THE INDEPENDENT
FOOTBALL OMBUDSMAN

IFO COMPLAINT REF: 14/05

AN ACCIDENT AT THE SOUTHAMPTON v STOKE CITY MATCH IN MAY 2013

The Role of the Independent Football Ombudsman (IFO)

1. The office of the IFO was established by the three English football authorities (The Football Association (FA), The Premier League and The Football League) with the agreement of Government. The IFO has been designated as the final stage for the adjudication of complaints which have not been resolved within football's complaints procedure. The IFO operates a system of non-binding arbitration. IFO Adjudications will normally comprise two parts: an impartial assessment of the substantive complaint and a review of the procedure by which the complaint was handled. The IFO's role is to investigate the complaint and judge whether it was dealt with properly and whether the outcomes were reasonable for all parties concerned. Under the procedure agreed by the Football Governing Bodies, the adjudication of the IFO is final and there is no right of appeal against IFO findings.

2. The IFO confirms that in investigating this complaint he has received the full cooperation of Southampton FC, the Premier League and the Sports Ground Safety Authority (SGSA).

The complaint

3. A Stoke City supporter now living in the South of England complained about an accident which befell her late mother at St Mary's Stadium, while attending the last match of the 2012-13 season. She alleges that the accident was avoidable and was due to lax and inadequate stewarding. She further argues that her complaint was not investigated fully by Southampton FC and wishes the Club to admit its shortcomings and confirm that it has improved its stewarding practice.

The facts of the case

4. On 19 May 2013 Southampton hosted Stoke City in the final match of the season. Both Clubs were safe from relegation and the day took on a carnival atmosphere, with many fans in fancy dress. The complainant's mother, a long-standing Stoke City supporter who regularly attended away matches, went to the match with another of her daughters. Though 93, the lady was fit and active and was well known to Stoke fans. She was unhappy with her allocated seats, because of the boisterousness of the away fans who obstructed her view, and so at her request, the stewards moved the two ladies to the very front row adjacent to the pitch. This was an example of good, pragmatic customer service. The complainant reports that her mother made several references to young men running up and down the gangways and the failure of the stewards to take any action. Several reports cite the celebrations following a Stoke goal as the cause of the accident. In fact, the Safety Officer's matchday log confirms that the accident occurred some 7 or 8 minutes after the goal was scored.

5. The basic facts are not in dispute. A number of youths (perhaps three to five) in the adjacent section were engaged in horseplay which spilled into the gangway and caused a domino effect, with the youths cascading diagonally into the next section. The mother's seat was the first one on the front row and she was leaning against the back of the seat, because in a sitting position her view was obstructed by pitchside photographers. A male supporter in the seat

immediately behind her, and in a sitting position, was thrust forward by the impact of the falling supporters. The effect was to push the lady headlong into the concrete track. She suffered cuts around her eyebrow, severe bruising and was bleeding profusely. She was immediately comforted by stewards and police and was attended to by St John Ambulance personnel. She was removed to the First Aid Room and her other daughter (the complainant) was summoned there from her seat elsewhere in the away section. The Club organised an ambulance and the lady was transferred to hospital where she was treated and remained overnight. The complainant has no concerns about how the Club responded once the accident occurred: her assertion is that the accident would have been avoided had the stewarding been effective. The concern of the family about the accident was exacerbated by the fact that sadly the mother died some four weeks after the incident, following a stroke.

6. On 23 May the complainant wrote to the Club asking for an investigation into "why the fans were allowed by the stewards to stand in the gangway during the match, which is clearly the cause of this accident". Dissatisfied with the Safety Officer's reply of the same date (which included an offer of hospitality at the next match between the Clubs), the complainant wrote again on 31 May and 13 June asserting that "your stewards were completely ineffective…in proactively dealing with a particular group of fans…who behaved anti socially in moving up and down the aisles". She questioned whether the accident had been reported under the Reporting of Injuries Diseases and Dangerous Occurrences Regulations (RIDDOR). The Club replied that it did not believe that the accident was reportable under RIDDOR since it was not work related. [The IFO has no jurisdiction over RIDDOR which is a matter for the Health and Safety Executive (HSE) and therefore will not be commenting on this aspect of the complaint. For the record, the SGSA Inspector comments that the HSE website information and guidance are ambiguous on reporting requirements. The IFO notes that the Club has now developed a RIDDOR compliance form to clarify reporting procedures].

7. The complainant requested the support of the Football Supporters Federation (FSF) and on 17 June the FSF offered the Safety Officer copies of 15 witness statements which they had received as a result of an appeal to supporters who had been at the game. Following a telephone conversation, these were

forwarded on 20 June. Allowing a period to elapse following the mother's funeral, the Safety Officer responded to the complaint on 19 July via the FSF, reporting that a Club and police review concluded that the accident "could not have been prevented by anyone…we do feel that everything that could possibly have been done in relation to her fall here was done on the day in question". Further correspondence followed reflecting the differing perspectives, with the Club maintaining that it had fully investigated the accident and the complainant asserting that her contention, that the accident had not been thoroughly investigated, had not been addressed. In August 2013 the complainant requested that the complaint be referred to the Premier League and at the end of the month the Safety Officer confirmed that the Premier League had been in touch. He invited the complainant to visit St Mary's to discuss the accident, to which she responded that she was awaiting documents which she had requested under the Freedom of Information Act. She renewed her claim that the accident should have been reported under RIDDOR.

8. Correspondence continued through the autumn and the Premier League concluded that it believed that the complaint had been thoroughly investigated, noting that both the SGSA and the local Safety Advisory Group (SAG) had considered the case. Due to compelling family reasons, there was a hiatus between November 2013 and March 2014. When the complaint was renewed, the Premier League offered to discuss the case personally with the complainant. Neither this offer nor the invitation to St Mary's was taken up. The complainant requested a referral to the IFO and on 19 March 2014 the Premier League confirmed that its stage of the complaints process had been completed.

The Investigation

9. The IFO carefully considered the extensive correspondence between the complainant and Southampton FC, together with the witness statements submitted by the FSF. The IFO also reviewed police witness statements, SAG minutes and the material obtained by the complainant under the Freedom of Information Act. On 27 March the IFO met with the complainant to discuss the case face to face. On 8 April the IFO and Deputy visited St Mary's and discussed stewarding and the accident with the Safety Operating Assistant (in the absence through illness of the Safety Officer himself). They were able to watch CCTV

records of the match and to view the location of both the incident and the away supporters. Subsequent to the visit the Safety Officer responded to specific questions about the security preparations, the CCTV evidence, the contact with the SGSA inspector and the follow up investigation. On 29 April the IFO and Deputy met two SGSA Inspectors, one who had been on duty at the match and the other who was now the Regional Inspector for Southampton and was familiar with the case and with security arrangements at St Mary's. The Duty Inspector had attended the pre-match briefing of stewards when one of the key messages had been to ensure that aisles were kept clear. He recalled there having been a lot of movement in the aisles, people going up to the vomitories and returning, but no persistent standing in them, hence he had used the term "predominantly clear" in his report.

10. In a witness statement produced some time later, a police officer said that some Stoke fans had been "jumping up and down a bit. This is not unusual for a football match and I didn't pay it much attention. This was maybe 5 or 6 rows back from where the lady was sitting and on the other side of the aisle to her. I only saw this for a matter of seconds before someone fell forward which in turn caused someone in front of them to fall forward, causing a domino effect of people falling forwards. This stopped when someone fell into the lady.... I do not remember there being people stood in the aisles at the time, although all of the aisle seats were occupied and the crowd were all stood up at the time."

11. Another police witness said that he had been at the bottom of the aisle with his back to the pitch when he saw some boisterous celebrations coming from a group 3 or 4 rows in front of him. "People were jumping on each other and there was a party atmosphere amongst these supporters. I then saw what I can only describe as a domino effect of supporters falling forward.... towards the elderly lady."

The Findings

12. As indicated in Paragraph 1, the complaint will be discussed in two parts, the original incident and the way the complaint was handled. The first issue to discuss is the stewarding arrangements and the complainant's assertion that the stewarding was ineffective. There were some 240 stewards on duty and there were clearly attempts to get the supporters to sit down. Viewing four separate discs of CCTV recordings indicated that there was regular activity by stewards

keeping the gangways free. The vast majority of the cameras were directed on the upper sections of the away supporters and there were regular patrols of stewards every 15 minutes, also additional steward activity up and down the gangways. There was occasional coverage of the short section where the lady was sitting which showed patrolling activity by stewards in that section, walking up and down the gangways, though there was no video of the accident itself and no evidence of people blocking aisles. There was a lot of movement in the aisles as people went to the concourse and returned. The SGSA Inspector was impressed with the activity of the stewards, for example in identifying and ejecting those responsible for discharging flares. The Inspector's conclusion was that the stewards were successful in keeping the gangways "predominantly" clear. One of the police officers stated that he did not remember there being fans standing in the aisle at the time of the incident (see paragraph 10). It is also worth noting that, as the IFO discovered when visiting the stadium, the control room is immediately over the away section and if the gangways had been crowded, this would surely have prompted urgent action by the Safety Officer and the Match Commander.

13. During the investigation the IFO discovered that the match had been the occasion for a "mystery shopper" report organised by the Premier League. (Surprisingly this had not been mentioned by either the Premier League or Southampton FC). The *VisitFootball* report by a Stoke City fan concluded, "the attitude and professionalism of the stewards was a strong point and the disturbance in the visiting supporters' stand was well handled". The grading awarded in the report for "Overall Stewarding" was 75% and the overall comment was, "There was a good level of policing and combined with the stewards helped to provide very good safety and security." The report confirmed that much of the rear section was standing, but that there was "effective management of the more unruly sections of the visiting supporters". Finally, it was confirmed that "numerous stewards at the front of the stand were good at monitoring, all facing inwards during play". It is not clear where this fan was sitting in relation to the accident.

14. The complainant noted that the Match Commander described the Stoke City fans as "horrible" and a great challenge for both stewards and police. The Safety

Officer confirmed that "police presence is there as a safety precaution and police were required several times on the day to assist and prevent disorder." In response, the complainant asserted that the Safety Officer should have been prepared for the presence of risk supporters, especially as it was the last match of the season and over 3000 away supporters were expected in the ground. The police Intelligence Assessment reported to the Club that the number of risk Stoke City supporters had declined in recent years, but that 20-30 youth risk supporters were expected to attend who were likely to have been drinking before the 4.00 pm kick-off. As a result of this, the Safety Officer deployed a special unit of stewards supported by the police to deal with any incidents involving such Stoke supporters. The police agreed with the Club that the match was medium risk, with 1 steward to 135 supporters in the away section, who were supplemented by further stewards towards the end of the game to prevent a pitch invasion.

15. The FSF submitted 15 anonymised witness statements which the Club read. The Club discussed this with the Hampshire Police Commander and the Football Liaison Officer (FLO) and decided that, as the statements were from Stoke City supporters, they would offer this evidence together with CCTV recordings to the Stoke City FLO via Hampshire Police, rather than follow up themselves. The IFO contacted two of these witnesses, one the man who fell into the back of the lady and the other who had contacted the FA after the match to complain about standing, thereby providing a contemporaneous account. Predictably there is some inconsistency among the witnesses, with most claiming that the stewards took insufficient action, but a few saying that the stewards did try to keep the gangways clear. The senior steward who attended the lady at the time of the accident included in her report the statement, "I can confirm that the aisle at the time was clear and her falling forward was a direct result of a surge of the fans sat behind her pushing forward". The FSF witnesses agreed that the accident occurred when the youths suddenly fell forward in a domino effect. They had shown no remorse for what they had done and most expressed disgust at the behaviour of these youths, pointing out that the vast majority of Stoke fans were boisterous and standing, but otherwise causing no trouble.

16. In summary, the IFO considered the following evidence in relation to the stewarding:

- The complainant's frequently expressed view that the stewarding was inadequate and commented upon by her mother prior to the accident
- The FSF witness statements submitted in support of the complainant
- Witness statements by two police officers
- The steward's report on the incident
- The Safety Officer's commentary
- The CCTV record of stewarding and supporters' behaviour in the away section
- The comments by the SGSA Inspector
- The discussion by the SAG (discussed below)
- The "mystery shopper" *VisitFootball* report

17. By definition the incident which caused the accident was sudden and difficult to predict. The CCTV evidence confirms that there was pro-active stewarding and supports the SGSA conclusion that the gangways were kept predominantly clear, ie although there was a lot of movement, there was no apparent blocking of the aisles by fans standing in them. The stewards and police did indeed find the Stoke City supporters a challenge, but managed to deal with flares and some disorder earlier in the game. It is relevant to quote one of the FSF witnesses at some length:

> The stewards were dealing pretty well with the Stoke crowd, they were never going to make everyone sit so they seemed to have adopted a respond to any incident type approach rather than get heavy handed.
>
> I thought the stewards did a reasonable job that day reacting very quickly to any flashpoints. The problem they had is the Stoke fans hell bent on causing problems were moving across the stands in smaller groups, crowding an area, then choosing their moment to rush forward down the aisles. Making it terribly difficult for them to predict where and when the next issue would come from

The notion of a sudden incursion into the gangways identified here is consistent with the police witness statement quoted in Paragraph 10.

18. Most of the FSF witnesses supported the complainant's view that more could have been done by the stewards. One expressed the opinion that the accident

would not have happened "if the stewards had kept the gangways clear", while another judged that "it could have been avoided if the stewards had actually been more diligent". The stewarding was variously described as "lax", "too soft", "inadequate" and "could have been more assertive". Yet among the FSF witness statements is the report that stewards were overheard telling supporters they should not be standing in the aisles and the conclusion that the stewards "did nothing wrong in the situation." One witness recalled "the stewards were very active and remained vigilant facing the crowd and making several interventions that I witnessed to stop people standing in the gangways etc".

19. Perhaps more could have been done by the stewards. However, the explosive and unexpected nature of the incident could not have been predicted. The most accurate assessment of what seems to have happened can probably be drawn from the police witness statements. The incident started with some fans jumping on each other a few rows back and across the aisle from the complainant's mother. The incident spilled across the aisle and, because everyone was standing, a domino effect resulted in the lady being injured. This was indeed a very unfortunate accident caused by unruly Stoke fans and **the IFO is unable to conclude that it was the result of inadequate stewarding.**

20. Although the fact that fans were standing was not the primary cause of the accident, a "domino effect" is unlikely to have occurred had fans been seated. In his Annual Reports the IFO has drawn attention to the continuing problem of standing in seated areas and has recommended that the Football Authorities discuss with SGSA and the Department for Culture, Media and Sport how to address concerns over the situation. From discussions with Safety Officers and Match Commanders the IFO is well aware of the belief in watchful monitoring of standing supporters and the unwillingness to take proactive action against them for fear of provoking a public order incident. However, as long as standing is tolerated there remains the likelihood of accidents such as the one in this case will occur. This is not, of course, a problem exclusive to Southampton, but is endemic throughout the Leagues.

21. The second part of the complaint concerned the claim that the accident and the complaint were not properly investigated. As cited in Paragraph 6, the Safety Officer replied on the same day he received the complaint. He explained the strategy which had been used, with the priority of keeping aisles and vomitories clear. When further correspondence indicated continued dissatisfaction, he confirmed that he was mounting a full enquiry, including reviewing CCTV records. In July he reported that "a thorough investigation" had been conducted, involving the Club's Safety Management Team, the Chief Operating Officer and the police. He copied his reply to the SGSA Inspectors, whom the complainant had contacted. The complainant asks why the SGSA Inspector present on the day had not been informed about the accident. This was indeed somewhat surprising, the Safety Officer stating that he was unaware that accidents were required to be reported to the Inspector. Yet this was a significant event requiring an ambulance and transfer to hospital, so it was something of which the Inspector should have been made aware.

22. The Inspector, along with the Safety Officer and the police, attended the next (July) meeting of the Southampton FC Safety Advisory Group (SAG) which discussed the accident. It received a report from the Club, following which the police confirmed that "all had been done to keep gangways and vomitories clear". After discussing the case, the SAG concluded that "this incident was an unfortunate accident". After the SAG meeting the Safety Officer confirmed to the complainant that he believed the Club report was "a thorough and transparent account of the incident on the day which is supported completely by Hampshire Police". He announced that his investigation was complete. Notwithstanding this club closure, the Safety Officer later advised that he would be referring the case back to the SAG's October meeting to discuss the accident again, as well as the RIDDOR requirements. In November 2013 the Safety Officer advised the complainant of the outcome of the SAG's further review. The SAG had concluded again that "the incident was an unfortunate accident involving Stoke City supporters who fell causing a domino effect". (The repetition of the erroneous timing, that it had been during a goal celebration, does not in the IFO's view undermine the validity of the conclusion). The SGSA Inspector had repeated his overview that "aisles and vomitories were predominantly kept clear by proactive stewarding". The SAG had been unanimous in its findings

23. The complainant has always recognised that what happened to her mother was an accident, but believes it to have been preventable and that its circumstances have not been investigated thoroughly. The accident and the circumstances surrounding it have been reviewed by the Safety Management Team and the Senior Management at the Club, by the Police and by the SGSA. It has also been discussed at two meetings of the SAG. In the light of this the **IFO finds that there has been a full and proper consideration of the matters raised by the complainant.**

Conclusion

24. The investigation into this complaint has thrown up a number of issues of wider concern which merit the attention of Southampton FC, Clubs in general and the Football Authorities. **The IFO, therefore, recommends that:**

- **The Safety and Operational Managers at Southampton build on their undoubted reputation (as attested by the SGSA and previous IFO assessment) by learning from this unfortunate accident, to improve stewarding practice further in relation to the management of unruly fans and in the seating and protection of frail or elderly supporters.**

- **Southampton FC makes certain that visiting SGSA Inspectors are fully apprised of all relevant safety related incidents before they leave the stadium**

- **Southampton FC reviews its arrangements for the positioning of pitchside photographers to ensure that they do not block the view of supporters seated on the front row**

- **Clubs advise their supporters of the need to behave in a reasonable manner and not put fellow supporters at risk.** (Stoke City only communicate with their travelling supporters if specific advice is given by the host club. The Southampton programme contains the

request, "Please behave appropriately at all away matches or you may receive a ban from St Mary's Stadium and from purchasing away tickets").

- **The Football Authorities encourage the education of fans about the standing issue and explore urgently the idea of an experiment in "Safe Standing" (this is in the context of the evidence from this and other IFO reports that the ground regulations on standing are becoming unenforceable).**

- **When selling away tickets clubs should proactively encourage those who might wish to stand to purchase tickets at the back of the stadium and assist those who cannot or do not wish to stand to acquire tickets at the front**

25. It is true in life generally, as well as in this incident, that accidents might have been avoided if certain behaviour or actions had been different. In that sense most accidents might have been avoided if different circumstances had prevailed. The question in this case is whether the particular sequence of sudden events which caused the accident could have been anticipated or prevented. After a very thorough enquiry into the evidence, the IFO concludes that it could not, and endorses the conclusion which the Safety Advisory Group reached on two occasions, that this was indeed an unfortunate accident. The IFO recognises the understandable distress of the complainant about what happened at St Mary's in May 2013 and hopes that this report will convince the complainant that her concerns have been rigorously investigated.

Professor Derek Fraser, Ombudsman **23 June 2014**
Alan Watson CBE, Deputy Ombudsman