch invasion.

Mechanisms for ongoing learning however, are not restricted to formal forums. For example, a useful mechanism was observed at F3. At the end of the match the directors retired to their board room. Similarly the supervisory level of staff including ticket office manager, safety officer, stadium manager, groundsman, chief and deputy chief steward retired to the 'boot room' with a bottle of blended whiskey. The group sat down and gossiped about the board and then discussed the match, not what happened on the pitch, of which they had seen little, but what had happened to each of them. Events were pieced together from the perspectives of those present. Real learning appeared to be taking place. Unfortunately I was

unable to record the conversation and I was, after some twenty minutes invited to join the directors in the board room where the conversation concerned the match and various business interests.

Neither formal or informal debriefings appear to be used. Exceptions include F3 (which was not identified by the club as it was an informal gathering), P3, F1, and S3 and Rangers. At other clubs, even though debriefings of stewards was identified as an element of the safety management process observed behaviour was that within ten to fifteen minutes of the end of a match stewards would hand in their high visibility jackets and leave. The safety officer was often not present at this time preventing him from debriefing staff. Police forces however, were observed to conduct a debrief, in reverse cascade from police constable to sergeant to inspector who attended the formal debrief.

#### **6.6.2.2.7 Summary**

Whilst there were extreme examples of bad practice (for example P1 and F3) most clubs did some things well and some things badly. There were few clubs (P3, the example of the locked fire exit as an exception and Rangers) who appeared consistently professional. This reinforced the view that complacency was rife and that there remained an over emphasis upon crowd control which weakened the importance of crowd safety. There was a reported emphasis of Club executives upon the physical improvement of stadia, an emphasis that appeared to play down the vital role played by stewards and safety management. The previous sections and chapters have argued that what cultural readjustment has occurred has been limited. The results of the direct observation tend to support this. There were some examples of good practice but the findings reported above highlight the difficulties that clubs have experienced in translating the knowledge acquired through the

public inquiry process into new operating norms and procedures. Culture, in the form of attitudes to cost and safety, the importance of control versus safety can be seen as one impediment to change. The structure of clubs, the marginalisation of the safety officer for example and the effect of this upon internal communications acts as a further impediment. In conclusion comments recorded at the end of one match may summarise the key findings:

“Mix of good and bad, there certainly seemed to be some sloppiness and overemphasis upon the pitch and lack of readiness to man the exits. The fire exit that was not manned and very poor communication with supporters during the end of normal time break.. I got a sense of panic amongst staff at the end of the game.” (Author: Tape transcript P3)

However, before concluding the chapter we turn to a brief consideration of other sporting venues.

#### **6.6.2.2.8 Other Sporting Venues**

Five other sporting venues (V1, V2 etc) were visited representing four different spectator sports. These have not been identified to maintain the anonymity of participants. Four of the venues were similar to football in terms of their focus upon a ‘pitch based sport’, the fifth was a type of racing track. All but one of the venues was used (three regularly) as an international venue. At V1 and V2 stewards were recruited on a volunteer basis. Staff were recruited from a very wide area with some travelling two hundred miles to assist. This posed problems for steward management as it was difficult to insist upon volunteers travelling four hundred miles for an evening training session. The standards of stewarding were very poor. At least 25% of those present had been drinking and an estimated 10% were happily inebriated. At V3 a number of stewards were observed sitting with their families eating a picnic during the event. A majority of stewards participated in the event in a manner little different to other spectators. At V4 many of the

stewards appeared to be old (over 70) and frail. Fire exits were locked shut with no steward present to unlock them should a fire break out. Many stewards appeared to be enjoying a day out, sitting at the front, eating and drinking. At V5 there was a large police and private security presence. Stewards were allocated to their positions and appeared to take note of the crowd and of the event.

This very short summary of experiences elsewhere may illustrate that the football industry, is in many ways far in advance of many other sports. The poverty of stewarding at most other venues was frightening. An emotive word for a thesis but one that indicates how little knowledge has been transferred to other venues. Toft & Reynolds (1992) notion of isomorphic learning is that organisations can learn from other system types. There is clearly much potential to transfer knowledge to other sports. However, evidence suggests that culture and structure in these other industries will impede such learning. Lord Justice Taylor himself was reported by a respondent to have said that his report was not intended for grounds such as Twickenham, suggesting that a different type of spectator did not need the same measures. Such statements reflect deeply held assumptions. However, a study of other industries is beyond the scope of this thesis.

## **6.7 Chapter Conclusions**

This Chapter has identified significant differences between the pre and post 1989 periods with regard to cultural change within the football industry. However, as the analysis of the survey of football safety officers indicates this cannot yet be considered a full cultural change; a view supported by the findings of the direct observation. The nature of the regulatory regime has also been examined and the more systematic enforcement of regulations identified. This Chapter also marks the end of the empirical detail presented in this thesis. Having presented the analytical

framework, presented an analysis and discussion of the data and identified preliminary conclusions, the final Chapter attempts to draw the findings together. It deals with an assessment of Turner's (1976, 1978) model of cultural readjustment and identifies key findings with regard to organisational learning.

## **Chapter 7**

### **Conclusions, Recommendations and Suggestions for Further Research**

## 7.1 Introduction

The principal objective of this thesis was to investigate organisational learning in the UK football industry following a series of major disasters. Turner (1976, 1978) and Toft & Reynolds (1992) had implicitly hypothesised that following a major man-made disaster a full cultural readjustment would occur; manifest in changes to operating norms and procedures. The analysis of the response of the Football Industry to the Bolton, Ibrox and Bradford Stadium tragedies does not lend support to this hypothesis, yet each had been investigated through the public inquiry process, the proxy measure by which the magnitude of disasters has been determined in previous studies (see Turner 1976, 1978; Toft & Reynolds, 1992). This raises questions concerning the ability of organisations to learn from crisis events. The aftermath of the Hillsborough Tragedy provided a focus for the examination of organisational learning, an incident recent enough to be still the subject of debate but historic enough for the initial emotional back-lash to have subsided. This Chapter considers the evidence with regard to our principal hypothesis and resulting research questions. It progresses to a consideration of the weaknesses and limitations of the study. Finally recommendations for further research are made.

## 7.2 Cultural Readjustment

In our opening Chapter it was hypothesised that **“A full cultural readjustment did not occur following each of the disasters”**. The evidence from the data collected and examined for the periods 1946-71, 1971-85 and 1985-9 provides little support for the view that a ‘full cultural readjustment’ occurred. The evidence is indicative of a persistently indulgent pattern, with a periodic switch to a punishment centred model in the immediate aftermath of disaster incidents (Gouldner,1955). The focus upon

hooliganism, in the latter two periods (i.e. 1971-89), is a further indicator of the ongoing failure of the industry to consider the social and technical aspects of the disasters.

Since 1989 there has been evidence of a partial cultural readjustment, although safety officer respondents scored highly in the two factors indicating complacency. In Chapter 3, figure 7.1 was introduced as a framework for assessing the extent of cultural readjustment. Drawing upon the analysis in earlier Chapters, this thesis considers the

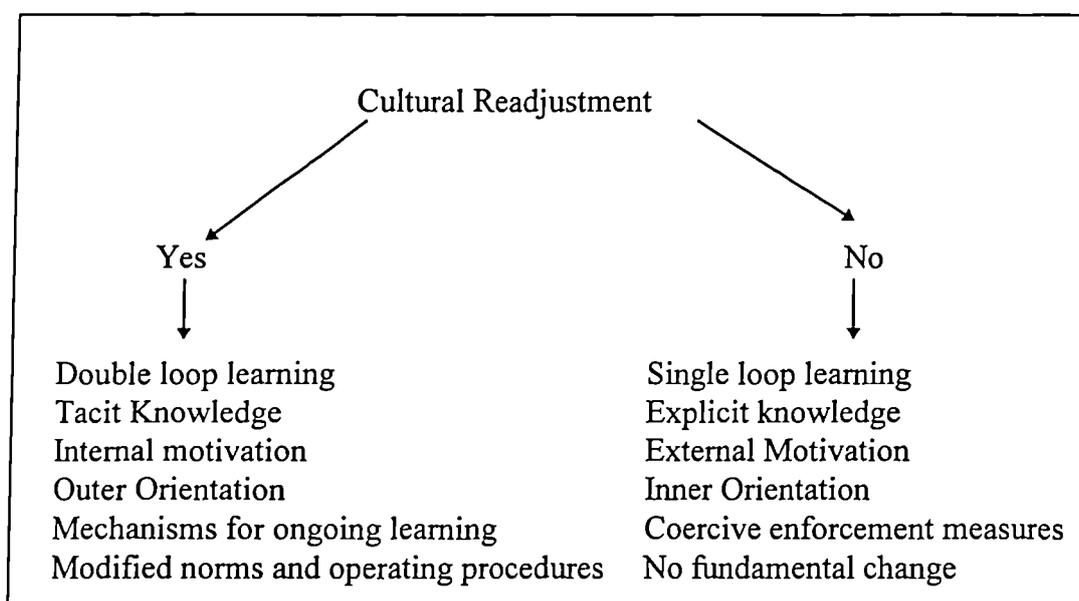


Figure 7.1: Cultural Readjustment Assessment Model

extent of cultural readjustment prior to and following 1989.

Chapter 5 indicated that organisational learning within the football industry was deficient in the pre-1989 period. The basis for this view rests upon the analysis of the various crisis incidents and an appraisal of the industry and its regulators in this period. Prior to 1989 there was little evidence of double loop learning within the UK Football Industry. The literal interpretation and application of the ‘Green Guide’ illustrated both the reliance upon explicit knowledge and an unwillingness to question the norms and

assumptions that underpinned it. Indeed, in the pre 1989 period, the persistence of a mock bureaucracy in the relations between Clubs and regulators, provided further evidence of the lack of double loop learning. The term 'business as usual' was used in Chapter 5 to describe the behaviour of football Clubs and regulators following the Bradford Fire. With regard to figure 7.1, this indicates no fundamental change to either Clubs or regulators. Motivation, for example, was neither internal or external. It was in many cases non-existent. Safety management was not a high priority for Football Clubs in this period, as indicated by Arnold & Benveniste's (1988) survey and the data presented in this thesis concerning the behaviour of Clubs. Despite the series of incidents, portrayed in table 1.1, the majority of Football Clubs in England and Wales failed to identify their own potential for crisis. As was shown in Chapter 5, Scotland was in a number of cases different. By 1980 a number of Scottish Clubs had redeveloped their stadia, reflecting the influence of the Ibrox Disaster and suggesting some internal motivation. In summary, in the pre 1989 period there has been little evidence of any cultural readjustment, with the exception of a limited number of Scottish Clubs.

Since 1989, despite the extensive redevelopment of many stadia and the clear improvements in the quality of stewarding ( a view expressed by the Safety Officers themselves and more independently by the Police Forces Middleham 1993), there is little evidence of a significant change in culture. Although the FLA has stated its commitment to promoting good safety practice, a view reinforced by some Local Authorities, it may be that the impetus provided by the Taylor Report (1989, 1990) has already waned, making a full change unlikely. This is however, speculation about the future. From the data collected there were few examples of double loop learning. The inner orientation of

many Clubs, identified in this study, may provide a barrier to ongoing learning (Smith, 1995 argued that external verification was a key driver of the learning process). The SAG may provide a means of challenging this inner orientation, although evidence presented in this thesis indicates that this has only occurred in some instances. In some cases the SAG appeared to be a positive forum for the free and frank discussion of safety matters, suggesting a useful mechanism for learning and cultural readjustment. However, even the 'better practice' SAGs were not without their problems. The usual exclusion of supporters and the absence of senior Club executives do not suggest a fundamental change to the inner orientation of football Clubs, identified as a key defence mechanism in Chapter 2. In 'worst practice' examples, the non-participation of the Clubs themselves in the SAGs provided further evidence of their inner orientation.

For cultural readjustment to occur, there is a need for mechanisms to assist and support ongoing learning. The SAGs and the Football Safety Officer's Association have the potential to fill this role but only if there is a commitment to learn on the part of the Clubs themselves. The evidence of the failure to learn from the disasters of 1946, 1971 and 1985, in addition to the mixed response to the Hillsborough Tragedy, does not encourage high expectations.

The analysis of the four principal crisis events and the intervening periods included in Chapter 5, provided limited evidence of fundamental change within the industry. The Hillsborough Tragedy appears to have had a symbolic importance that the other stadium disasters did not; a view expressed by respondents from Football Clubs, Local Authorities and other agencies. It is difficult to ascertain however, just what the Hillsborough Tragedy meant to these organisations. As this thesis has shown there are

still very different perceptions regarding the underlying causes of the Hillsborough tragedy and different assessments of the lessons to be learnt. The cultural response does not appear to have challenged the technical mindset identified in Chapter 1. For example, there is still a general tendency for Clubs and Local Authorities to accept guidelines without question. There was evidence in one case only of their use in a flexible rather than a rigid way. The weaknesses of the current SAG system and the persistence of a 'punishment centred' approach are also indicative of limited cultural change. Clearly this is a complex phenomena given the evidence of the desire by all Clubs to improve their safety practice. The expression of such desires may be criticised as 'empty words', yet they were sincerely expressed. This indicates the complexity of the phenomena and highlights the role played by a number of factors of which culture, structure, communications and economic context have been identified as key. In short, while the mechanisms to support ongoing learning may exist, barriers to cultural readjustment continue to exert a powerful restraining influence. Thus, it has been argued that cultural readjustment concerns the translation of challenged assumptions into new norms and operating procedures. There is little evidence, however, of changed procedures prior to 1989. Since then all 113 Clubs have appointed Safety Officers and have 'improved' their training of stewards. The evidence suggests that despite the obvious improvements, old beliefs and assumptions regarding the nature of football crowds and the importance of technical modifications have impeded real cultural change.

In summary, there is little evidence to refute our hypothesis from the pre-1989 period. Since 1989, although it is difficult to argue that a full cultural readjustment has occurred, there is some evidence of change and the existence of 'vehicles' that can drive

this process (e.g. Football Safety Officers' Association, Football Licensing Authority). Given the apparent significance of the Hillsborough tragedy, described by Taylor (1990) as an 'endpoint,' why has only limited cultural change occurred?

### **7.3 Organisational Learning from crisis**

The second focus of this thesis concerned organisational learning from crisis and represented an attempt to understand why knowledge acquired through the public inquiry process was not translated into changed behaviour. This section summarises the findings with regard to organisational learning and seeks to address those issues raised in Chapters 1 and 2. Particular attention is drawn to the role played by organisational filters including culture, structure and communication. The key research questions identified in the conclusions to Chapter 1 concerned the role played by these factors in influencing or restricting learning in the aftermath of the stadium disasters. In Chapter 2 a number of frameworks were introduced to assist in the examination of these factors. These frameworks provided the basis for the analysis in Chapters 4, 5 and 6, the results of which are now summarised with regard to the question: "Why did the football industry fail to learn following the disasters?"

#### **7.3.1 Culture: Views of the Underlying Causes of the Stadium Disasters**

In Chapter 1 it was argued that the views of decision makers regarding the causes of crises would act as a powerful mindset, and thus influence both their interpretation of public inquiry findings and their behaviour in forming and implementing stadium management policies.

### 7.3.1.1 Culture: Crises have Simple Causes

There is still a persistent view that crises have simple causes with a particular emphasis given to technical failures. This view is closely connected to the perception that each disaster is unique, which constrains learning to incident specific lessons. The reported views of Club Secretaries regarding the causes of the Bradford and Hillsborough disasters indicates that this perception is still prevalent within the UK Football industry.

A majority of respondents failed to grasp that the underlying causes of crises, as shown in Chapter 5, combine many factors in a complex relationship. Chapter 6 indicated that some 73% of safety officer respondents were outside the safety zone on this particular factor (factor 5). Concentration upon one or two causes is unlikely to be sufficient to prevent future disasters, as the failure of the technical solutions 'implemented' prior to 1989 illustrates. This persistent view, indicated by the current rigid interpretation of guidelines, has been identified as one barrier to the effective learning process and provides examples of the defence mechanisms fixation, and splitting.

An underlying premise of this thesis is that crises were the result of a combination of social and technical elements, and that systems failures result from the complex interaction between these component parts. The analysis of the stadium disasters supports this view, yet, as has been shown, many of the measures implemented to 'deal' with the problem of safety management within the industry have concentrated upon technical failures rather than social-organisational ones. The prevalence of the view amongst football industry officers indicates an emphasis towards single loop learning, and thus it acts as a barrier to effective learning.

### 7.3.1.2 Culture: The Hooliganism Mindset

The popularity of this view was outlined in Chapters 1 and 4. The coincidence of the Bradford Fire and the Heysel Disaster led to Popplewell's (1986) focus upon the 'problems of violence' and his effectively downplaying the importance of his own findings that hooliganism played no part in the Bradford Disaster. For many authors (see for example, Redhead (1991), Dunning et al (1986, 1991), Guilianotti et al (1994) hooliganism has been the defining characteristic of football in the UK. The high prominence given to 'soccer violence' has contributed to a mindset in which the issues of crowd safety and control have become inseparable in the minds of official agencies and the Football Clubs themselves. This influence was most pronounced in the summarising comments of the Popplewell (1986) Report, but was also noticeable in the number of official reports dealing with 'soccer hooliganism' in the 1960s, 1970s and 1980s. The causes of the Hillsborough Tragedy, as perceived by Club secretaries, illustrate the strength of this view within the football industry to the current day. Indeed, the Guardian (22/11/97) reported the calls of Jack Straw (Home Secretary) for an intergovernmental convention to raise the issue of hooliganism prior to the Football World Cup (to be held in France, 1998). The issue of crowd safety appears to be no longer on the agenda.

The persistence of this view acts as a barrier to learning because it encourages those organisations with responsibility for crowd safety to apportion blame to a disparate, dispersed and ill defined group of individuals. In short, it permits these organisations to avoid reflecting upon their own deficiencies and thus limits the likelihood of their changing their own behaviour.

The Hooliganism mindset also influences the preparations that Clubs make for dealing with issues of crowd control and safety (the controversy surrounding the policing of the Italy-England football match, held in Rome on 11th October 1997 is one example). In three Clubs, stewards reported that their **primary duty** was to 'kick out troublemakers'. Two other Clubs employed a 'mobile team' of large male stewards to deal with 'any trouble'. Alternatively, the stewards at two other Clubs placed a high priority upon crowd safety with the expectation that Police would deal with illegal behaviour. Hooliganism still exerts a powerful influence upon the perceptions, organisation, training and behaviour of Club stewards and their employers.

In summary, as this thesis has argued, the hooliganism issue may still be regarded as the defining characteristic of British Football. The Home Secretary's call for a 'soccer violence summit' indicates the continued strength of this view of football and the spectator. The Hooliganism issue is still a major concern to the Football Industry and can be seen to exert influence from board room to steward. It has been shown to have influenced Popplewell's Report (1985, 1986) and Lord Chief Justice Taylor's comment at Twickenham indicates that while he may not have emphasised it in his Reports, it was an overriding consideration.

### **7.3.2 Culture: The Five Factors and Defence Mechanisms**

Chapter 2 identified the range of defence mechanisms that crisis prone organisations may employ to avoid taking action. Chapter 6 identified five factors that highlight the role played by defence mechanisms within the UK football industry in the Post 1989 period.

### **7.3.2.1 Fatalism: Nothing We do Will Matter**

This defence mechanism is closely related to the belief in the simple causes of crises and the belief that disasters, by their very nature, are impossible to prepare for. A number of respondents reminisced about the 'good old days' when ground capacities were twice as large and 'there were no problems'. From the data collected (Chapter 6, factors 1 and 5) there was a significant difference between the responses of Club secretaries and Safety Officers; the latter group indicated a less 'idyllic' perception of the past. This suggests conflict within Clubs regarding safety management. However, the marginalisation of many Safety Officers, discussed earlier, indicates that this defence mechanism is frequently employed by those officials with budgetary authority within Clubs. Given the earlier argument that learning involves the translation of knowledge into behaviour, the marginalisation of Safety Officers acts as an important barrier to learning. The fatalistic view is most influential, however, as a means of justifying doing nothing. As F1 commented 'its low, low odds'.

### **7.3.2.2 Complacency**

This defence mechanism, linked closely to denial and disavowal, indicates assumptions concerning the value of preparing for crises and the ability of Clubs to deal with them effectively. As was shown in Chapter 6 (factors 2 and 4), a high level of complacency was indicated by both Club Secretaries and Safety Officers. Evidence of incidents and near misses since 1989 has been provided in this thesis, indicating that such complacency is misplaced. Further, the assumption that what is being done is sufficient, or that current procedures are adequate will stifle the critical questioning that is vital to the double loop learning process that is, in turn, vital to cultural readjustment.

Our survey of football Safety Officers indicated dangerously high levels of complacency with regard to their ability to deal with crises. This complacency contrasts with the difficulties reported in the immediate aftermath of each of the disasters analysed. Further, in the course of direct observations, there were instances at every ground visited, except one, of poor practice. These included stewards leaving locked gates and fire doors unattended; stewards attired in inappropriate clothing (e.g. platform shoes) and; inaudible public address speakers. Moreover despite claims by many Clubs to monitor stewards' training, these reports appeared to represent an ideal rather than the actual state of affairs. The training of stewards at a number of Clubs included no more than a tour of the ground, instruction in the use of fire extinguishers and a video of either the Bradford Fire or the Hillsborough tragedy. In many grounds the fire extinguishers are of various sorts and as a number of stewards indicated, although they had been trained in the use of one, there were many other types with which they were unfamiliar.

Complacency influences learning because it may suggest that 'we already do enough' or 'it cannot happen to us'. In particular, a belief that compliance with the 'Green Guide' is sufficient may lull Clubs into a false sense of security concerning their vulnerability and ability to deal with crisis incident. The concerns of the police that at least 25% of Clubs have stewarding that is less than satisfactory (Middleham, 1993) indicates that improvements to stewarding remain imperfect.

### **7.3.2.3 Displacement**

Displacement of responsibility can be seen to act as a barrier to Clubs, and other agencies, from taking responsibility for ensuring the safety of their spectators; creating the illusion that safety management is beyond their control. In the period 1946-89, given

the confusion between crowd safety and control, both were perceived to be the responsibility of the police. This perception was shared, from the evidence collected, by Clubs, Local Authorities and police alike. George (1993) in a report for ACPO recommended that the role of police and Club be clearly defined to avoid any misunderstandings. The George (1993) Report may be seen as a part of the movement reducing police presence inside football grounds. This has been physically recognised by the renaming of what were formerly 'police control rooms' as 'matchday control rooms' emphasising either the Club's primary responsibility for crowd matters, or that at the least that it be a multi-agency effort. It should be noted that in Scotland the police still perform a major role inside football grounds.

Although displacement largely refers to statutory agencies, displacement also refers to the smoke screen of the badly behaved spectator. The idealised view of the past does not stand up to rigorous examination as Williams et al (1987) have argued and our Table 1.1 illustrates. The ongoing confusion of crowd control with crowd safety, evident in this study, has acted to block effective learning. The evidence presented in Chapter 4 indicated that this focus upon hooliganism was general to all agencies within the football industry. The views of respondents concerning the causes of the Hillsborough Disaster suggests that this is still a widely held view within the industry. It has been argued throughout this thesis that the focus upon the issue of hooliganism has been to the detriment of crowd safety. On one level it prejudices the responses of those tasked with ensuring crowd safety, encouraging individuals to misinterpret warning signals as crowd trouble rather than crowd distress. The most striking example being the Hillsborough tragedy. At another level it creates the mindset in which new stadia are designed and

modified. Finally, the focus upon hooliganism has dominated any discussion of crowd related issues, as illustrated by Popplewell's (1986) concluding remarks concerning 'no panacea for crowd violence.' This has created the smokescreen, convenient to some, that has prevented a proper examination of crowd safety management and has hindered the application of relevant legislation to other sports.

#### **7.3.2.4 Blame Avoidance**

'Blame avoidance' concerns the openness of the various agencies involved to learn. Taylor (1990) reported a sharp criticism of the South Yorkshire Police following the Hillsborough disaster:

"In all some 65 police officers gave oral evidence at the Inquiry. Sadly I must report that for the most part the quality of their evidence was in inverse proportion to their rank. There were many young constables who as witnesses were alert, intelligent and open..... By contrast, with some notable exceptions, the senior officers in command were defensive and evasive witnesses." (p49)

and

"It is a matter of regret that at the hearing, and in their submissions, the South Yorkshire Police were not prepared to concede they were in any respect at fault in what occurred. Mr. Duckenfield, under pressure of cross-examination, apologised for blaming the Liverpool fans for causing the deaths. But, that apart, the police case was to blame the fans for being late and drunk, and to blame the Club for failing to monitor the pens. It was argued that the fatal crush was not caused by the influx through gate C but was due to barrier 124a being defective. Such an unrealistic approach gives cause for anxiety as to whether lessons have been learnt. It would have been more seemly and encouraging for the future if responsibility had been faced." (Taylor, 1989, p50)

The search for scapegoats has impeded the search for full explanations of what happened. Some respondents reported that safety advisory groups could be characterised by the aim of each agency to ensure that it could not be blamed if an incident occurred. Such a culture is likely to encourage a rigid application of any code rather than facilitate a flexible approach to meet the needs of each stadium as envisaged by the FLA. This

reflects an inner orientation identified in Chapter 2 as a potential barrier to learning. As the examples illustrate, evidence of blame avoidance was identified with regard to all agencies involved in the football industry. This may reflect a weakness of the public inquiry system that seeks to apportion blame.

#### **7.2.3.5 Inner Orientation**

Smith (1995) identified 'self generated turbulence' as a mechanism for assisting double loop learning, (which underpins cultural readjustment as it suggests the questioning of underlying assumptions). External verification was identified as one potential element of such turbulence. The purpose of this process is to challenge organisational assumptions by looking at processes, norms, etc., from alternative perspectives. The inner orientation of football Clubs and authorities, identified in Chapters, 4, 5 and 6, counters such a process. The reluctance of many Clubs to canvas supporter views, to attend SAGs or to support in some instances the Safety Officers' Association is indicative of this inner orientation which blocks double loop learning by seeking to avoid contrary views.

An inner orientation closes down opportunities to learn, by encouraging a 'virtual' siege mentality. The comments of secretaries regarding supporters' comments were indicative of this mentality. This orientation also affects relations between the various agencies involved in the SAGs and arguably, makes them less effective as a result.

#### **7.3.2 Structure**

The analysis of structure within this thesis was based largely upon Mintzberg's (1983) configurational approach. As argued previously, such an approach emphasises the importance of a consistency between structure, culture, strategy pattern, co-ordination and

other features appropriate to a particular environment. It should be noted that although the three key factors are treated separately, they are inextricably linked.

### **7.3.2.2 The Structure of Football Clubs**

The organisational structures of football Clubs do not lend themselves to rigorous safety management. The 'jack of all trades' role of many chief executives and secretaries, combined with the part time employment of many Safety Officers, may lead to safety issues falling betwixt the two. The Bradford tragedy provided a stern warning of the dangers of this. Lack of time and resources may increase the pressures to focus upon explicit knowledge and thus to treat the Green Guide as 'gospel'. This is because it is easier to deal with the well structured, technical issues, than with the ill structured problems associated with developing a safety culture. Our analysis suggests that for many Clubs, particularly those in Scotland and the Football League, this structure still persists and that safety management is, as a result, neither properly resourced nor properly attended to. This indicates a structural impediment to effective learning as it creates a context in which explicit knowledge is not necessarily translated into the tacit form which would lead to changed operating norms and procedures. A further impediment concerns the status of Safety Officers.

### **7.2.4 The Status of Football Safety Officers**

A related point concerns the status of Safety Officers within their organisations. While many are isolated from day to day decision making by their part time contracts, many are marginalised by lowly status and a perception that their task is that of chief steward, to ensure that stewards turn up on time. Evidence in support of this conclusion was provided in Chapters 4 and 5. There are cultural, structural and communication

issues here. Perceptions of the relative unimportance of the task result in a part time appointment, with a reporting line to an executive, at best, who has limited time owing to the wide range of responsibilities held. Lack of time and structural isolation combine to limit communications. Additionally, as shown in Chapter 4, the safety officer may be so poorly regarded that funding for vital training and education is not forthcoming from the employing Club. The role and status of the safety officer plays a vital part in determining the effectiveness of the translation of explicit knowledge from inquiries into the behaviour of the Club with regard to safety. It is argued that frequently the safety officer is unable to influence adequately Club behaviour thereby restricting the effectiveness of real learning.

#### **7.2.5 Communications**

Closely linked to structure is the issue of communication. The frequently observed structural isolation and lowly status of the Club Safety Officer acted as an impediment to the communication of relevant information, either concerning what was required or reports based on the monitoring of previous events. As Braithwaite & Fisse (1987) argued, effective self regulation requires a good deal of informal communication between top management and those responsible for compliance. The perception of safety officer as chief steward, evident in many non-Premiership Clubs indicates that such informal communications are unlikely.

#### **7.2.6 Legislation: A Technical Response**

Without exception, all legislation relevant to safety in sports grounds has been enacted as a response to disaster (de Quidt's 1997b 'tombstone legislation'). There has been an apparent willingness for government, football authorities and Clubs to seek

technical solutions and formulas to help ensure that such tragedies never happen again.

However, as we have seen, purely technical solutions rarely take full account of the complexity of crowd related disaster, as Canter et al (1989) argued:

"There is one other very simple flaw in the engineering considerations. The calculation of the use of a set of exits is made by identifying all the exit widths available to people in particular spectating positions and dividing the total number of unit widths by the total number of people. This is an elementary averaging exercise. But anybody who has looked around in a theatre, or at any other public place of entertainment at the end of the performance, will have noticed that unlike engineers' numbers people do not divide themselves evenly between the exits available. People will tend to go to the exits they know or to the ones that lead in directions they wish to take." (p96)

Technical "solutions" only serve to create a climate of incubation unless the core behavioural aspects of organisations are also addressed. Promoting good standards is a less well structured problem than identifying and dealing with extreme examples of bad practice. This poses particular problems for the type of regulatory regime.

Gouldner's (1955) analysis identified the weaknesses of both the 'mock' and 'punishment-centred' approaches. Yet those tasked with overseeing the stadium licensing process are those with either technical or enforcement expertise. The concentration upon compliance, within a context in which each agency is keen to avoid blame if a disaster occurs, limits the potential for the exchange of ideas suggested in Gouldner's representative pattern. Braithwaite & Fisses' (1987) 5 characteristics of the effective self regulating organisation do not apply well to many football Clubs. Power is highly centralised and remote from the safety officer, there is little monitoring of safety compliance and training is minimal. The adversarial relationship noted between some Clubs and Local Authorities acts as a further barrier to real organisational learning, although it may achieve the objective of ensuring a minimum standard of compliance.

This tendency to over emphasise the technical elements only of socio-technical failure reflects the prevailing beliefs and assumptions of key decision makers. Pauchant & Mitroff (1992) criticise the tendency of some professionals to fragment complex questions into microscopic parts that distort the real issue. Of course this does mean that 'we dispose of the baby and the bathwater' but that it is argued that a stronger balance must be created between the complexity of the 'technology concerned' and the complexity of human behaviour which manages it. Turner (1994) suggests, from a study of public inquiry recommendations, that approximately seventy per cent deal with social issues. This study has indicated that those recommendations of a technical nature are most likely to be implemented. This requires further investigation to determine whether the findings from the football industry can be translated to others. The real problem may be to encourage organisations to go beyond implementing recommendations concerning tangible changes (for example, introducing all seater stadia, painted gangways etc.) to implementing the spirit of the legislation. Technical 'improvements' may be introduced with little understanding of why they should be introduced or as a key element of socio-technical development. The evidence that has been collected indicates that for many clubs technical changes have been introduced because of regulation and external pressures. For these clubs the introduction of change has been an end in itself and some key decision makers have not sought to understand the underlying rationale for such changes. For example, the apparent conflict between club chairmen and their safety officers reflect the differing views within football clubs themselves. This also indicates that the particular pattern of interplay and integration between social and technical issues will vary significantly between clubs and reflect not only cultural assumptions, but

organisational politics, structure and financial considerations. Any understanding of what we have described as a largely ‘technical response’ to the stadia disasters or socio-technical failures of the past must be firmly rooted in an understanding of the varying influence of culture, structure, finance and organisational politics. The development of Turner’s (1976, 1978) model of cultural readjustment aims to highlight the interplay of these factors and show that the process of knowledge transfer is a complex one and that the forces (identified throughout this thesis) that shape its interpretation and implementation are as important, if not more important, than the knowledge itself.

The reliance upon ‘technical solutions’, identified in this study reflects the strength of a confidence in a technocratic approach. That is, such beliefs and assumptions are firmly embedded in the social framework.

### **7.2.9 Organisational Learning in the Football Industry 1946-97**

In Chapter 1 a modified version of Turner’s (1976, 1978) model of organisational learning from crisis was shown. It was argued in Chapter 1 that a weakness in this approach concerned the limited emphasis upon the post crisis incident phase. This weakness arises from the failure of this study to examine how the findings and recommendations from public inquiries are translated into behaviour. Figure 7.2 represents, more completely, the organisational learning and cultural readjustment process. There are two key additions to the frameworks utilised in earlier studies. First, the organisational filters, through which explicit knowledge is interpreted, are identified. These, it has been argued throughout this thesis, represent a key stage in the translation of organisational learning into behaviour. The roles played by culture, structure and communications have been examined at length in this thesis. This

Chapter has thus far, highlighted how these factors have acted as barriers to learning within the football industry. The evidence presented in this thesis strongly supports the view that prior to 1989 there was little change to the operating norms and procedures within football stadia. In the post 1989 period the points identified in the preceding section indicate that despite significant changes in the regulatory climate these impediments to organisational learning remain. Culture plays an important role through defence mechanisms that deny or minimise the potential threat or simply displace blame or responsibility to other agencies or groups. High levels of complacency may reflect confidence in the technical changes to many football stadia but ignore the slower development of safety management through the effective management of crowds. The status and structural isolation of the safety officer may, in some cases, enable the continuation of the convenient ignorance of football chairmen and directors with regard to safety. This ignorance is further encouraged by the frequent absence of these groups from SAG. Further, the 'jack of all trades' role of the secretary or chief executive ensures that only high priority tasks receive proper attention. With reference to figure 7.1 the degree and type of organisational learning appears, from the data examined, to be primarily single rather than double loop and concern the transfer of explicit rather than tacit knowledge.

The model resulting from this study identifies three further stages to those suggested by Turner (1976) and Toft & Reynolds (1992), namely knowledge transfer(6.1), the learning process (6.2) and active learning (6.3). These are shown in table 7.1 alongside Turner's (1976) six stage model.

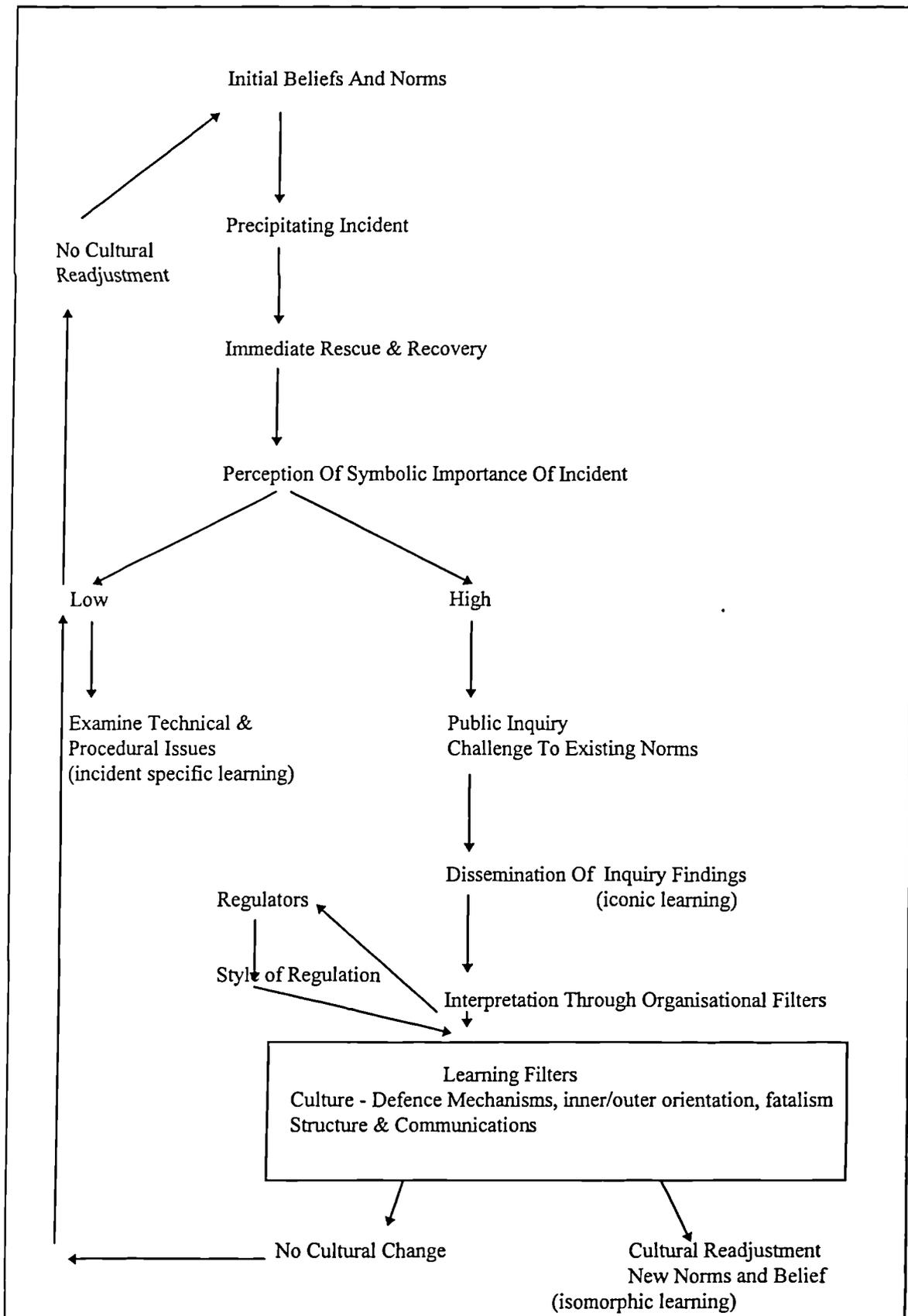


Figure 7.2 Organisational Learning and Cultural Readjustment Process

A deficiency of the model utilised by Turner (1976) and Toft & Reynolds (1992) is that it places too little emphasis on the post recovery stage. Table 7.1 highlighted that in the case of the football disasters the public inquiry process did identify many of the problems and solutions some forty years prior to Taylor's (1989, 1990) Reports. That is, the relevant knowledge had been acquired. What was missing from the process of cultural readjustment was the means by which that knowledge could be transferred to relevant organisations. This was a particular problem in the football industry given the convenient ignorance of administrators and directors of Clubs. From our analysis the various regulatory agencies play an important role in transferring that knowledge to football Clubs. However, the learning process is integral to the Clubs themselves. The regulatory agencies cannot learn for them. The punitive approaches identified in this analysis, it appears, may provide a useful means of ensuring technical compliance but are less effective in promoting good practice. Punitive approaches try to alter behaviour without changing the 'personality' or makeup of individual Clubs. Conversely the seemingly weaker consensual approach seeks to encourage more basic changes to the culture and structures of football Clubs. In so doing, an unstated aim, must be to change a resistant culture into a proactive one. The acid test for cultural readjustment, must be in our opinion, un-coerced changes to operating norms and procedures. As has been shown, this is a lengthy process and one that is not simply dependent upon the symbolic importance of a crisis incident. The 'status' of an incident will be one factor, but as we illustrate in figure 7.3 there are many system components, including the various regulatory agencies, that contribute to the learning process.

Stage of Development	Feature	Comments
Stage 1: Initial Beliefs & Norms	Failure to comply with existing regulations	Violation of existing precautions
Stage 2: Incubation Period	Rigidities of beliefs and perceptions. Decoy Phenomena Disregard complaints from outsiders. Information difficulties and noise. The involvement of strangers. Failure to comply with discredited or out of date regulations. Minimising of emergent danger	A. Events unnoticed or misunderstood because of erroneous assumptions B. Events unnoticed or misunderstood because of difficulties of handling information in complex situations C. Effective violation of precautions passing unnoticed because of cultural lag in formal precautions D. Events unnoticed or misunderstood because of a reluctance to fear the worst outcome
Stage 3: Precipitating Event		
Stage 4: Onset		
Stage 5: Rescue & Salvage		
Stage 6: Full Cultural Readjustment	Definition of new well structured problems and appropriate precautions in inquiries following the disaster.	The establishment of a new level of precautions and expectations.
<i>Stage 6.1: Knowledge Transfer</i>	<i>Dissemination of knowledge acquired from inquiry</i>	<i>Communication of new expectations to target organisations</i>
<i>Stage 6.2: Learning Process</i>	<i>Consideration of knowledge from inquiries. Knowledge filtered through culture, communications and structures of organisational personnel. Questioning of organisational norms and operating procedures. Organisational cultural readjustment occurs</i>	<i>Cultural readjustment process triggered by perceptions re. the symbolic importance of precipitating event. Propensity of an organisation to learn determines effectiveness of learning process.</i>
<i>Stage 6.3: Active Learning</i>	<i>New norms and operating procedures reflect new state of knowledge</i>	<i>Establishment of mechanisms to facilitate ongoing learning (ideally).</i>

Table : 7.1 : Cultural Readjustment and Learning from Crisis Model  
(italics represent additions to Turner's model of cultural readjustment)

### **7.2.10 Regulation**

The failure of self regulation in the pre 1989 period lies at the heart of the current regulatory system. Drawing from Gouldner's (1955) framework, it can be argued that one reason for the ineffectiveness of self regulation was the failure of Clubs to recognise the value of safety management. The use of the various defence mechanisms, inner orientation and fatalistic beliefs of executives combined to create an environment in which crowd safety was not taken sufficiently serious. This failure was compounded by the apparent failure of regulatory bodies in the 1975 - 89 period which saw the emergence of a mock bureaucracy. Other factors influencing the failure of self regulation included, the lack of resources given to routine administrative, including safety, tasks and the lack of adequate training. It is apparent since 1989 that more resources have been provided, in the form of the safety officer. However, it is clear that the cultural climate in many Clubs is not conducive to effective self regulation given the lowly status of the safety officer.

### **7.10.2 The Style of Regulation**

A key finding which emerged from the data concerned the different styles adopted by the various Local Authorities. Although two pure styles (punishment centred and consensual) were identified, the responses suggested a continuum. The approach adopted by the regulatory authority may influence organisational learning, as represented in Figure 7.2 and Table 7.1. The punishment centred approach may encourage the application of technical solutions because these are well defined and lend themselves to a legalistic approach. Promoting good practice is less well defined and may be better suited to a representative approach, such as that advocated by the

FLA. As argued previously, this latter style was complemented, where appropriate, by 'coercive' measures, indicating that the two approaches are not mutually exclusive.

It should be noted that the current regulatory system emerged from a system of self regulation that evidently was ineffective. However, there is an apparent danger that by focusing upon the punitive aspects of regulation valuable learning opportunities may be lost. A sound punitive base is required but it forms only one element of the process of ensuring effective safety management. As Smith & Tombs (1995) argued, other elements include the involvement of third parties and a move towards participative form of decision making. The consensual style reflected in the relations between a number of Local Authorities and Clubs represents an example of this type of system. However, a notable weakness evident in the majority of cases was the exclusion of supporters from most SAG's.

In Scotland where the FLA have no role the picture of regulation is more complex. First the police play a more hands on role in safety management, still taking charge of matchday operations in most cases. This may reinforce the view that the primary concern is crowd control rather than safety. Second, although Authorities such as Strathclyde Regional Council (before local government reorganisation) play an important role, it was evident from the data that they were further removed than their English and Welsh counterparts.

#### **7.4 Pauchant & Mitroff's (1988, 1992a) Onion Model**

Pauchant & Mitroff (1988, 1992a) depict a four level model of organisational culture. The factor analysis, reported in Chapter 6, indicated that there is little justification for distinguishing between levels 1 and 2. Each of the five factors drew

upon elements from both levels 1 and 2 indicating that the two are closely related if not inseparable. A more accurate depiction, as suggested earlier, of the model might be of a network of elements linked together. It should be noted that the distinction between individual beliefs and core organisational assumptions is not unique to Pauchant & Mitroff (1988, 1992a) but is shared, as table 2.1 indicated, with a number of other theorists. This suggests that culture is a phenomenon, or phenomena, that is not yet properly understood.

## **7.5 Review of the Study**

The analysis presented suggests strongly that it is often social or organisational failures which lead, ultimately to technical failures. It is people who design, construct, operate and maintain both the physical and social elements of the systems that fail. Despite the major contribution of social factors to the stadium disasters it is evident from the analysis presented that technical changes are the most likely to be implemented. This may reflect the often well structured nature of technical problems particularly when contrasted with the ill structure of many organisational problems.

The study has however, identified a range of different beliefs and practices within the industry providing evidence of a partial cultural readjustment. The Football Licensing Authority recognise the importance of changing values and state their intention of modifying their emphasis from technical conformity to the promotion of good safety practice. However, the data collected from Local Authorities illustrates that this may be problematic given the ongoing emphasis upon punitive measures aimed at ensuring 'technical' compliance with the Green Guide.

There was mixed evidence concerning the extent of cultural readjustment. The evidence from Local Authorities suggested that whilst the Safety Advisory Groups frequently provided a valuable forum for discussing safety and for pointing Clubs in the right direction, there was still the need in many cases to use the threat of prohibition notices or to reduce capacities via the safety certificate to coerce behaviour. In some cases members of the Board were regular attendees at SAG's indicating the importance of safety issues in those Clubs and ensuring that issues discussed could be fed back to a Club's executive team.

## **7.6 Practical Recommendations**

This thesis has examined the response of the football industry and associated agencies to the various disasters 1946 - 97, in an attempt to assess the extent of cultural readjustment following each incident and to explore the process of organisational learning within it. From this analysis a number of practical recommendations have emerged which are aimed at the various agencies involved in the setting, enforcement and implementation of regulations. This section details these areas before moving on to recommend areas for further research. Figure 7.3 identifies the key agencies and groups operating within and around the UK football industry. The model highlights how different agencies may exert different forms of influence or pressure to assist in the change process.

### **7.6.1 Football Club Executives and Chairmen**

The most basic, yet fundamental, recommendation that can be made is that football Club directors and executives become more involved in the safety management process either through attendance at SAG meetings or by liaising with supporters. One

feasible suggestion is that they occasionally make use of the stadia facilities as if they were ordinary members of the public. There can be no replacement for the experience of queuing to enter a ground through a turnstile, of being pushed and shoved as one moves through the various passageways, of using the catering facilities, toilets and sitting in the cramped seats. There was a sense from many respondents from all agencies that Club directors are cushioned from the reality of attending the match. Braithwaite & Fisse's (1987) recommendations for effective self regulation emphasise the importance of informal measures.

Additional measures should include clear performance guidelines that emphasise the development of 'safety management' practices in addition to technical improvements. As Mintzberg (1983) argued, organisations have to be trusted in the first place because it is managers who have day to day responsibility for, and day to day contact with, these issues.

With regard to safety management, it is the responsibility of directors to ensure that safety management is properly recognised, resourced and monitored. This has implications for smaller Clubs but a related recommendation is made in the next section.

#### **7.6.2 Football Safety Officers**

Despite the obvious financial implications for smaller Clubs there is a need for ample resources to be provided for the role of Safety Officers. The many examples of Club Secretaries and Chief Executives having responsibility for safety amongst many other duties prevents safety issues from always being effectively managed. Where part time Safety Officers are employed it is vital that they have sufficient status and

adequate recognition by the directors of Clubs to ensure that safety management issues are considered at board level. A possible solution for smaller Clubs would separate the safety management responsibilities from those of Chief Steward. A professional Safety Manager could be employed by a number of Clubs. Safety management would include responsibility for planning and developing steward training, a board level profile and a brief to liaise with other agencies in designing and modifying stadia and in planning for future events. The chief steward would have responsibility for administering stewards, ensuring that they attend matches and training events. A full time safety officer, with responsibility for a number of Clubs would ensure a professional approach while not placing too heavy a financial burden upon individual Clubs.

#### **7.6.4. Safety Advisory Groups**

The SAG clearly plays an essential role in ensuring that safety issues are fully discussed. There is a danger, expressed by some respondents, that as new stadia development and modernisation cease the SAG's will become talking shops. This concern indicates a misunderstanding of the role of the SAG, which should develop more fully the promotion of the good safety practice part of its responsibility. The role of the Football Safety Officers Association should receive formal recognition from the various Clubs and leagues, and consideration should be given to providing a bursary scheme to ensure that all Safety Officers can participate in its activities and meetings.

The influence of the different types of regulatory style have been discussed already. The role of the SAG is to lead the football Club towards a participatory model of regulation which previous studies have indicated to be the most effective. Support needs to be provided to the various Local Authorities, to aid in the exchange of

information between them and to promote a consistent , but not uniform, approach. The FLA may be the body to achieve this, although it does not appear to have yet done this.

The FLA's emphasis upon consistency rather than uniformity appears positive in that it recognises the differences between Clubs. To support this Clubs and Local Authorities need to be encouraged to interpret the 'Green Guide' flexibly rather than literally. Such encouragement could be achieved via a regulatory system that seeks to promote a representative rather than punishment centred pattern. This is not to suggest that coercion should be ignored as a tactic, but that it should be combined with persuasive and educational methods.

#### **7.6.5 Football Agencies**

A role for the various football authorities should be to co-ordinate and support member Clubs in developing safety management practices; the guidance on stewards training, published by the Football League, for example. The Football Authorities could set the tone for safety management practice, by raising its profile and by ensuring that hooliganism does not dominate any agenda.

#### **7.6.2 Private Security Firms**

The use of private security companies has grown as Clubs and police have striven to reduce the numbers of police officers at football grounds. Private security companies are supposed to provide training to their staff . It was reported in a number of cases however, that Local Authorities did not check this training as rigorously as that of Club stewards. Further, a number of examples were cited, including one experienced by the author, where someone could turn up on a match day, put on a

stewards jacket and work as a steward. As there is a switch in emphasis from ensuring sound structures to promoting safety management practices there is a need for greater scrutiny to ensure that high standards of stewarding are maintained and developed.

### 7.7 Push and Pull

From the discussion above it follows that ensuring high standards of safety management concerns a number of different agencies and groups. As figure 7.3 indicates those with a formal relationship with football Clubs are in a position to ‘push’

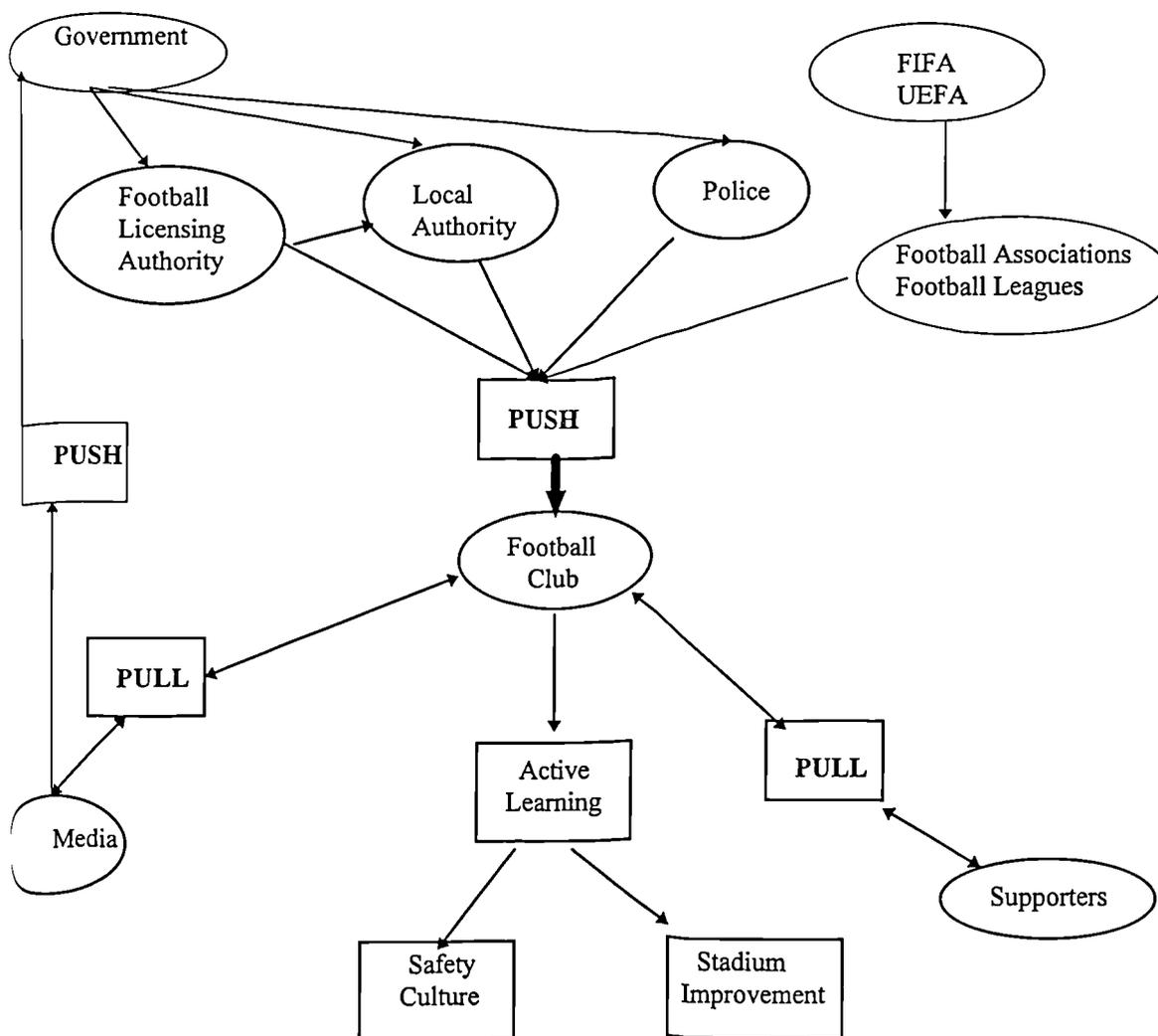


Figure 7.3: A Model for Controlling the Football Industry

for better practice through formal regulations and ongoing interaction with football Clubs. Although Government is shown one step removed from the football Club it plays a key role through legislation and by keeping stadium safety high on the political agenda. Given the systemic nature of the industry, Government is seen linked to media and supporter interest groups who may play a vital role in pushing Government interest whilst 'pulling' for better standards through complaints, and exposing examples of poor practice. Following our earlier discussion of regulation, it is apparent that self regulation rarely works effectively, certainly not in the case of the football industry in the 1946-89 period.

## **7.8 Recommendations for Further research**

This thesis has concerned the study of one industry over a long time period. The role of culture, configuration and communications have been considered with regard to organisational learning from crisis in the football industry. There is a need to extend this investigation to other industries in order to test the generalisability of these findings. Two important questions need to be addressed. First, what influence does the style of regulation (punitive or consensual) have on the ability of organisations to learn? Second, what means of knowledge transfer are most effective at promoting changed behaviour?

Of particular importance is the notion of symbolically important events. Implicit within the theory of cultural readjustment is the importance of the trigger event. To utilise Pauchant & Mitroff's (1992a) typology of crisis: "How can managers be encouraged to see accidents as crises and thereby trigger a full or partial cultural readjustment?" More fundamentally, how can the learning organisation be created so

that organisations may benefit from foresight as well as hindsight and avoid the costly implications of experiencing crisis events? Inevitably, given this study's focus upon learning from crisis, and its emphasis upon response to crisis events, the subject of 'learning organisations' per se has not been addressed in detail.

Given the limitations of the public inquiry process as a means of achieving cultural change in this context, what other mechanisms might be used to achieve effective organisational learning from crises?

## **7.8 Conclusions**

This Chapter has attempted to summarise the key findings, make practical recommendations and provide a justification for amendments to theory. The purpose of these conclusions is to assess these findings with a view to determining the contribution of this thesis to knowledge.

### **7.8.1 Cultural Readjustment**

Turner's (1976, 1978) influential work is well respected and highly cited. This critique provides evidence of limitations, rather than deficiencies, in Turner's model of cultural readjustment. As stated earlier, Turner's (1976, 1978) primary concern was with 'readjustment' following public inquiries into a variety of man-made disasters. This focus encouraged Turner (1976, 1978) to concentrate upon the pre crisis incident phases. The focus of this study upon a series of crisis incidents within the same industry has permitted consideration of the post crisis stages and the learning that may take place. Since Turner's (1976, 1978) analysis there has been a dramatic growth in organisational studies and interest in the phenomenon of the learning organisation. The combination of these two factors has provided the platform for this study and the

identification of additional stages to Turner's model of cultural readjustment. This adjusted model (see figure 7.2, table 7.1), grounded empirically, suggests that there are a number of forces that may influence organisational learning. Figure 7.2 also identifies the role played by other agencies in the cultural readjustment process, a role not made explicit in Turner's (1976, 1978) analysis.

### **7.8.2 Organisational Learning from Crisis in the UK Football Industry 1946-97**

The major area of contribution made by this thesis concerns our understanding of the football industry. Previous studies of the industry have included historical (see for example, Walvin, Mason), sociological (see for example, Dunning et al 1981, Guilianotti 1994) or economic (see for example Sloane, Arnold & Benveniste ) analyses. The peculiar administrative and cultural characteristics of the industry have received scant attention outside popular studies or official reports (see for example Chester ). With regard to the crises that have provided a focus to this study, this represents the first attempt to deal with the industry from an organisational theory perspective. Additionally, the inclusion of Local Authorities and the FLA is unusual for studies of this kind, despite the vital role these agencies play in setting much of the context in which current stadium safety issues are considered. The different styles of regulation, identified within this thesis, may provide the basis for further study and greater understanding of the regulatory process.

It is argued in this thesis that previous studies of the football industry have been deficient for two main reasons. First, many of these studies have examined the industry from a single perspective. Although the studies of hooliganism have made a major contribution to our understanding of that particular phenomenon, they have, as

has been argued, supported the mindset that perceives soccer violence as the industry's defining characteristic. Second, and related to this first point, is that many previous studies have focused upon football Clubs and authorities rather than upon the wider system of which it is a part. The inclusion of Local Authorities and the FLA was vital to understanding the context of football Clubs.

More specifically, the contribution of this thesis to our understanding of the football industry concerns the specific research objectives outlined in Chapter 1. There is little evidence in support of a full cultural readjustment occurring in the 1946-89 period. The 1989 Hillsborough tragedy did have a symbolic importance greater than preceding disasters, but it is unclear whether or not a full cultural change has occurred since then. The evidence within this study supports the view that the failure to learn from previous disasters has been strongly influenced by cultural forces including not only the persistence of strongly held beliefs but the ongoing employment of defence mechanisms. Changes to core assumptions require the analysis and understanding of these mechanisms so that active learning can take place. However, in addition to culture the means of communication and structures of organisations may also act to distort information, impede its flow or prevent the translation of knowledge into new operating norms and procedures. Given the systemic relationship between these factors any attempt to encourage a cultural readjustment requires that attention be focused upon each of these elements, if such an attempt is to succeed. For cultural readjustment to occur there is a need for mechanisms to assist and support ongoing learning. The SAGs and the Football Safety Officer's Association have the potential to fill this role but only if there is a commitment to learn on the part of the Clubs themselves. The evidence

of the failure to learn from the disasters of 1946, 1971 and 1985 in addition to the mixed response to the Hillsborough Tragedy does not encourage high expectations.

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## Appendices

## Appendix 1.1

### Statistics from Selected World Wide stadia

## Statistics from Selected World-wide Stadia

Country : City	Capacity	Previous Capacity	Present site
<b>Italy</b>			
Milan: San Siro	83,107		1926
Turin (new)			1990
Turin (old)	49941	70000	1933
Genoa	44000	51000	1928
Verona	25000	42500	1963
Udine	42133 (38685 FIFA limit)	47616	1976
Bologna	40782 (38000 FIFA limit)	50100	1927
Florence	49033 (44781 FIFA limit)	66344	1932
Cagliari	42855 (41000 FIFA limit)	60000	1970
Palermo	40500	44860	1932
Bari	34000	43000	1934
Naples	86000 (74090 FIFA limit)	86000	1960
Rome: Stadio Flaminio	31630	65000	1959
Rome: Stadio Olimpico	80000	80000 (90000)	1953
<b>Germany</b>			
Munich	74000	77895	1972
Nuremberg	55670	60000	1929
Frankfurt: Neckar	67963	74000 (103000)	1933
Frankfurt: Wald	61992	87000	1925
Cologne	60584	63000	1923
Dusseldorf	68360	68360	1926/1972
Monchengladbach	36800	36800	1978
Gelsenkirchen	70298	70298	1973
Dortmund	53970	53970	1974
Bochum	49417	49417	1979
Hanover	60355	86500	1954
Bremen	40000	40000	1921
Hamburg	61351	75000	1953
Berlin	76006	86000 (100000)	1936
<b>Holland</b>			
Amsterdam: Olympisch	41433	41433	1928
Amsterdam: De Meer	27000	27000	1934
The Hague	23500	23500	1927-85
Utrecht	20000	20000	1982
Rotterdam: Feynoord	58000	61500	1937
Rotterdam: Het Kassel	26000	26000	1916
Eindhoven	28000	28000	1977
Arnhem	26000	26000	1991

<b>France</b>			
Nantes	52467	52467	1984
Bordeaux	51460	51460	1938
Toulouse	29900	39540	1938-1950
Nimes	26180	26180	1938
Marseille	45000	54848	1938
Monaco	20000	20000	1939
St. Etienne	48274	48274	1931
Lyon	51680	51680	1920
Strasbourg	42756	49982	1914
Lens	51000	51000	1934
Colombes	Closed after Heysel	60000 (61772)	1922
Paris: Stade de Paris	21000	21000	1922
Paris: des Princes	49700	49700	1897
<b>Spain</b>			
Barcelona: Nou	115000	120000	1957
Barcelona: de Sarria	41000	44000	1923
Valencia	49373	49373 (50000)	1923
Elche	38750	53000	1976
Alicante	38700	38700	1974
Malaga	42000	42000	1941
Seville	47500	47500	1928
Seville: Pizjuan	70000	70000 (110000)	1958-75
Madrid: Bernabeu	90200	90200 (120000)	1947
Madrid: Calderon	62000	62000	1966
Valladolid	37500	37500	1982
Vigo	33000	33000	1922
La Coruna	28956	40000	1945
Gijon	45000	45000	1917
Oviedo	22284	22284	1932
Bilbao	46223	46223	1913
San Sebastian	27400	27400	1913
Zaragoza	46290	43349	1923
<b>Great Britain</b>			
Wembley	76000	100000	1922
Ibrox	45000	68000	1899
Old Trafford	47985	76982	1910
Anfield	39858	61905	1892
St James Park	30348	68386	1892
Goodison Park	38500	78299	1892
Hillsborough	40247	72841	1899
Villa Park	40277	76588	1897
Elland Road	33235	57892	1919
Ayresome Park	26500	53596	1899
Roker Park	31887	75518	1906
Highbury	47000	73295	1913
City Ground	31920	44946	1898

## Appendix 1.2

### Selected Statistics from UK Rugby League Stadia

## Selected Statistics from UK Rugby League Stadia

Club	Current Capacity	Highest Gate	Year	Highest 1995-6
Barrow Braves		21,651	1938	948
Batley		23,989	1925	3018
Bradford		69,429	1953	5546
Bramley		12,600 (old) 760 (new)	1947 1996	760
Carlisle		2042	1994	850
Castleford		25,449	1935	5695
Chorley		2851	1994	1236
Dewsbury		26584	1920	2221
Doncaster		10000 (old) 1240 (new)	1952 1995	1240
Featherstone Rovers		17531	1959	2422
Halifax		29153	1959	7776
Highfield		18000 (old) 1071 (new)	1922 1994	468
Huddersfield		32912 (old) 9348 (new)	1950 1950	6026
Hull		28798	1936	4180
Hull KR		27670 (old) 8557 (new)	1953 1991	2073
Hunslet		24700 (old) 2350 (new)	1924 1995	2350
Keighley		14500	1951	4812
Leeds		40175	1947	18000
Leigh		31324	1953	1543
London Broncos		15013	1981	1465
Oldham		28000	1912	4316
Rochdale		26664 (old) 8150 (new)	1922 1989	3038
St Helens		35695	1949	17590
Salford		26470	1937	5194
Sheffield		7984	1990	4639
Swinton		26891 (old) 3501 (new)	1964 1992	1221
Wakefield Trinity		30676	1921	2463
Warrington		34304	1949	7714
Whitehaven		18500	1960	1819
Widnes		24205	1961	5495
Wigan		47747	1959	13700
Workington		17741	1965	5960
York		4977	1990	1077

## Appendix 1.3

### Statistics from UK Football Stadia

## Statistics from UK Football Stadia

### Premier Division

	1995-6 Capacity	1988-9 Capacity (seated)	Record Gate	Post Taylor Costs £	Planned Expenditure
Arsenal	38,500	57,000 (17,200)	73,295 (1932)	30m	
Aston Villa	39,341	48,000 (19,900)	76,588 (1946)	18.5m	
Bolton	22,616 (8,759)	29,000 (7962)	69,912 (1933)	1m	25,000 seat stadium 1997
Blackburn	31,149	21,956 (2,656)	61,783	25m	Replace Stand
Chelsea	31,760	43,900 920,624)	82,905	15.3m	Build new stand to capacity of 40,000
Coventry	24,003	29,800 (18,496)	51,455 (1967)	7m	Seat corner areas
Everton	40,103	50,271 (26,471)	78,299 (1948)	5.6m	redevelop stands
Leeds	39,775	39,133	59,892 (1967)	10.3m	rebuild west stand
Liverpool	41,210	46,628 (22,528)	61,905 (1952)	18.7m	Extend stand to capacity of 44,500
Manchester City	32,344	51,993 (25,883)	84,569 (1934)	19m	Capacity to 45,000 by 2000
Manchester United	55,800	56,385 (25,686)	76,962 (1939)	43.5m	Enhance exterior
Middlesboro'	29,977*		53,802 (1949)	18m	Extend to 34,000 capacity
Newcastle	36,610	37,703 (11,413)	68,386 (1930)	23.5m	Increase capacity to 41,000
Nottingham Forest	30,602	35,367 (15,009)	49,946 (1967)	10.1m	long term to replace main stand
QPR	19,017	27,330 (15,330)	35,353 (1974)	5.4m	Extend roof
Sheffield Wednesday	39,800	54,324 (23,324)	72,841 (1934)	10m	Upgrade stands
Southampton	15,352	25,175 (9,175)	31,044 (1969)	2m	relocate
Tottenham	33,157	48,200 (17,681)	75,038 (1938)	12.25m	Upper tier
West Ham	25,982	35,556 (8,740)	42,322 (1970)	11.5m#	Rebuild main stand
Wimbledon	Ground share				

## First Division

	1995-6 Capacity	1988-9 Capacity (seated)	Record Gate	Post Taylor Costs £	Planned Expenditure
Barnsley	19,073	36,987 (2,287)	40,255 (1936)	5m	Rebuild main stand & disused spion kop
Birmingham	25,936	38,408 (9,368)	67,341 (1939)	6.5m	Increase capacity by 10,000
Charlton	15,222	20,000 (10,000)	75,031	8.6m#	rebuild stand to capacity of 20,000
Crystal Palace	26,309	38,366 (11,508)	51,482 (1979)	10.2m	Reseat to 42,000 capacity
Derby	17,451	26,500 (10,222)	41,826	700,000	relocate by 1997
Grimsby	8,807	20,685 (5,021)	31,651 (1937)	1.3m	Relocate?
Huddersfield	19,663	17,010 (5,300)*	67,037*	15m	New stand
Ipswich	22,465	37,345 (14,168)	38,010	1.2m	long term to redevelop stand
Leicester	22,517	31,057 (15,123)	47,298 (1928)	7m	long term, redevelop east stand
Luton	9,975	14,470 (6,810)	30,069	1.1m	relocate
Millwall	20,146*	25,850 (3,200)	48,672 (1937)	15.7m	
Norwich	21,272	26,812 (11,225)	43,984 (1963)	5.1m#	build 9,500 stand
Oldham	13,679	21,949 (3,200)	47,671 (1930)	4.22m	Unknown
Portsmouth	26,452 (6,757)	29,664 (6,676)	51,385 (1949)	2m (include s .75m on relocation costs)	Redevelop two sides of ground
Port Vale	22,356 (17,046)	20,962 (4,768)	50,000 (1960)	2.8m	Build new 10,000 seat stand
Reading	14,058 (2,242)	13,500 (1,953)	33,042 (1927)	300,000	relocate
Sheffield United	23,530	44,010 (13,597)	68,287	3.5m	Build new stand
Southend	12,549	12,753 (12,651)	31,090 (1979)	3.5m	Build new stand while looking for new site
Stoke	24,071 (8,996)	35,812 (11,312)	51,380 (1937)	200,000	relocate in 1997-8
Sunderland	22,657	37,775	75,118	1.3m +	relocate in

	(7,799)	(9,025)	(1933)	850,000 on relocati on	1997 (14.5m)
Tranmere	16,789	18,500 (3,500)	24,424 (1972)	3.1m	Extend main stand roof
Watford	22,011	26,956 (6,906)	34,099 (1969)	4m	New East Stand
West Bromwich	25,329	35,091 (10,675)	64,815 (1937)	5.2m	Rebuild stand
Wolves	28,464	25,000 (9,320)	61,315 (1939)	16.5m	Extend capacity

# includes land purchase costs

## Second Division

	1995-6 Capacity	1988-9 Capacity (seated)	Record Gate	Post Taylor Costs £	Planned Expenditure
Blackpool	10,337 (2,987)	16,696 (3,196)	38,098 (1955)	400,000	40,000 all seater stadium
Bournemouth	10,700 (3,080)	12,038 (4,038)	28,799	180,000	5.5m, 12,000 seat stadia
Bradford	14,359 (6,320)	15,519 (4,582)	39,146	600,000	Rebuild stand & seat Kop
Brentford	13,870 (3,905)	12,100 (2,917)	39,626	300,000	Seat terraces (relocate eventually)
Brighton	17,100 (5,188)	29,026 (4,754)	36,747	235,000	Relocate - uncertain
Bristol City	20,540	30,868 (7,416)	43,335	3m	Seat stand and build boxes
Bristol Rovers	8,943 (1,026)	8,844 (658)	38,742	*	*
Burnley	22,966 (7,385)	20,961 (6,761)	54,775	250,000	build 2 all seater stands
Carlisle	13,288 (2,161)	18,506 (2,162)	27,603	3m	3 new stands for all seater 2004
Chesterfield	8,870 (2,200)	12,838 (2,638)	30,968 (1939)	265,000	Relocate
Crewe	5,914 (4,814)	5,900 (1,100)	20,000 (1960)	1.5m	Rebuild main stand to 15,000 seater
Hull	14,996 (5,495)	19,797 (6,040)	55,019 (1949)	200,000	redevelop terraces
Notts County	20,300	24,077 (3,877)	47,310 (1955)	8m	Upgrade facilities
Oxford	9,572 (2,803)	14,374 (2,785)	22,750 (1964)	500,000	relocate
Peterborough	13,350 (9,650)	17,440 (3,440)	30,096 (1965)	2.25m	Long term to convert terraces
Rotherham	11,533 (4,486)	17,913 (3,407)	25,170 (1952)	125,000	Redevelop ground
Shrewsbury	8,000 (3,000)	15,983 (4,153)	18,917 (1961)	500,000	All seater by 2,000
Stockport	11,761 (9,110)	7,250 (1,840)	27,833 (1950)	2m	Reseat main stand
Swansea	15,638 (3,635)	18,165 (3,165)	32,796 (1968)	500,000	Relocate or redevelop
Swindon	15,341	19,652 (5,062)	32,000 (1972)	2.65m	Recover stand
Walsall	8,985 (6,685)	16,018 (1,358)*	25,453 (1961)	4.5m	Develop
Wrexham	9,350 (5,046)	22,426 (5,026)	34,445 (1957)	150,000	redevelop
Wycombe	9,649 (1,267)		9,007 (1195)	1.9m	new stand
York	9,459 (3,645)	14,109 (3,059)	28,123 (1938)	500,000	rebuild terrace

### Third Division

	1995-6 Capacity	1988-9 Capacity (seated)	Record Gate	Post Taylor Costs £	Planned Expenditure
Barnet	3,994 (1,779)	11,120 (880)	11,026 (1952)	750,000	relocate ground
Bury	11,000	8,337 (2,700)	35,000	2.9m	Seat main stand
Cambridge	9,667 (3,242)	12,500 (3,396)	14,000	280,000	Relocate or redevelop
Cardiff	17,759 (12,807)	39,545 (5,545)	61,566	1.5m	Seat terraces
Chester	6,000	8,784 (2,834)**	5,638 (1994)		
Colchester	7,618 (1,144)	6,500 (1,084)	19,072	450,000	Seek new site?
Darlington	7,046 (1,212)	16,511 (973)	21,023 (1960)	110,000	rebuild.
Doncaster	8,254 (905)	8,529 m(1,259)	37,149	250,000	redevelop or relocate
Exeter	10,570 (1,690)	9,230 (1,608)	20,984 (1931)	500,000	To survive, relocate or redevelop
Fulham	14,350 (5,742)	19,400 (7,540)	49,335 (1938)	750,000	redevelop ground
Gillingham	6,123 (1,111)	19,589 (1,225)	23,002 (1948)	150,000	Redevelop stand
Hartlepool	7,229 (3,966)	6,620 (1,582)	17,426 (1957)	1.1m	Build conference centre
Hereford	8,856 (2,754)	16,119 92,304)	18,114 (1958)	150,000	relocate or redevelop
Leyton Orient	17,050 (7,130)	26,500 (7,172)	34,345 (1964)	375,000	9.75m rebuild + facilities
Lincoln	10,918 (9,251)	11,248 (2,029)	23,196 (1967)	3.5m	
Mansfield	7,033 (2,863)	12,298 (3,448)	24,467 (1953)	750,000	Build new stadium
Northampton	7,653*	8,432 (357)	24,523 (1966)	5.2m	New stand
Plymouth	19,960 (6,859)	28,000 (3,259)	44,526 (1934)	500,000	Relocate
Preston	18,907 (9,168)	18,500 (3,928)	42,684 (1938)	5m	rebuild 3 stands
Rochdale	4,895 (2,054)	12,001 (730)	24,231 (1949)	2.3m	New stand
Scarborough	4,980 (3,500)	11,000 (833)	11,130 (1938)	1.1m	refurbish ground
Scunthorpe	9,183 (6,410)	11,226 (4,800)	8,775 (1989)	150,000	Training facilities
Torquay	5,987 (2,362)	4,999 (1,450)	21,908 (1954)	2.2m	Rebuild stand
Wigan	7,201 (1,299)	12,500 (1,100)	30,611 (1929)	170,000	relocate

\*\* Switched stadium in period

## Summary of Expenditure on Stadium Development Costs for England and Wales

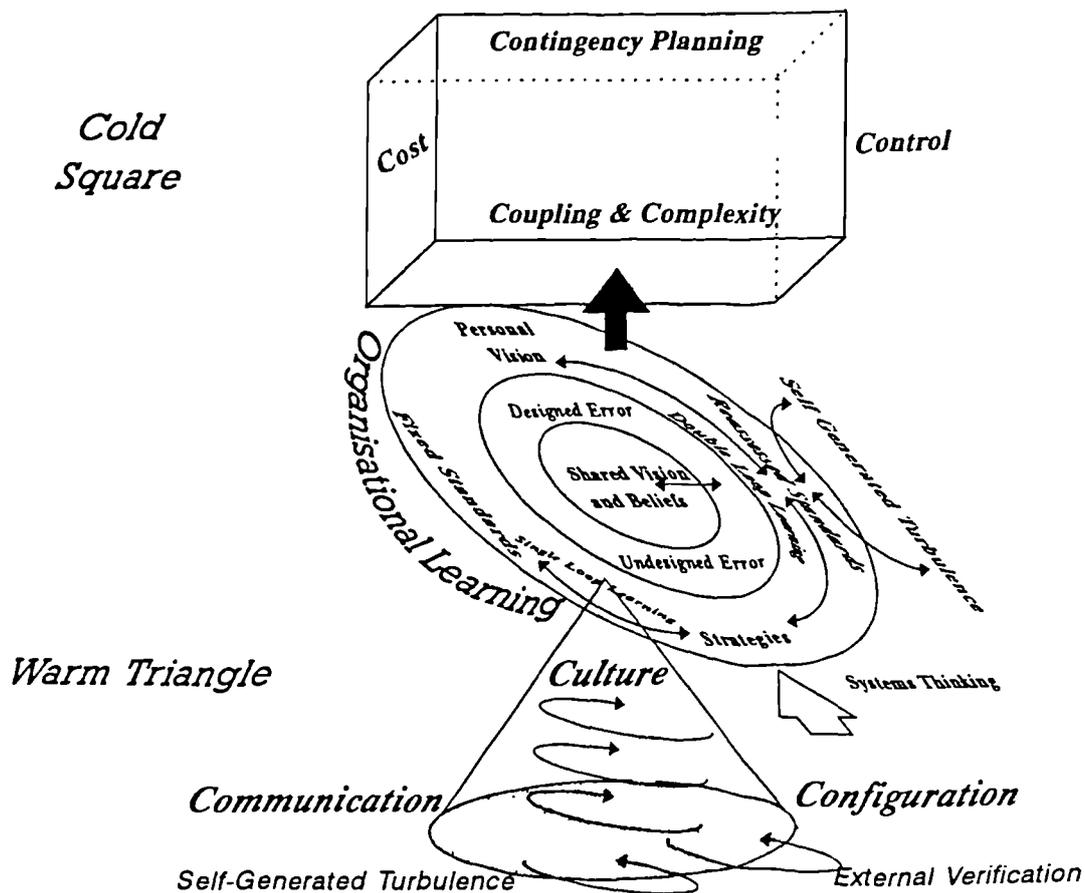
Division	Premier	First	Second	Third
Mean Expenditure 1989-95	14.33M	5.2M	1.4M	1.42M
SD	10.7	4.8	1.86	1.58
Min	0	.2	0	.11
Max	43.5	16.5	8	5.2
N	20	24	24	24

Expenditure on Ground Improvement/Redevelopment 1989-95 in Football League/Premier League

## Appendix 2.1

### The Learning Process for Crisis Management

*The Learning Process for Crisis Management*



Source: Smith 1995

## Appendix 3.1

### Interview Checklist for Football Club Executives

Have you read either the Taylor or Popplewell Reports?

What do you think were the causes of the Hillsborough Tragedy?

What do you think were the causes of the Bradford Tragedy?

How was the club affected by the Hillsborough Tragedy?

Was Bradford any different

Have there been any near misses here?

What significant problems has the club had?

What is the club's attitude to safety now?

What has the club done to ensure that a similar tragedy does not occur here

Could the club do more?

How did the club respond to the Taylor Report

What physical changes were made

Were other changes to the management of crowds made too?

How would you summarise the club's financial position?

Club Structure:

No. of playing staff

No. of non-playing staff

How are these organised?

Who reports to the chairman

What are the roles of board and chairman

What is the role of the safety officer

How was he appointed

What was his previous job

What links are there with external agencies, spectators etc.

Do you have a crisis plan

What does it cover

Do you keep accident stats - ask to see them

## Appendix 3.2

### Football Safety Officers of England, Scotland and Wales Questionnaire

## **SCOTTISH FOOTBALL SAFETY OFFICERS QUESTIONNAIRE :**

### **SOME QUESTIONS ANSWERED**

#### **Why has the questionnaire been sent to you ?**

This questionnaire has been designed as part of a research project looking at the issue of safety and crisis management in the football industry. A copy of this questionnaire has been sent to every professional football club in Scotland, Wales and England. Interviews with thirty six clubs across Great Britain have been undertaken.

#### **Who should complete the questionnaire ?**

Either the Club Match Day Safety Officer or the Club Official (e.g. Secretary ?) responsible for day to day safety issues.

#### **How long will it take ?**

Probably between fifteen and twenty minutes. Most answers involve ticking boxes or circling numbers. A limited number may require a little more information.

#### **What happens to the replies ?**

All responses will be treated in confidence. The aggregate findings will be written up for final publication, but individual club responses will remain anonymous. These aggregated findings will be presented to the Football Safety Officer's Association (England & Wales) and individual clubs (Scotland) and to the various football authorities.

#### **How can you benefit from this project ?**

We will be happy to provide you with the results of our research findings. These will be provided in a short, easy to read form. Findings will also be sent to the various Football Leagues and Football Associations. The findings from earlier parts of this project have already shaped guidelines on stewarding and football safety management.

#### **What if some questions appear inappropriate ?**

Please write in your response to the question, even if it differs from the choices you are presented with.

#### **Where do I return the questionnaire ?**

Please return in the enclosed stamped, addressed envelope to:

Dominic Elliott  
Principal Lecturer in Corporate Strategy  
Leicester Business School  
De Montfort University  
The Gateway  
LEICESTER LE1 9BH

**THANK YOU FOR YOUR CO-OPERATION**

**WOULD YOU LIKE TO RECEIVE A COPY OF OUR RESEARCH FINDINGS ?**

1.                      Yes                      No

**PART A : YOU AND YOUR CLUB**

2. Club.....

3. Division.....

4. Are you :(please tick)

- Full Time Club Safety Officer ( )
- Part Time Club Safety Officer ( )
- Club Secretary ( )
- Other (please specify)..... ( )

5. Previous Employment

- Police ( )
- Building Surveyor ( )
- Safety Management ( )
- Other Club ( )
- Club Administration ( )
- Other (please specify)..... ( )

6. Length of time in current post

- Less than 1 year ( )
- 1 - 3 years ( )
- 4 - 5 years ( )
- More than 5 years ( )

7. How old are you ?

- 18-30 ( )
- 31-40 ( )
- 41-50 ( )
- 50-60 ( )
- 61+ ( )

Which of the following do you believe will result from the introduction of all seater stadia ?

	Strongly Disagree	Don't Know	Know	Strongly Agree
8. Improved public safety	1	2	3	5
9. Faster evacuation	1	2	3	5
10. Improved spectator behaviour	1	2	3	5
11. Easier crowd control	1	2	3	5
12. Fewer police	1	2	3	5
13. Fewer stewards	1	2	3	5
14. Improved spectator comfort	1	2	3	5
15. Reduced hooliganism	1	2	3	5

**PART B : STEWARDING AND MATCH CONTROL**

16. Does your stadium have a match control room

- (please tick) **Yes** ( )
- No** (if no please go to question 18) ( )

17. If yes, which of the following are usually located within the Control Room during matches

- a) Police
- b) Club Safety Officer/Steward/Security Co.
- d) Ambulance Service
- e) Fire Service
- f) Other (please specify).....

19. Who is usually in charge of match operations : (tick one only)

- a) Police Match Commander
- b) Club Safety Officer/Steward/Security Co.
- c) Joint effort
- d) Other (please specify).....

20. What is the primary role of your stewards at a football match ? (tick one only)

- a) Ensuring Crowd Safety
- b) Ensuring Public Order
- c) Other (please specify).....

21. What is the primary role of the police at a football match ? (tick one only)

- a) Ensuring Crowd Safety
- b) Ensuring Public Order
- c) Other (please specify).....

22. Do you consider a match supervised by stewards only, i.e. with no police presence, to be a genuine possibility at your club in the foreseeable future ? (please tick)

- Yes
- No

If no, then could you explain briefly your reasons ?

23. How would you rate the overall quality of stewarding at your club now ? (where 1 is very poor and 5 is excellent)

Very Poor		Just Adequate		Excellent
1	2	3	4	5

24. How would you rate the overall quality of policing at your club now ? (where 1 is very poor and 5 is excellent)

Very Poor		Just Adequate		Excellent
1	2	3	4	5



**PART C : GROUND IMPROVEMENTS**

31. Have you undergone any major ground re-development since publication of the Taylor Report ?  
(please tick)

- Yes** (please go to question 33)   
**No**

32. If no, is this because: (tick one only)

- a) not required to do so   
 b) Lack of finance   
 c) Uncertainty over future divisional status   
 d) Ground already meets all safety standards   
 (please go to question 37)

How important were the following in your club's decision to redevelop your ground ? (where 1 is vital and 5 is unimportant)

	Vital		Important		Negligible
	1	2	3	4	5
33. Availability of finance	1	2	3	4	5
34. Need to respond to Stadia Tragedies	1	2	3	4	5
35. Taylor Report Recommendations	1	2	3	4	5
36. Local Council Safety Committee	1	2	3	4	5
37. Commitment to improve stadium	1	2	3	4	5
38. New Chairman/Board	1	2	3	4	5

39. Please indicate which of the following best describes how you are able to introduce all forms of safety measures ? (tick one box only)

- a) We sometimes are unable to comply with regulations   
 b) We always comply and sometimes do more than we are required to   
 c) We always fully comply with legislation   
 d) We always do more than required   
 e) We have been unable to comply with new regulations

40. Do you believe that crowds using your stadium are safer now than they were before the publication of the Taylor Report ? (please tick)

- Safer**   
**About the Same**   
**Less Safe**   
**Don't Know**

41. If yes, which of the following do you consider to have been the single most important factor in increased safety. (tick one box only)

- a) Improvements to the Stadium   
 b) Improved Stewarding   
 c) Other (please specify).....

42. Do you believe that you could have done more

- (please tick) **Yes**   
**No**

43. If yes, what has prevented you from doing more ?
44. Using your knowledge of the Club for which you work, please place in order of priority, the three most important objectives from the following list
- a) Playing Success ( )
  - b) Financial Success ( )
  - c) Financial Stability ( )
  - d) Entertainment ( )
  - e) Crowd Safety ( )
  - f) Ground Improvement ( )
  - g) Local Area Success ( )
  - h) Other (please specify)..... ( )

**PART D : ATTITUDES**

Please indicate on a scale of 1 to 5 your view of the following where 1 is to strongly agree and 5 is to strongly disagree. (please circle)

	strongly agree		unsure		strongly disagree
	1	2	3	4	5
45. We can handle any crowd incident.	1	2	3	4	5
46. A major tragedy can not happen in our ground.	1	2	3	4	5
47. We now do enough in safety management.	1	2	3	4	5
48. Disasters just happen, we cannot prepare for them.	1	2	3	4	5
49. Only badly managed clubs have crises.	1	2	3	4	5
50. Crises are usually caused by the mistakes of a few people.	1	2	3	4	5
51. A crisis has one or two causes.	1	2	3	4	5
52. We do not have time to fully prepare for crises.	1	2	3	4	5
53. Well managed clubs do not have crises.	1	2	3	4	5
54. Extensive safety management is a luxury.	1	2	3	4	5
55. If a major crisis happens someone else will rescue us.	1	2	3	4	5

	strongly agree		unsure	strongly disagree	
	1	2	3	4	5
56. Every disaster is so different that it is impossible to prepare for it.	1	2	3	4	5
57. In a crisis our contingency plans will see us through.	1	2	3	4	5
58. We will be able to react to a crisis in an objective and rational manner.	1	2	3	4	5
59. Our communication systems are sufficient to deal with a major incident.	1	2	3	4	5
60. The police are responsible for public safety.	1	2	3	4	5
61. The police should, normally, have no role within a football ground.	1	2	3	4	5
62. Hillsborough was terrible but current regulations are too much of a burden.	1	2	3	4	5
63. My board of directors would never compromise safety.	1	2	3	4	5
64. The board never questions my advice on safety expenditure.	1	2	3	4	5
65. Our local safety committee have little understanding of the way football clubs are managed.	1	2	3	4	5
66. The enforcement bodies expect too much from clubs.	1	2	3	4	5

THANK YOU FOR YOUR CO-OPERATION IN COMPLETING THIS QUESTIONNAIRE.

SHOULD YOU HAVE ANY QUESTIONS OR QUERIES, PLEASE CONTACT DOMINIC ELLIOTT ON 0116-257 7245.

PLEASE RETURN TO :  
D. ELLIOTT  
PRINCIPAL LECTURER IN CORPORATE STRATEGY  
LEICESTER BUSINESS SCHOOL  
DE MONTFORT UNIVERSITY  
LEICESTER LE1 9BH

## Appendix 3.3

### Club Executive Interview Respondent Characteristics

## Appendix 3.3

### Club Executive Interview Respondent Characteristics

Club	P1	P2	P3	P4	F1	F2	F3	F4
Title of interviewee	Sec.	Sec.	Gen. Mgr	Sec	Sec	Stadium Mgr	Sec.	Chief Exec
At Club	23 years	23 years	28 yrs	17 years	3 years	3 years	23 years	18 months
Background	Soccer admin.	Soccer admin.	Various	Soccer admin.	Police	Police	Accountant	Accountant
Estimated Age(rounded to nearest 5 years)	45	60	50	40	50	50	60	35
Av. attendance 91/2	16,834	23,148	29,459	17,618	12,400	14,703	18,390	6,786
Board Member	No	Yes	No	Yes	Yes	No	Yes	No
Full time safety officer/stadium mgr	Private security/ Part time	Yes	Yes	Consultant	Yes	Yes	Yes	Part time
Safety officer background	Police	Police	Soccer admin.	Police	Police	Police	Soccer admin.	Police

	S1	S2	S3	S4	T1	T2	T3	T4
Title	Chief Exec	Sec.	Sec	Sec	Sec	Chief Exec	Sec.	Sec
At Club	40 years	2 years	1 year	17 years	5 years	1 year	2 years	18 months
Background	Soccer admin.	4 years in soccer admin.	Commerce	Soccer admin.	Soccer admin.	Accountant	Soccer admin	N/A
Estimated Age(rounded to nearest 5 years)	65	30	35	55	55	40	50	25
Av. attendance 91/2	8,511	10,521	6,279	2,608	2,904	4,492	1,857	1,677
Board Member	Yes	No	No	Yes	No	No	No	No
Full time safety officer	Yes	Consultant	Part time	Matchday only	Matchday only	Consultant	Matchday only	Matchday only
Safety officer background	Police	Private security	Police	Surveyor	Police	Police	Unknown	Local authority

	Sc1	Sc2	Sc3	Sc4
Title	Safety Officer	Safety Officer	Club Secretary	Club Secretary
At Club	5 years	3 years	18 years	12 years
Background	Police	Police	Club admin.	Club admin
Estimated Age(rounded to nearest 5 years)	60	60	45	45
Av. attendance 91/2	N/A confidentiality	N/A confidentiality	N/A confidentiality	N/A confidentiality
Board Member	No	No	Yes	Yes
Full time safety officer	Yes	No	No	No
Safety officer background			Police	Police

### **Premier Division**

P1 had some thirty years of experience in the football industry and had been at the club for over fifteen years. The Club had recently been purchased by a prominent businessman and had experienced a major turnaround in its fortunes. The interview took place in F2's office with minimal interruption.

P2 had had over thirty years experience within the football industry and had spent some twenty five years at the present club. The interview took place in P2's office and lasted for one hour and twenty minutes. P2 was a member of the board.

Although P3 had been in post for some five years, F4 had had twenty eight years working for the club, originally as a part time turnstile operator. The interview took places in F4's office with minimal interruption.

P4 combined the club secretary and safety officer. Both had been with the club for over twenty years and were clearly good friends.

### **First Division**

F1 was a former police officer who had been in the post with the club for less than five years. The Club had recently emerged from severe financial difficulties and had been recently purchased by a prominent businessman. The interview took place at the Club in an open plan office with other administrative staff present. F1 was a member of the board.

F2 consisted of two members of staff, one the safety officer the other the stadium manager. One had been with the club for some 10 years following a successful commercial career. The other had been with the club for three years following a police career. A high level of trust appeared to exist between the two and the interview lasted for two and a half hours.

F3 had been the Club secretary for over twenty years, following a career as an accountant, and was a member of the board. The interview lasted for some three hours and the safety officer joined the interview for the last hour.

F4 had been a keen semi-professional footballer and Chartered accountant and had been in post for eighteen months.

### **Second Division**

S1 had been a professional footballer and had had experience as a football administrator in a number of clubs. S1 had been at the club for over twenty years. the interview lasted for two hours.

S2 was an ex lower league football player and after two years experience at another club had been in post for eighteen months.

S3 had worked for the club over a twelve year period, interrupted by an eight year stint in commerce.

S2 had been in current post for twelve months. The meeting lasted for some three hours and the interview was used by the interviewee to avoid another meeting with a 'difficult player'.

S4 had been in post, as Chief Executive, for some eighteen years. S4 was a board member and used the interview to avoid listening to the chairman talk 'a lot of waffle'.

### **Third Division**

T1 had worked in a senior capacity for a number of clubs in the preceding twenty five years and had been in post for some two years.

T2 had been in post for twelve months and had been brought in to 'turnaround the club'. T2's background was as a management accountant and had little experience of football.

T3 had worked for a number of clubs over a period of twenty years, with a four year break, and had held the current position for some two years.

T4 had been in post for less than twelve months and had had little work experience before joining the club.

### **Scottish Clubs**

SC 1 had been in post for more than 10 years and the club had complied with Taylor's recommendations for some time

SC2 was a retired police officer who had been in post for five years.

SC3 had been in post, as part time safety officer, for some 18 months. Prior to this he had been a retired police officer.

SC4 had held the post of club secretary/chief executive for 7 years. Prior to this he had held another administrative post at another club.

## **Appendix 3.4**

### **Letter to Local Authorities Safety Advisory Group Chairpersons**

April 21, 1997

Dear Sir/Madam,

I am currently completing a five year study of crowd safety and the UK Football Industry. The study, which has been undertaken with the support of the football authorities, has two main objectives.

- (i) Examination of the underlying causes of the UK football stadia disasters 1946 - 89
- (ii) Analysis of the responses of clubs and the various agencies associated with the football industry to the tragedies.

In addition to extensive interviews with football club executives, I have interviewed and surveyed members of those agencies with an interest in crowd safety (including FA, Police, FLA, Home Office, Politicians, Local Authorities, and members of the Football Safety Officers' Association) The result, to date, has been one of the most comprehensive analyses of this subject.

As a final stage in this study I intend to examine the role of the Safety Advisory Group. To enable me to do this I would be grateful if you would grant me a 10-15 minute telephone interview to discuss the role of your Safety Advisory Group. I shall treat all discussions sensitively and in the strictest confidence - an assurance given to all participants in this study.

The areas of interest to me currently concern the following broad areas:

- a) The responsiveness of the Club to S.A.G. recommendations.
- b) The nature of the contribution of members of the S.A.G.
- c) Strengths and Weaknesses of the S.A.G. system.

Your local authority is one of a small, carefully selected sample (reflecting the geographical dispersion, league status and size of the football clubs for which you have responsibility). I would be very grateful, therefore, if you could confirm your willingness to participate in this study by either writing to me or by fax indicating your support to Dominic Elliott 0116 251 7548 or of course by phone 0116 257 7245 (work) 0116 2858292 (home).

I will however, endeavour to make contact with you weeks commencing April 28th and May 5th. Should you require further information or background please do not hesitate to contact me. You will of course be sent copies of the final research report.

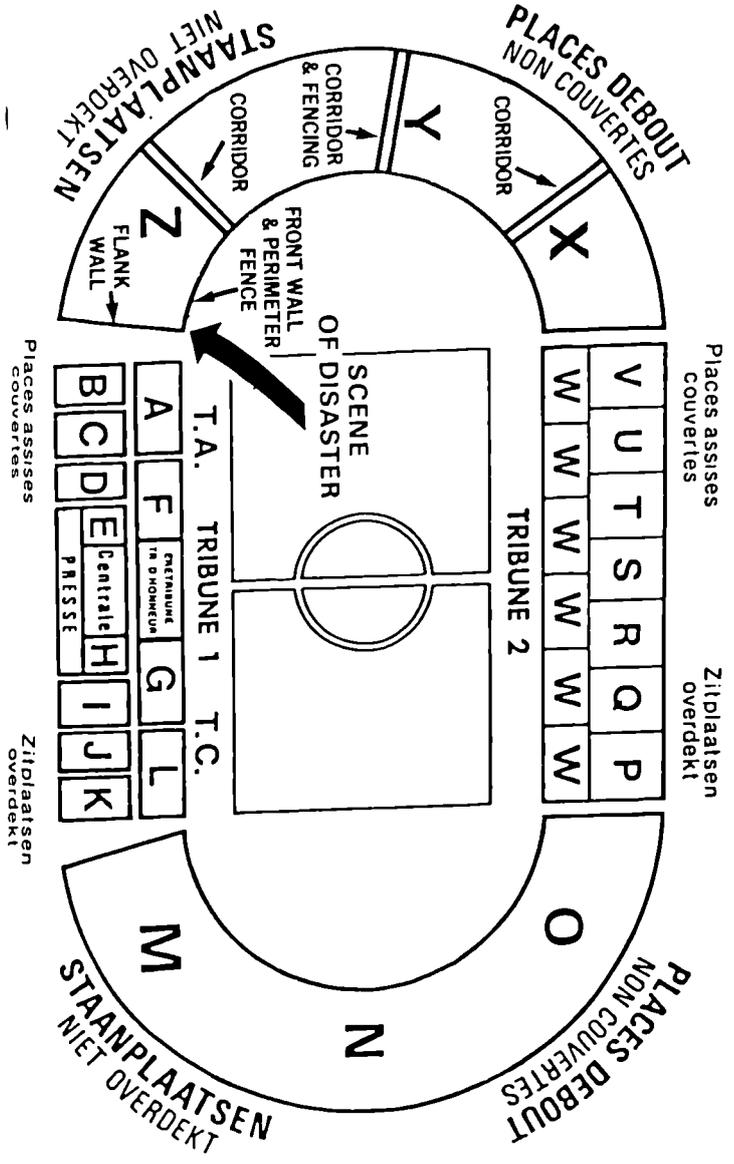
Yours faithfully

Dominic Elliott  
Principal Lecturer in Corporate Strategy



## Appendix 5.1

### Plan of Heysel Stadium Layout



## Appendix 6.1

### Pre rotation Factor variable Loadings

## Appendix 6.1

### Pre Rotation Factor variable Loadings

1997	Pre-Factor 1	Pre-Factor 2	Pre-Factor 3	Pre-Factor 4	Pre-Factor 5	Pre-Factor 6	Pre-Factor 7
Q45	.14410	<b>.68260</b>	.20530	.04316	-.32917	.01156	-.02852
Q46	.35062	<b>.50216</b>	.04475	-.31895	-.23272	.07119	-.25571
Q47	.01908	<b>.47635</b>	.06440	-.34560	.02967	.14230	<b>-.61400</b>
Q48	<b>.59419</b>	.07191	-.11591	-.06069	-.28117	-.42063	-.06575
Q49	<b>.51569</b>	-.01381	<b>.47197</b>	.29480	-.24486	.05441	-.08978
Q50	.30269	.23824	<b>.48253</b>	-.14788	.39654	-.32370	.23129
Q51	.26320	.44096	<b>.47916</b>	-.00797	.41630	-.06347	-.01853
Q52	<b>.59013</b>	-.30689	-.28893	.09811	.17340	.35655	-.15883
Q53	<b>.48357</b>	-.05085	.39807	<b>.45133</b>	-.16444	.16829	.15163
Q54	<b>.63470</b>	-.25754	.14707	.15471	.19123	.00137	-.32377
Q55	<b>.71012</b>	-.35314	-.07407	.06027	.00851	.24581	.09237
Q56	<b>.66869</b>	.13191	-.43083	.12512	.04872	-.02956	.01952
Q57	-.01429	<b>.68445</b>	.09205	.16375	-.30942	.05416	.28306
Q58	-.17829	<b>.53430</b>	-.06007	.20338	.19448	<b>.57102</b>	.22318
Q59	-.02012	<b>.67101</b>	-.29558	.06261	.28441	.11014	-.05164
Q60	.11504	.29814	-.27586	.36494	<b>.55181</b>	-.31972	-.02860
Q61	.32563	-.18334	.42178	<b>-.58399</b>	.15263	.09738	.27790
Q62	<b>.46398</b>	.05970	-.34453	<b>-.56971</b>	.05916	.18011	.27984
Q66	.44792	.30759	<b>-.51038</b>	-.01436	-.21503	-.26126	.21773
% of total variance explained	18.0	15.4	10.2	7.7	7.0	5.7	5.3