

# ABERFAN – CONTINUING LESSONS FROM YESTERYEAR?

by Pete Davis

*It is now just over 53 years since disaster befell the small Welsh mining village of Aberfan. Despite the passage of time, this article highlights the continued relevance of reflecting upon that awful day and considers what it still has to teach those who are charged with planning our response to today's emergencies.*

*For those particularly interested in the events at Aberfan, there were many television and radio programmes aired during the week of the 50th anniversary in 2016, some of which were almost too painful and poignant to watch – but watch them we should. The BBC News anchor Huw Edwards presented Aberfan: The Fight for Justice on BBC One on 18 October 2016 and traced the village's decades-long battle for justice. Meanwhile, veteran broadcaster John Humphrys returned to Aberfan for a special report for BBC Breakfast which is also available online.*

## Introduction

At 9:15am on Friday 21 October 1966 a waste tip slid down a mountainside into the mining village of Aberfan near Merthyr Tydfil, South Wales. It first destroyed a farm cottage in its path, killing all the occupants. At Pantglas Junior School, just below, the children were in their classrooms beginning the last day before half-term<sup>1</sup>. It was sunny on the mountain but foggy in the village, with visibility about 50 yards. The tipping gang up on the mountain had seen the slide start, but could not raise the alarm because their telephone cable had been repeatedly stolen. (The Tribunal of Inquiry later established that the disaster happened so quickly that

a telephone warning would not have saved lives.<sup>2</sup>) Down in the village nobody saw anything, but everybody heard the noise.

Gaynor Minett, an eight-year-old at the school, remembered four years later: *"It was a tremendous rumbling sound and all the school went dead. You could hear a pin drop. Everyone just froze in their seats. I just managed to get up and I reached the end of my desk when the sound got louder and nearer, until I could see the black out of the window. I can't remember any more but I woke up to find that a horrible nightmare had just begun in front of my eyes."<sup>3</sup>*

The slide engulfed the school and about 20 houses in the village before coming to rest. Then there was total silence. George Williams, who was trapped in the wreckage, remembered that "... in that silence you couldn't hear a bird or a child."

144 people died in the Aberfan disaster; 116 of them were school children. About half of the children at Pantglas Junior School, and five of their teachers, were killed.

So horrifying was the disaster that everybody wanted to do something. Hundreds of people stopped what they were doing, threw a shovel in the car, and drove to Aberfan to try and help with the rescue. It was futile: the untrained rescuers merely got in the way of the trained rescue teams. Nobody was rescued alive after 11:00am on the day of the disaster, but it was nearly a week before all the bodies were recovered<sup>4</sup>.

## Lessons from yesteryear ... but still equally valid today?

In 1967 – less than a year after the disaster itself – Tony Austin wrote a very powerful and moving book entitled Aberfan: The Story of a Disaster<sup>5</sup>. The book was dedicated



to "... the hope that lessons will not only be appreciated but applied." Owing to the passage of time and the withdrawal of the volume from public libraries in the intervening 50 years it's not an easy book to obtain, although copies occasionally appear on internet auction sites and of course a reference copy is available in the British Library for those so inclined to search it out. Having recounted the story of the Aberfan disaster, Austin adds a personal note in Chapter 12 in which he reflects on the events and one of the original aims of the book. He says: "While the precautionary lessons of coal board failure before October 21 were acted upon promptly, might not there also be lessons from that muddled scramble out

of which a rescue operation emerged, more by just happening than any design?" What follows that question is a remarkable list of 12 lessons emerging from the response to Aberfan, not captured by an author with any professional interest in disaster management but by a concerned layman who recognised that an analysis of the response to one incident – his incident – could lead to lessons being learned to improve the response to future emergencies. In Austin's own words in the introduction to his book:

"There is no suggestion that action, or lack of action, during the rescue operation caused further unnecessary loss of life. All who went to Aberfan acted to the full

extent of their ability. Yet if that ability is sometimes in question who shall be the judge of effort in the face of an appalling situation, emotionally explosive, without the guidelines of precedent? But there is another vital and valid question: what would have happened given the same rescue operation in circumstances in which life could still be saved? It is within the context of the second question that a major part of this book is set."

The set of 12 recommendations is striking to today's student or practitioner of civil emergency management and will instantly strike a chord in terms of similarities with some of today's ongoing issues.

**Table 1: Lessons identified from the Aberfan disaster (Austin, 1967)**

	Lessons Learned	Remarks
1.	Clear and instant recognition that the officials, headed by the Chief Constable in whose area a disaster occurs, assume at least initial responsibility. Coupled with an understanding on their part that in catastrophe the army can provide – under the command of the civil authority – a disciplined body of men, complete with communications. At Aberfan eight hours elapsed before a command structure even began to be generally understood. The objection that smaller local authorities do not have the ability or resources to cope with major emergencies will be overcome by the reorganisation of local government into larger units <sup>6</sup> .	<p>'Clear and instant recognition' – surely exactly the same issue which has most recently been tackled by the JESIP programme and the drive for tabard use across the emergency services (particularly the police) and not just the fire and rescue service as keen advocates of the incident command system<sup>7</sup>. If anyone thinks that the JESIP principles are new then perhaps they should think again – they are simply the most recent reincarnation of a set of fundamentals which have been highlighted time after time in the aftermath of major incidents in the past.</p> <p>This recommendation is of particular interest to anyone who ever wondered why the default chair of the Strategic Co-ordinating Group in the immediate response phase of a 'no notice' civil emergency is a chief officer of police of the host Home Office force<sup>8</sup> and also to those interested in the beginnings of the Military Aid to the Civil Authorities scheme.</p>
2.	Need for a main headquarters, away from the site, to direct overall policy and handle offers of help, in liaison with an operational headquarters on-site to conduct the rescue operation unhampered by non-essential people – plus an administrative headquarters at the approach to the site to regulate essential personnel and equipment. At Aberfan a main headquarters was established officially; an operational headquarters on-site grew of its own accord; a conveniently situated administrative headquarters was never set up.	Again, the experience of responding to Aberfan is reflected in modern day practice including the remote Strategic Co-ordinating Group (SCG) established in the Strategic Co-ordination Centre (SCC) and JESIP principle of co-location of on-scene commanders.

	Lessons Learned	Remarks
3.	Immediate appointment of a quartermaster through whom all requests for materials should go to avoid who-ordered-what arguments when the bills come in. At Aberfan there was no quartermaster and no effective, embracing ordering system.	
4.	Proper signposting of the main offices. At Aberfan this did not happen until the army came in.	
5.	The effective cordoning of the immediate area. At Aberfan this was not done effectively until the army came in, at which time it was of little more value than a late gesture.	Again, cordoning forms a fundamental element of the incident command system <sup>7</sup> embedded in emergency response across the UK (and elsewhere).
6.	Good liaison and communications, pre-requisites of smooth control, invariably lacking at first, can soon be achieved through police-fire-ambulance radio communications backed by Home Office and GPO <sup>9</sup> radio and telephone assistance. At Aberfan it was not realised soon enough that the Home Office and GPO were capable of providing efficient communications in an emergency.	<p>Older members of the UK's emergency services – and particularly those closely involved in the specialism of major incident planning – will recall that 'blue light' interoperable radio communications in the pre-Airwave era were provided by the Home Office UHF Channels 69 (simplex) and 70 (half duplex). However, they were rarely used and often only available in radios installed on, or available within, major incident or command units and not on a day-to-day basis.</p> <p>Since the introduction of Airwave and the universal availability of interoperable voice communications (IVC) talkgroups the establishment of on-scene command networks has become easier and is encouraged by JESIP to reinforce the principle of co-location. However, just as the technological capability provided by Airwave seems to be better understood by frontline commanders (encouraged, no doubt, by mandatory JESIP training) the system's demise looms on the horizon and the equivalent capabilities of the new Emergency Services' Mobile Communications Project (ESMCP) will need to be understood.</p> <p>It is interesting that in 1966, a central government department was able to provide a bespoke operational communications capability – not something we would necessarily expect today (unless it happened to be in development via a centrally-sponsored project by, say, the Centre for Applied Science and Technology (formerly the Home Office Scientific Development Branch). A similar capability was provided by the Home Office to the Moorgate tube disaster some nine years later when the experimental Figaro system was used to enhance underground radio communications at the London Underground station<sup>10</sup>.</p> <p>See also BT civil resilience capabilities.</p>

	Lessons Learned	Remarks
7.	Understanding that liaison means everyone knowing who is in charge and all subordinate commanders making their presence known to the main control first. At Aberfan some organisations worked independently, partly due to the failure of the main control to create a situation in which they could only work through an operational headquarters.	
8.	WRVS, Red Cross, St John Ambulance, Salvation Army and any other voluntary organisation should work together under one joint command, responsible to one control. At Aberfan the voluntary organisations did fine work, on a competitive rather than coordinated basis.	
9.	Integration of medical services. At Aberfan the hospital's disaster plan worked well, but it was almost overwhelmed by the volume of uncoordinated medical help available.	
10.	All in authority to be instantly recognisable. Uniforms are the obvious identification, and those likely to be involved in emergencies should always have their uniforms at hand. A further aid could be the permanent issue of cheap brightly coloured plastic helmets to a limited number of non-uniformed key personnel. At Aberfan those with authority and without identification were at a distinct disadvantage.	See the remarks annotated against lesson #1 above and the fundamental similarity with the recent JESIP drive towards the universal use of identifying tabards.
11.	An understanding with rescue organisations and with press and broadcasting authorities that all appeals for aid should emanate from one official source only. At Aberfan there was a failure to use methods of communication properly; when they were used wrong information was given.	See BBC Connecting in a Crisis.
12.	The need for a simple Home Office instruction on disaster procedure to local authorities and organisations likely to be involved in disaster operations, defining their approach and responsibility.	The Home Office subsequently published the first edition of Dealing with Disaster, with the revised third edition being published by the Cabinet Office (owing to machinery of Government changes in the intervening years) before subsequently being superseded by Emergency Response and Recovery – Non statutory guidance accompanying the Civil Contingencies Act 2004.

### Lessons from the past – never too late to learn?

On 8 September 2016, Cardiff University's School of Journalism, Media and Cultural Studies held a one-day conference focussing on the themes of remembering, forgetting and moving on in the media and in the community<sup>11 12</sup>. It brought together survivors

of the tragedy, media practitioners and academics including photojournalist I. C. ('Chuck'<sup>13</sup>) Rapoport whose presentation was breathtakingly poignant and moved many to tears, and the elder statesman of the Welsh media, Vincent Kane, who reported from Aberfan in 1966.

Kane gave a journalist's judgement on those to blame for the tip slide that engulfed Pantglas school and its neighbouring homes, as well as the way in which the community was treated afterwards. He believes that there was a conspiracy of silence before the disaster among those who knew of the real danger that No. 7 tip could slide and was

devastating in his condemnation of both the National Coal Board and the National Union of Mineworkers. They had known about the tip being built upon two underground springs on a sloping hillside clearly shown on Ordnance Survey maps. They were, he said, "guilty of moral cowardice"<sup>14</sup> – failing to act on the knowledge that the tip could slide at any moment. But those who knew of the potential for tragedy failed to act because they knew that attempting to do so would put the existence of mining in Merthyr (and beyond) in peril. In his keynote address<sup>15</sup> delivered in a "... beautifully passionate, poetic, angry and robust" manner, Kane said:

"The Tribunal report said there were no villains at Aberfan<sup>16</sup>. Yes there was, there was one big villain. Coal. King Coal to which we all paid grateful homage in Wales for most of the twentieth century. It was coal and the determination to keep producing it at all costs which caused the tip slide, it was coal which killed the children and it was coal and the desperate fear of losing it which prompted the dereliction of duty before the disaster and the cover-ups and half-truths which followed."

The conference was also attended by some of the survivors of the disaster and in the first session some of them rose to their feet to speak for the first time in 50 years about what they went through on the day. Yvonne Price from Merthyr Tydfil, one of the first police officers on the scene and being of petite stature, gave a harrowing account of being sent through a small hole and into one of the classrooms of Pantglas school where she spent the rest of the day passing children – dead and alive – back out to the rescuers outside. When she reported for duty on the second day, she was assigned to the chapel where a body holding area had been established and subsequently became, in her

words, the "mortician's assistant" where they were given brandy to drink all day and they slept in coffins when they were tired. She said she had kept it to herself for 45 years but finally "... had to get it out of my system" seven years ago.

Gaynor Madgwick also noted that there were some in the community still not ready to speak about what happened. "There are people at the moment ... one woman is seeing a psychiatrist because she cannot face the 50th anniversary. She knows it will open so many wounds. She doesn't know how she's going to cope. Others who are in their 70s, 80s, 90s want to tell their stories because an end is coming."

The opposing views which emerged through the discussion were also striking: on the one hand, some survivors who had been relatively vocal about their experiences in the last five decades were asking "What is there left to say after 50 years?" Others are only now, after 50 years, feeling able to start to talk about their experiences. The question which might arise for those charged with planning the response to future disasters is: "How do we make sure that the lessons which are possibly yet to emerge from those who are only just starting to feel able to talk about their experiences are captured and learned – especially when others seem to want to finally lay their experiences to rest?"

## Conclusion

As the media spotlight fell on Aberfan once again some 53 years after tragedy struck, the two principal points emerging from this discussion may perhaps be summarised as follows:

1. Never forget the lessons of the past – many of them, albeit in their most fundamental form, will still be relevant to professional practice today; and

2. Don't assume that the passing of time means that every lesson which can be learnt has been learnt. Some people may not start talking about their experiences until many years later and they may be the very people who can provide insights into things which, in their valuable experience, can be improved in the future. **▲**

## About the Author



Pete Davis is currently the HMICFRS Service Liaison Officer for Avon Fire & Rescue Service and has previously worked within local authorities, the NHS and ambulance service. He joined the fire and rescue service in 2004 to head up the implementation of the Civil Contingencies Act 2004 and has since developed Avon's National Inter-Agency Liaison Officer (NILO) scheme and co-ordinated the south west NILO cadre. He is a Founding Fellow of the Institute of Civil Protection and Emergency Management and is currently Chair of the Institute's Historical Special Interest Group..

## References

1. 1. Some previous reports suggest that they had only just returned to their classrooms after singing All Things Bright and Beautiful at their morning assembly. However, in her latest book on Aberfan, Gaynor Madgwick sought out other survivors of the disaster including Howell Williams who, at the time, was a 22-year-old teacher at Pantglas School. She writes: "The teachers I had met had raised a doubt in my mind about one of my memories of the day. I wondered if Howell could clear it up for me. 'Did we have a service that morning in the hall and sing All Things Bright and Beautiful?' 'No,' he said. 'I can't understand. Why did we think that?' Howell shrugged. 'Mrs. Williams used to take the dinner money in the hall. I sent two pupils over from the class to the secondary school with the dinner money. I was in my class, it was as simple as that. If we had been in the hall for assembly, we would have all survived; all survived, yes'"
2. Davies, Lord Justice Edmund (1967) Report of the Tribunal appointed to inquire into the Disaster at Aberfan on October 21st, 1966. HL316 and HC 53. pp 1-151. London: HMSO.
3. Madgwick, G. (1996) Aberfan: Struggling out of the Darkness. A Survivor's Story. pp 1-73. Blaenarwg: Valley & Vale. ISBN 1 898986 05 3.
4. McLean, I. and Johnes, M. (2000) Aberfan:

- Government and Disasters. pp 1-274. Cardiff: Ashley Drake Publishing Ltd. ISBN 1 86057 033X.
5. Austin, T. (1967) *Aberfan: The Story of a Disaster*. pp 1-230. London: Hutchinson & Co. (Publishing) Ltd.
  6. This comment refers to the planned reorganisation of local government which came into effect in April 1974.
  7. See also Brunacini, A. V. (1985) *Fire Command*. pp 1-262. Quincy, MA: NFPA. ISBN 0-87765-28408.
  8. See *Emergency Response and Recovery – Non statutory guidance accompanying the Civil Contingencies Act 2004*.
  9. As the 50th anniversary of the Aberfan disaster approached, the author's next door neighbour alerted him to an article in the *Western Mail* ('Aberfan 'betrayal and lies' to be revealed at uni talks', 3 September 2016) – see later in these notes. In subsequent discussion, it emerged that at the time of the disaster in October 1966 she worked as a GPO telephony operator at government switchboard in Cardiff. Given the circumstances at Aberfan, it seemed almost unnerving to learn that the two departments serviced by the particular switchboard on which she worked were, quite unbelievably, the Inspectorate of Mines and Quarries and the Department for Education.
  10. See Holloway, S. (1988) *Moorgate: Anatomy of a Railway Disaster*. pp 1-208. Newton Abbot: David & Charles Publishers Plc. ISBN 0 7153 8913 0.
  11. See <http://www.bbc.co.uk/news/uk-wales-south-east-wales-37313514>
  12. See <http://www.jomec.co.uk/blog/where-have-all-the-flowers-gone-remembering-aberfan>
  13. See Rapoport, I. C. (2005) *Aberfan: The Days After. A Journey in Pictures*. pp 1-128. Cardigan: Parthian. ISBN 1 902638 56 5
  14. "Then how the hell did it happen? How did 144 people including 116 children come to lose their lives? Because, I believe, the learned judge omitted one reason, one vice from the list he tabled and it was the most glaring vice of all. Cowardice. Moral cowardice. They failed to look, they failed to report, they failed to question – these decent, conscientious and able men – because they were afraid or half afraid of what they would see, of what they would hear, of what they might be required to do. They dare not even talk to each other about it because they knew intuitively that there was something wrong with tip 7. They were aware of the fears expressed time and again by the villagers, by the Borough Council. In January '64 the *Merthyr Express* reported a meeting of the Town Planning Committee quoting verbatim from the minutes, Councillor Mrs. Williams: "There are dangers from surface tipping. We had a lot of trouble from slurry causing flooding, but if the tip moved it could threaten the whole school." Some of the ten, even just one of them, must have read or been made aware of that newspaper report. So serious, so startling, so threatening would it have been for the NCB to be criticised in public in this way that somebody – anybody – would have been delegated to check it out in order to deny it."
  15. Based largely on his introduction to Gaynor Madgwick's new book *Aberfan: A Story of Survival, Love and Community in One of Britain's Worst Disasters*.
  16. See para. 47 of the Report of the Tribunal appointed to inquire into the Disaster at Aberfan on October 21st, 1966: "47. On the other hand, we reject out of hand Mr. Ackner's observation that what has been revealed here is "callous indifference" by senior National Coal Board officials to the fears of a tip-slide expressed to them. Callousness betokens villainy, and in truth there are no villains in this harrowing story. In one way, it might possibly be less alarming if there were, for villains are few and far between. But the Aberfan disaster is a terrifying tale of bungling ineptitude by many men charged with tasks for which they were totally unfitted, of failure to heed clear warnings, and a total lack of direction from above. Not villains, but decent men, led astray by foolishness or by ignorance or by both in combination, are responsible for what happened at Aberfan. That, in all consciences, is a burden heavy enough for them to have to bear without the additional brand of villainy."

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