

## LEARNING FROM DISASTERS THE LOVEPARADE (Duisburg, Germany 2010)

## WHAT CAN / MUST WE LEARN?

#### Sabine Funk, 22.02.2019

INTERNATIONALES BILDUNGS- UND TRAININGSZENTRUM FÜR VERANSTALTUNGSSICHERHEIT





## **SABINE FUNK**

#### EDUCATION

- Master Eventtechnology
- Health & Safety Officer
- Business economist
- Crowd & Safety Manager, FdA, BA (Hons)

#### EXPERIENCE

- ✓ working in the event industry since 1992
- ✓ general manager events > 50.000 since 2000
- ✓ consulting & education since 2007

#### TODAY

- Education (lectures, workshops, trainings) & research
- Consulting Service (promoters & licensind authorities)
- General Manager IBIT International Centre for Education & Training in Crowd Safety Management





#### **The Loveparade Disaster**

## On July 24th 2010, 21 one people died, more than 500 were injured in a crowd crush during the Techno Event Loveparade in Duisburg, Germany

Everyone working at events will remember this (maybe forever)



Von Beademung in der Wikipedia auf Deutsch - Eigenes Werk (Originaltext: eigene Aufnahme), CC BY-SA 3.0 de, https://commons.wikimedia.org/w/index.p hp?curid=11041310

## BUT: "TO REMEMBER" is not enough!





#### Of course: everyone wants to know

- What happened
  - Stampede?
  - Individual fault?
  - Fate? Accident? Coincident?
- Why did this happen
- Who is liable? Who is GUILTY?

## BUT: "BEING INTERESTED " is not enough!





Of course: everyone wants to know

## • Why did this happen

- Bad ingress management?
- Bad emergency management?
- Lack of communication?
- Bad / wrong crowd control measures?
- Too many people at all?
- Wrong event site?
- ...
- Who is liable? Who is GUILTY?

## BUT: "BEING INTERESTED " is not enough!





#### Of course: everyone wants to know

## • Who is liable? Who is GUILTY?

- The promoter?
- The licensing authority?
- The construction authority ?
- The police?
- The security company?
- The mayor of Duisburg?

## **BUT: "BLAMING OTHERS" is not enough!**





# The trial started in 2017 and ended for 7 out of 10\* defendants in 2019 with a penalty

## Because

- It was not a single fault
- It was not a single person
- It was not a single reason

#### Instead

-> Interrelation of different factors -> concurrence

\* 3 defendants want a decision / a verdict - for them, the trial continues



21 people died, more than 500 were injured because of a chain reaction / a series of reaction

It is NOT possible to identify WHAT the central problem / fault / the trigger was

The event was like a balloon: wherever you stick a needle into it: it will explode.







## LEARNING FROM DISASTERS WHAT CAN WE LEARN?

## Planning has to be RESILIENT

# You HAVE TO MAKE SURE that whenever one component fails, there is a

- replacement or
- a plan B

if you have a vulnerable system (limited space) than you need more than just a plan (close the entrance) but a Plan B (what happens, if the closure fails)





## LEARNING FROM DISASTERS WHAT CAN WE LEARN?

## When everything is "only just"

## When you've "just made it"

(just enough time / ressources etc.)

Than you create a highly vulnerable (= dangerous) system





#### WHAT CAN WE LEARN?

## A PROBLEM IN A RESILIENT SYSTEM ...



#### ... can be solved / fixed....







#### WHAT CAN WE LEARN?

## A PROBLEM IN A VULNERABLE SYSTEM ...



... can be the beginning of something much bigger...



A root or a fence lying on the ground ...

- If you have someone to control the site
- If you have someone to remove the obstacle
- If you have someone to control the measures
- ... then they won't be a problem.

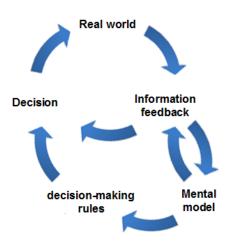
And even if someone falls

- If you have enough space
- If you have enough staff
- ... than it won't be a problem, neither But if not, than they probably turn into a (deadly) tripping hazard



#### MAKE SURE THIS CANNOT HAPPEN TO YOU

## Create a shared mental model with all people involved. (If people have different understanding / ideas, then trainings / exercises can help to develop this shared understanding of what "safe" event is)



"Teams that perfom well hold shared mental models" (Rouse, Cannon-Bowers, Salas 1992)

https://commons.wikimedia.org/wiki/File:Smycka3eng.png

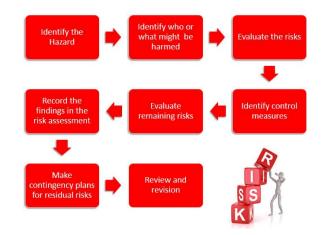




#### MAKE SURE THIS CANNOT HAPPEN TO YOU

## Do a proper risk assessment.

Don't ignore things because they look bad in the risk assessment. If there is a high risk – there is a high risk – regardless if you write it down or not



By writing it down you make sure, everyone is aware – and everyone has to say yes / no in regard to accepting the risk



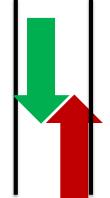


#### MAKE SURE THIS CANNOT HAPPEN TO YOU

#### Visualize as much as possible.

## Sometimes, a coloured line says more than a column of numbers

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### Make sure, everyone REALLY understands!





#### MAKE SURE THIS CANNOT HAPPEN TO YOU

## Learn from others.

Be happy, that nothing happened to you yet. But make sure that you learn from things happend to others.

## ALWAYS ASK:

- How would I / How would we deal with a situation like this ?
- Can this happen to us, also?
- What can we learn from this?



#### MAKE SURE THIS CANNOT HAPPEN TO YOU

#### Learn from others.

## **NETWORK! SPEAK! EXCHANGE**

Sometimes others know more than you. Perfect! Don't be arrogant & ignore that. It's a CHANCE!





By creating strong partnerships, networks and shared mental models you will not only make sure that you will plan the best event possible ... ... but you also will be able to stand political **pressure** (which is a good start not to repeat what happend on the 24th July, 2010 in Duisburg / Germany)





## **THANKS FOR YOUR ATTENTION!**

## Sabine Funk – IBIT GmbH

sabine.funk@ibit.eu

Stay in contact



- Twitter <u>www.twitter.com/ibitgmbh</u>
- Xing <u>www.xing.com/companies/ibitgmbh</u>
- in
- Linkedin www.linkedin.com/companies/ibit-gmbh

