



# Strategic Programme Example Case Study Roskilde Festival

Developed by Chris Kemp & Pascal Viot

The SAFE Project has been developed in a partnership between:



Erasmus+



Mind Over Matter  
Consultancy Ltd  
[www.momconsultancy.com](http://www.momconsultancy.com)

**iSSUE**

Institut Suisse de Sécurité  
Urbaine et Événementielle  
[www.issue.ch](http://www.issue.ch)

**TSC**  
Crowd Management



## A risk mitigation platform in crisis response

### Introduction

The sustainable mitigation of risk is difficult to deliver in an age of profit versus safety. In many areas of the event industry, cutting corners means disturbing the safety equilibrium. This, in turn, heightens the event space's risk and resilience. For many years we have dismissed the notion that near misses provide an insight into future incidents. However, after reflecting on this issue and a small number of event producers using pattern recognition possibilities, it has been acknowledged that some near misses were indeed precursors of subsequent major incidents.

Dickie (1995) states that there are four key factors associated with the majority of crowd disasters: Inadequate planning; an excited crowd; lack of crowd management and control; and a flaw or hazard in the facility design. In the UK, we only need to go back to the disaster at the Hillsborough football stadium in 1999 – in which 96 people died and nearly 800 were injured – to realise this. Two previous semi-finals before the Hillsborough disaster were blighted with similar crowd issues, but no steps were taken to mitigate the risk.

In his article on the Hillsborough Disaster for the Guardian on May 10, 2016, David Conn identified that: “The inquests heard evidence of problems at all three semi-finals the FA held at Hillsborough in the 1980s, before it selected the ground again in 1989. In 1981, there was a serious crush on the Leppings Lane terrace where catastrophe would descend eight years later: 38 Tottenham Hotspur supporters suffered injuries serious enough to be treated in hospital or by St John Ambulance, including broken arms, legs and ribs.”

This lack of foresight and an inevitable blinkered approach to security and safety will inexorably result in future challenges where heed is not taken of previous issues, or of identifying the possible shortcomings of an event. Langston, Masling and Asmar (2006) state that: “Poor venue design and crowd management as a result of inadequate research into crowd behaviour has led to many disasters resulting in a loss of life and injury.” Fruin (1985, 1993) identifies a range of factors related to the occurrence of crowd disasters. He states that increased force, lack of information, inappropriately designed or inadequate



space and the lack of consideration given to the management of crowd flow and density all contribute to such issues. Sime (1995) and Pauls (1984) also concur with the main findings of academics and practitioners in this area.

Au et al (1993) define overcrowding as: “The situation where an excessively large number of people are gathered in a defined area. This may in turn lead to injuries or death.” These authors go on to say: “The point at which an area is deemed to be overcrowded can be derived in two distinctly different ways: (1) Objectively in terms of the number of people in an area (crowd density), this may be in any given area within the venue or within the venue as a whole; and (2) Subjectively in terms of the viewpoint of individuals (ie crowding may be viewed as a psychological phenomenon).”

## **Crowd psychology**

This approach shows that crowd research is not just focused on the dynamics but is also linked to crowd psychology and social interaction.

Roskilde Festival in Denmark has learnt the hard way, through suffering the full brunt of an accident in 2000 where nine young people were crushed to death during a Pearl Jam concert. The findings of the nine judges appointed to review the event were important, as they identified elements that were difficult to mitigate unless there was a known understanding of their applications. The fine balance between blame and unforeseeable circumstances is an important lesson to be learned from the Roskilde case. One element cited in the Zealand public prosecutor’s report just after the incident, identifies that the crowd pushed forward towards the stage owing to poor sound quality. However, the report adds: “The poor sound was probably due to the relatively strong wind which blew across the audience area.” Such occurrences are difficult to mitigate, given the underpinning rationales related to natural features that are not within the gift of the most experienced concert promoter to forecast.



The only way to mitigate unknown risks is to create assessment possibilities that will allow those tasked with creating a risk assessment and managing risk to ensure they cover every eventuality, and that these vital support mechanisms are fluid and dynamic. Working with the Roskilde team of seasoned professionals and new dynamic providers, it is clear to see that their safety culture is based around a generative approach, with a fallback to proactive in cases of the unknown unknowns.

This is unusual at events and venues, as most staff members would place themselves in a reactive to proactive stance, as identified through our research with event managers. So, what has engendered this type of approach? The members of the Roskilde management team are very aware of the circumstances that took place before, during and after the accident. However, rather than consign these circumstances to memory – with the consequent possibility of a loss of dynamic – they have taken proactive steps to focus on the next possible issue or challenge that might occur, using the accident as a starting point in a development process.

To highlight the generative approach to crisis response, the author showed a video of an incident at another outdoor event to the Roskilde Security Manager. In the video, the circular motion of the crowd was enhanced by the configuration and shape of the front-of-stage barrier, which was similar to that used by the festival team at Roskilde. This resulted in a crowd collapse at this particular event and significant issues within the crowd took place, which could have resulted in fatalities and serious injuries.

After observing the video, the Roskilde team elected to remove the curved area in the barrier, even though this barrier configuration, which was similar to that shown in the video, had been safely utilised and managed for 17 years. Thus the configuration was modified, turning the two pens into a single pen and employing carefully thought out angles and safety planning to mitigate the possible risks and, hopefully, avert the need for a crisis response.

To mitigate the possibility of lateral movement, the team created a small nipple in the centre of the barrier, which enabled both a steadying effect and a two-way access-egress point rather than the former configuration, which had one way in and the same way out.



The pain of the incident at the Love Parade in Germany 2010 was also still fresh at all outdoor events, as this incident was caused by a similar system where the same ingress-egress delivery was used; this caused too many people to pass through a space that was too small, creating one of the distal causes of the fatality of 21 persons at the event.

By understanding the dynamics of two incidents – The Love Parade in 2010, where 21 people died in a crowd disaster, and the Libertines at Hyde Park in 2014, where a crowd crush led to eight people being taken to hospital – then taking steps to mitigate the underlying causation of the incidents both proximate and distal, the Roskilde team worked with experts to create an alternative and safer method of managing the crowd. This was carried out by creating a more structured and managed space into which the crowd was delivered, providing safer ingress, circulation and egress.

The only way to create a generative risk strategy and thus a sustainable crisis response platform is to create an interdisciplinary and interoperable approach to working at events. With Roskilde Festival, this structured approach to all areas of the event is being applied systematically, so that each year new areas of the festival are falling in line with each other, providing a gradual but sustainable and auditable process that delivers increased resilience as it is developed. This holistic approach focuses on the prioritisation of safety elements and transparent delivery, so that all of those involved are continually apprised of any challenges that arise.

All staff, no matter whatever their level, are empowered in their role within the organisation, which provides trust and support if an incident occurs. This is supported by a measurement system that not only utilises a quantitative approach, but tempers it this with a qualitative delivery, providing both a physical and psychosocial view of the event.

## **Malleable delivery envelope**

The elements already in place comprise psychosocial delivery focused on creating a community of support from all stakeholders linked to the festival, which speeds up



communication and creates a malleable delivery envelope. Counter terrorism activities are integrated into the event structure, both physically and psychosocially, to provide a holistic approach to the delivery of threat and risk activities. Crowd safety, which is often ignored as many think that this is carried out through osmosis, is actually a central column to the Roskilde event. Finally, ingress and egress strategies are constantly refined and developed year on year, to ensure the safest possible crowd movement related to crowd flow into, out of and through the festival footprint.

The balanced approach provided by Roskilde helps to develop the psychosocial health of the internal and external customers while maintaining the physical necessities that create an excellent and safe event. This is maintained through the interoperable delivery between the blue light and emergency services, linked to other key stakeholders including paid staff, volunteers and the public, all of which contribute fully to the festival experience. This enables command and control and counter terrorism support to remain a central plank in the structure, with key delivery of challenges related to the sick and injured being carefully supported. These elements underpin risk mitigation strategies and help all stakeholders to understand both the spatial and psychological elements linked to the temporal and logistical issues underpinned by effective planning.

In conclusion, this balanced approach by the festival management team at Roskilde demonstrates buy-in from all of the key stakeholders, as well as a wealth of interdisciplinary knowledge, supported by team empowerment, where the 'Orange Together' motto stands proud in mitigating risk and providing a sustainable and resilient crisis response strategy.

Author

PROFESSOR CHRIS KEMP, CEO of Mind Over Matter Consultancy Ltd

Taken from the article "A risk mitigation platform in crisis response" in the Crisis Response Journal. Volume 14, Issue 3, June 2019.



Extract of report of 11 June 2002  
concerning accident at the Roskilde  
Festival on 30 June 2000

Prepared by  
The Public Prosecutor for Zealand



## Introduction

After having obtained permission from the Chief of Police in Roskilde, the Roskilde Foundation held the Roskilde Festival in the period from 29 June to 2 July 2000. As usual, the festival was held in the area near the site called Dyrskuepladsen in the City of Roskilde.

On 30 June the rock band Pearl Jam played on the Orange Stage of the festival for an audience of about 50,000 people. The concert started at 10:30pm.

Around 11:00pm some vigorous wave movements started in the audience. Allegedly as a result of these wave movements, a group of 40 – 50 people in the audience fell to the ground. This group was standing in an area close to the barrier in front of the stage (the front stage barrier).

Because of pressure from the rest of the crowd, the people who had fallen could not get up again on their own or with the help of people standing near them. The people in question had fallen at a distance from the front of the stage barrier where the stewards on the other side of the barrier could not reach them.

The music was stopped and the people who had fallen, several of whom were lifeless, were lifted across the front of the stage barrier and taken to a tent in the backstage area (the medical tent) where a number of doctors and nurses began to treat those who were lifeless as well as other spectators who had been injured after having fallen or being squeezed.

Ambulances from Roskilde Fire Department were called to the scene. The ambulances arrived and several of the injured people were immediately taken to Roskilde County Hospital in Roskilde. As a result of the alarm, police were also sent to the scene of the accident. Police officers assisted in the rescue work and also carried out various other police activities in connection with the accident.

On the day after the accident, the Chief of Police in Roskilde initiated an investigation of the accident in order to clarify what had happened and, if possible, to establish why nine young men died at the concert.



On 14 July 2002 the Chief of Police in Roskilde submitted a preliminary report. It is stated in the conclusion of the report that, in the opinion of the Chief of Police, the accident was caused by a number of unfortunate, concurrent circumstances, the behaviour of the crowd being the most essential, and that there was no basis for holding anybody responsible under criminal law in connection with the accident.

On 15 December 2000 the Chief of Police in Roskilde submitted his final report. It appears from the report that it only concerns events before and during the accident – not the rescue operations. The summary contains the following paragraphs:

“All in all it must be concluded that the accident and its serious consequences were the result of unfortunate circumstances, including the weather, air conditions, the sound and – not least- the crowd’s behaviour, which must be said to be the main cause of the accident.

The severity of the accident must also be assumed to have been increased by the – understandably – slow realisation of the seriousness of the situation, uncertainty about chains of command, belief that the situation could be controlled from the area in front of the stage and the fact that it was a major decision to stop the music. Finally the slowness with which the audience left the area after the concert was stopped has had an impact as well.

It is my opinion that there is no reason to initiate any criminal investigation as a result of the accident.”

The accident and the two reports prepared by the Chief of Police in Roskilde gave rise to extensive press coverage and public debate.

The main criticism raised in public debate concerning the two reports was that the basis on which the Chief of Police had made his assessment of the situation was insufficient and that the assessments of the Chief of Police could not be trusted, since he had given permission to hold the festival and consequently could be held liable if the permission was found to have been given on an insufficient basis.



On 8 February 2001, the Danish Ministry of Justice asked the Public Prosecutor for Zealand, Erik Merlung, to review the incident again and prepare a new assessment of the events leading to the accident and of the subsequent rescue operations.

In this connection it was decided that the investigation was to be conducted in accordance with the ordinary provisions of the Administration of Justice Act and the Serious Crime Squad under the National Commissioner of Police was to assist the public prosecutor in the investigation.



## Summary and Conclusion

In this section I will summarise the results of my investigation of the accident at the Roskilde Festival in 2000 and give my assessment of whether there is any basis for initiating criminal proceedings for criminal actions or omissions in relation to the accident.

On the basis of the information at hand it is my opinion that there is no reasonable cause to assume that any criminal actions that require public proceedings have been committed, either in the Chief of Police's processing of the application to hold the festival in 2000 or in connection with the accident itself or the subsequent rescue work. Consequently nobody will be prosecuted (see section 721 (1) 2 of the Danish Administration of Justice Act).

In May 2000 the festival management submitted an application to the Chief of Police in Roskilde for permission to hold the Roskilde festival in 2000. The Chief of Police granted the permission on a number of conditions. These conditions concern practical matters such as opening hours, concert hours and the like, as well as conditions concerning safety and security, e.g. the number of stewards and the number of medical emergency staff.

The processing of the application by the Chief of Police in Roskilde was to a great extent based on oral communication, specific knowledge about individuals, experience gained in relation to festivals held in previous years and trust that the festival management would meet previous years' standards in terms of the number of stewards and medical staff and their 'training'. The police did not check compliance with the security conditions.

It is not satisfactory that it is impossible to document details of the police's processing of the application to hold the festival. Likewise, it is not satisfactory that the police did not check compliance with the security conditions formulated.

Considering the actual number of stewards, doctors and nurses at the Orange Stage at the time of the accident in relation to the severity of the accident, I think that the number of staff present was reasonable. However, it should be noted that the number of both stewards and medical staff was considerably higher than the number stated in the plan, since the accident took place at a time when people on duty were about to be relieved and both



people who were about to leave and people who were about to go on duty participated in the rescue work.

As regards the recruitment and training of stewards it should be noted that many of the stewards had experience from many other festivals in Roskilde and could therefore be considered to be competent. My investigation has shown that it is reasonable to assume that the vast majority of stewards were not inhibited in their performance of duties as a result of the intake of alcohol or other substances.

About 10:30pm on 30 June 2000 about 50,000 people had gathered in the area in front of the Orange Stage to attend a Pearl Jam concert. There is no reason to believe that the number of people in the audience was the cause of the accident. It is evident that there was ample space in the audience area between the mixing tower and the pallet stand.

Although there was space at the back of the audience area, the audience standing close to the stage felt they were being squeezed from behind as early as 22:35 pm.

The reason for this pressure on the crowd standing at the front was partly that fans want to be as physically close to their idols as possible, but 'poor' sound from the loudspeakers at the back of the audience area may also have made many people go closer to the stage. However, there is no reason to believe that there were technical problems with the sound/the loudspeakers. The poor sound was probably due to the relatively strong wind which blew across the audience area at the time of the concert, the result of which was that the sound from the rear loudspeakers occasionally disappeared in another direction.

As the concert progressed the pressure on the people standing in front increased, and major wave movements began in the crowd. The reason for these is said to be the constant flow of people arriving in the audience area after the start of the concert who wanted to get closer to the stage. On their way towards the stage, several groups in the crowd behaved in an aggressive way that caused agitation. In this connection, it should be noted that a concert on the Green Stage, which has attracted a large crowd, ended at about the same time as the Pearl Jam concert began. It must be assumed that some of this crowd went to the Orange Stage to attend the Pearl Jam concert.



There is no reason to believe that Pearl Jam to the crowd or otherwise acted in a way that could cause or contribute to causing the heavy pressure and the wave movements in the audience.

Almost from the start of the concert people in the crowd fell in the area between the mixing tower and the stage. Some people are said to have fallen because of pressure from crowdsurfers, others as a direct result of being squeezed and pushed by people who wanted to get through the crowd, and others again fell because of the wave movements in the crowd. The location of the 'wave breakers' (safety barriers) in the crowd was good from a safety and security point of view, but the accident showed that the lack of safety barriers in the area immediately outside the fence enclosing the area in front of the stage i.e. the area close to the stage, made the crowd in that area vulnerable to wave movements in the crowd.

As a result of the vigorous wave movements a group of about fifty people fell around 23:05pm in an area in front of the centre of the stage between the front fence and the front row of 'wave breakers'. The crowd was so dense that those who fell lay on top of each other in several layers. The pressure exerted by the crowd was such that it was difficult for those standing nearby to help those who had fallen. Moreover crowdsurfers, who continued to come from behind, fell on top of the people who had fallen, since there was nobody to bring the crowdsurfers to the front fence.

When those who had fallen realised that they could not get up, several of them – as well as several of the people standing near to them who had realised the severity of the situation – panicked. They shouted to the stewards standing on the other side of the fence that the music should stop.

The crowdsurfers who had reached the area in front of the stage and people in the crowd who had been helped over the fence told the stewards and the medical staff in the area in front of the stage that the situation in the crowd was serious and that the music should be stopped. In addition some people in the crowd contacted people at other stages to get assistance to help those who had fallen.



At about 23:25pm the music stopped when Pearl Jam's manager went on stage to tell the band to stop the music because of problems in the crowd.

It should be noted that the stewards in the area in front of the stage who were standing near the area where the large group of people had fallen at around 23:05 pm had noticed the dangerous situations and realised that it would only be possible for those who had fallen to get up if the music was stopped and the crowd pulled back.

The stewards tried to pull the people in the fallen group up but had to give up. They then contacted the person in charge of the area in front of the stage to make her stop the music.

The festival management had not issued any guidelines as to when and how a concert could be stopped. It should be taken into consideration that the festival staff in charge of the concert and the senior stewards did not know what action to take in a situation like the one described here. For example, they did not know who had authority to decide that the music should be stopped.

It is my assessment that it took much too long to stop the music once the stewards had realised the severity of the situation. In my opinion the main reason for this is that there were no clear guidelines specifying who should do what. I think the preparation of such guidelines and the communication of them is the responsibility of management. The festival management must therefore bear some of the responsibility for the fact that it took about twenty minutes from the time when the large group of people fell to the music stopped. In this connection it should be noted that the Institute of Forensic Medicine has stated that, in the most unfortunate circumstances, a person exposed to such a severe compression of the thorax as that to which the nine dead men were exposed would die within 3-5 minutes.

It should be taken into consideration that it took about seven minutes from the music stopped at around 23:25pm until the crowd had been persuaded to pull back and the people who had fallen could be pulled out and those who were injured could be taken to the first-aid tent for medical treatment. The first of the injured people were taken to the first-aid tent around 23:32 pm at which time an alarm call was also made on 112.



The festival management had prepared guidelines for the actions to be taken by stage managers at individual stages so as to ensure that the crowd would realise that a serious message to them from the stage manager is not part of the entertainment.

The festival management had prepared guidelines to stage managers specifying how they should act and what they should say to the audience in the event of a major accident or disaster.

However, when the music had been stopped it was the lead singer of the band and one of the band's managers who tried to make the crowd pull back. It was not until 23:48 pm – twenty three minutes after the music had stopped – that the stage manager talked to the audience in Danish and English.

It should be noted that the guidelines concerning the stage manager's behaviour in a situation of the kind described here were not followed.

It is likely that the reason for the slowness with which the crowd pulled back, despite the lead singer's persistent attempts to make them do so, was that the crowd did not immediately and to a sufficient extent realise the severity of the situation, the reason being the unprofessional way in which they received the information from the stage.

As mentioned above the injured people were taken to the first-aid tent for treatment around 23:32 pm, and ambulances were called to the scene at the same time by means of a 112 call. It must be taken into consideration that before the music stopped and before the injured people had been brought to the tent for treatment, the doctors and nurses working in the stage medical unit had been informed that there were people in the crowd who were seriously injured and that ambulances had to be called to the scene.

It should also be noted that the stage medical unit had tried to contact the Emergency Office of the festival via the festival radio in order to ask them to call for ambulances to the Orange Stage, but no actual contact was made to the Emergency Office, probably because of incorrect operation of the radio. The result was that the alarm call was delayed by a few minutes.



In addition it should be noted that the Emergency Office was informed of the accident by the Orange Stage Coordinator and that the Emergency Office consequently alarmed the Roskilde Fire Department duty officer at the festival, who immediately (23:32) informed Roskilde Fire Station of the accident.

Around the time when the first injured people were brought to the first-aid tent, the medical coordinator in the stage medical unit called in assistance from the doctors on duty at the other stages. The doctors and nurses from the other stages as well as doctors and nurses who were about to go on duty at the Orange Stage immediately started treatment of the injured people.

Several of the injured people seemed lifeless and resuscitation was initiated at once. In addition they were given adrenaline and atropine. It is the opinion of the doctors that the lifeless people who were brought in for treatment had been dead for some time when this treatment was initiated. The doctors and nurses did not succeed in saving any of those who seemed lifeless when they were brought in for treatment.

The treatment that the doctors and nurses, assisted by police officers, stewards and first aiders, gave to the injured people, as well as the first aid treatment given was correct from a medical point of view. Nothing suggests that errors or mistakes have been made in connection with the accident.

It should be noted that each of the people who dies were declared dead by a doctor either at the festival or after their arrival at the hospital.

No records or the like have been made of the doctors' and nurses' treatment of individual injured people. In this connection the National Board of Health has stated that the failure to write records in circumstances as those described here cannot be considered violation of the rules and regulations applying to doctors.

In my opinion it must be taken into consideration that the medical preparedness at the festival was quite substantial since doctors and nurses were working in the stage medical unit and there were doctors and nurses in the First-Aid Service as well as first aiders from Danish Red Cross.



Although the so-called Network Group had a number of meetings concerning the manning of individual medical functions at the festival, it should be noted that no overall emergency plan had been prepared for the festival. Consequently there was no plan outlining how the various medical functions should cooperate in the event of a major accident like the one described here, which means that the emergency reaction was not optimal.

The lack of detailed planning of rapid medical reaction resulting in a reaction that cannot be considered to be optimal is also illustrated by the fact that when the doctors working with the injured people in and at the first-aid tent at the Orange Stage 'ran out of' adrenaline and atropine there were plenty of these drugs in the First-Aid Doctors' tent at the Main area but they were not brought to the place where they were needed.

However, nothing suggests that an overall plan for rapid medical reaction would have changed the outcome of this accident.

As mentioned above, Roskilde Police received an alarm call at about 23:33 pm concerning five cases of cardiac arrest at the Orange Stage. The alarm was made to the duty officer at Roskilde Police Station. The duty officer at the police station immediately passed on the information to Roskilde Fire Department and also informed the police base at Slagteriskolen.

Police patrols were immediately sent to the scene, partly to assist and partly to confirm the alarm. Several police officers who were on patrol in the festival area at the time heard the announcement over the radio and went to Orange Stage on their own initiative to assist. A few minutes after the alarm call, the first police patrol report back to the duty officer to confirm the alarm and announce that they will assist in the resuscitation of injured people. At that time (around 23:35 pm) several patrols had arrived at the area behind the Orange Stage, including a senior police officer.

Ambulance corridors were established to ensure that ambulances from Roskilde Fire Department could drive to the scene of the accident and from the scene of the accident to the hospital without obstructions.



The police officers on site quickly established a collection site for the dead people and a collection site for people who were slightly injured or in a state of shock. They began to identify the deceased persons and to register the names of injured people.

The area in front of the stage was checked for additional injured people. This work was not easy since it was difficult to make the crowd pull back from the area, but after a few attempts the crowd pulled back. No additional injured people were found.

The police have plans specifying what actions to take in the event of major accidents or disasters in connection with the Roskilde Festival. According to these plans, Roskilde County Hospital in Roskilde (RASR) and the festival management must be informed in the event of a major accident, and the plans also specify that a command post (KST) for management of rescue work must be established in the festival area.

Based on an assessment of the situation made by the duty officer at the Police Station, these plans were not fully implemented, one result of which was that the RASR had not been informed of the accident when the first injured people arrived at the hospital.

At 23:32 pm Roskilde Fire Department received a call from Roskilde Police concerning the accident. Roskilde Fire Department immediately sent ambulances to the Orange Stage. The first ambulances were reported to have arrived at 23:37 pm.

One of the first ambulance drivers who arrived at the scene of the accident assumed the responsibility of acting as Ambulance Manager. It is the job of the Ambulance Manager to prioritise the order in which injured people should be brought back to hospital. In collaboration with rescue workers from Falck, who had been called to the scene, the ambulance staff examined the injured people and arranged for their transport to the hospital.

According to internal instructions an emergency operations manager must be sent to the scene in the event of major accidents, partly to manage the staff working at the scene and partly to be a part of KST.

The emergency operations manager from Roskilde Fire Department did not arrive at the scene until 01:28 am, when most of the rescue action was over.



Roskilde County Hospital in Roskilde (RASR) seems not to have been notified of the accident at the festival until the first ambulance with an injured person arrived at the hospital at 23:45 pm. A telephone call to Roskilde Fire Department confirmed that a major accident had occurred at the festival and that there were several injured people. The hospital then acted in accordance with the emergency plan prepared by the regional authority.

According to the emergency plan and its guidelines, a coordinating doctor (Kool doctor) and a nurse must be sent to the KST in the festival area in the event of a major accident to coordinate the rescue operations in collaboration with representatives of the police, the fire departments and the festival management.

However, Roskilde Fire Department brought the Kool doctor to the scene of the accident and not to the KST, and the coordinating doctor in the stage medical unit told the Kool doctor that no Kool doctor was needed since there were no more injured people. The Kool doctor then returned to the hospital without having spoken to other people in KST.





Mind Over Matter  
Consultancy Ltd  
[www.momconsultancy.com](http://www.momconsultancy.com)



Institut Suisse de  
Sécurité Urbaine  
et Événementielle  
[www.issue.ch](http://www.issue.ch)

Institut Suisse de Sécurité Urbaine et Événementielle

**Please note:**

All IP within this document is owned and copywrited by Chris Kemp (MOM Consultancy Ltd) and Pascal Viot (iSSUE).  
No part of this can be used, copied or presented without prior permission.

The SAFE Project has been developed in partnership with:



Erasmus+



**TSC**

Crowd Management

