In the matter of

THE STARDUST FIRE INQUESTS

Ruling on Scope of the Inquests

Delivered by Dr. Myra Cullinane, Coroner for the Dublin District, on 13th of August 2021

A. Introduction

A1. On Wednesday, 28 July, 2021, I heard submissions from legal representatives on behalf of a number of interested persons at a pre-inquest hearing concerning the deaths that occurred arising from the fire at the Stardust nightclub in February 1981. Prior to that hearing date, I had received written submissions on behalf of some of those interested persons.

A2. It had previously been indicated on behalf of the majority of the families of the deceased that they sought a hearing as to the applicability of Article 2 of the European Convention on Human Rights. Although they did not formally change their position, I inferred from their written submissions that any question of the applicability of Article 2 depended on the matters to be inquired into at the inquests. This was confirmed by their legal representatives at the pre-inquest hearing.

A3. It therefore falls to me to determine the matters to be inquired into at these inquests, and no determination is required at this juncture in relation to the applicability of Article 2.

B. Background

B1. Because of the nature of some of the submissions, it is necessary to have regard to some of the previous inquiries into the Stardust Fire, and some of the matters determined by those processes.

(a) The Keane Tribunal

B2. The Keane Tribunal was established shortly after the Stardust fire, by order of the Minister for the Environment on 20 February 1981, and reported on 30 June 1982.

B3. The report of the Tribunal ranges over a number of relevant subjects, and makes some detailed findings and recommendations. It will be necessary to refer to these in more detail later in this ruling.

B4. However, it is important to observe at this stage that, with one notable exception, the findings and recommendations of the Keane Tribunal report have not been challenged or significantly questioned in the intervening period. Many of the recommendations in the report were subsequently adopted by the State in legislation and regulations.

(b) Criminal damage compensation claim

B5. In June 1983, a claim was brought by the owners of the Stardust for compensation for malicious damage. It was determined by the Circuit Court after a two-day hearing that the fire had been started maliciously, although it is notable that evidence was only heard from witnesses on behalf of the claimants.

(c) Criminal proceedings

B6. No criminal prosecutions were brought against anybody arising from the Stardust fire, although over 1,400 statements were taken by Gardaí, and two files were sent to the Director of Public Prosecutions.

(d) Compensation tribunal

B7. A statutory compensation tribunal was established by the State in the 1980s, and the last award was made by the tribunal in 1991. It is usual practice in such tribunals for the claimants to waive any right to other civil process, and it is understood that this procedure was adopted. As is also usual in such tribunals, there was no investigation into the cause of the fire or any civil liability.

(e) Inquests

B8. Inquests were conducted into each of the deaths arising from the fire. The findings were limited to the medical cause of death in relation to each deceased. No findings were made concerning the cause or spread of the fire or the wider circumstances of each death.

(f) The Coffey Inquiry

B9. In 2008, Paul Coffey SC was commissioned by the Government, following submissions by the Stardust Victims Committee, to examine the case for a renewed inquiry into the fire at the Stardust. He conducted a thorough review, assisted by experts. He concluded that the finding by the Keane Tribunal that the fire had been caused by arson was not objectively justifiable on the evidence.

B10. However, he came to the view that it would not be possible to establish the cause of the fire based on any new evidence available to him at that time.

B11. He recommended that the change of conclusion concerning a finding of arson should be placed on the public record by the Oireachtas, and that any further inquiry should only take place if this were not possible. If a further inquiry were to be held, it should be limited to the purpose of establishing the cause of the fire.

(g) The determination of the European Court of Human Rights

B12. In 2009, two family members of deceased persons brought actions against the State in the European Court of Human Rights, seeking determinations, including determinations relating to Article 2. The applications were lodged on 3 April 2009 (23213/09) and 15 October 2009 (62652/09). The Applicants argued that time had run from the completion of the work of the independent review in

2009. However, the Court held that time had begun to run, at the very latest, in 1991 when the Compensation Tribunal published its report, by which time it had also become clear that no further investigative steps would be taken, because the last file had been sent to the DPP in 1982. Nor were there any development that could have suggested to the applicant that there was a possibility of any further criminal prosecution. The Court also did not consider that any new evidence had come to light which would create a fresh obligation through the review procedure which was established in 2008.

(h) The McCartan Review

B13. In 2017, the Government established an assessment to evaluate materials put forward by the Stardust Relatives and Victims Committee. The assessment was conducted by retired Circuit Court Judge Pat McCartan. He considered the materials put forward, and concluded that it did not amount to new or updated evidence such as would warrant a further enquiry.

(i) Application for fresh inquests

B14. On 31 March 2019, an application was made to the Attorney General for fresh inquests, under section 24 of the Coroner's Act 1962. A detailed 37-page submission was filed by Phoenix Law on behalf of Antoinette Keegan and relatives of 42 of the 48 persons who died as a result of the fire.

B15. It is important to note that paragraph 8 of the submissions states as follows, having outlined the reasons why they believed new inquests should be ordered:

> "*At the same [time] new inquests will be manageable.* ***Much of the evidence heard at the Keane Tribunal, in particular the uncontroversial evidence and findings, can be taken as read.*** *The Coroner overseeing the fresh inquests may wish to concentrate in the first instance on whether fresh fire expert evidence helps show how and where the fire was started*." (Emphasis added.)

B15. The submissions did not outline what evidence heard at the Keane Tribunal was uncontroversial or could be 'taken as read'.

B16. The submissions also outlined some fresh evidence, which was relied upon by the applicants to ground an application that the fresh inquests should investigate the cause and location of the original fire. These included seven witness statements, and a number of commentaries from experts suggesting that the determination by the Keane Tribunal of the cause and location of the original fire was or might be in error.

(j) Direction by Attorney General

B17. On 25 September 2019, the then Attorney General, Seamus Woulfe SC, pursuant to the provisions of Section 24(1) of the Coroners Act 1962-2020, directed that fresh inquests should be held into the deaths. In particular, he wrote:

> "*This is because I consider that in the original inquests there was an insufficiency of inquiry as to how the deaths occurred, namely,* ***a failure to sufficiently consider those of the surrounding circumstances that concern the cause or causes of the fire***." (Emphasis added.)

C. Statutory basis for inquiry at inquests

C1. Section 18A of the Coroners Act 1962 (as inserted by section 12 of the Coroners (Amendment) Act 2019) provides:

> "*(1) The purpose of an inquest shall be to establish—*
>
> *(a) the identity of the person in relation to whose death the inquest is being held,*
> *(b) how, when and where the death occurred, and*
> *(c) to the extent that the coroner holding the inquest considers it necessary, the circumstances in which the death occurred, and to make findings in respect of those matters (in this Act referred to as 'findings') and return a verdict.*"

C2. Section 30 of the 1962 Act states as follows (as amended by section 18 of the 2019 Act which deleted the words struck through in the following text):

> "*Questions of civil or criminal liability shall not be considered or investigated at an inquest ~~and accordingly every inquest shall be confined to ascertaining the identity of the person in relation to whose death the inquest is being held and how, when, and where the death occurred~~*."

C3. Further guidance has been provided in judgments of the superior courts including in *Eastern Health Board v. Farrell* [2001] 4 IR 627; and *Ramsayer v. Mahon* [2005] IESC 82.

C4. The principal purpose of a coronial inquest is to ascertain the answers to four factual questions and sufficient evidence must be called to enable those questions to be addressed.

C5. The coroner's inquiry will however go further than may be strictly necessary to answer those questions and in the circumstances of these inquests I will outline those matters that I consider to come into the scope of my inquiry insofar as they are causally related to the deaths.

D. Previous submissions on scope of inquests

D1. In a letter dated the 6th of November 2020, I wrote to Phoenix Law, who act for a majority of the families of the deceased, in the following terms:

> "*My preliminary view is that the scope of the inquests will therefore encompass the relevant circumstances of the deaths that occurred on the night of the 14th-15th February 1981 and in particular the following elements (I set these issues out in chronological order as they appear from a preliminary consideration of the papers and not in any particular order of gravity):*
>
> *1. Establishing, insofar as possible and in accordance with the direction of the Attorney General, the cause of the fire, including any relevant evidence at to the condition of the premises at the time of the fire and relevant evidence insofar as is relevant to (i) predisposing factors, (ii) the origin and (ii) the spread of the fire;*

2. The circumstances that prevailed within the Stardust Nightclub following the outbreak of the fire;

3. The response, both within the Stardust Ballroom and by the emergency services, to the outbreak of fire."

D2. In a letter to me of 24 November 2020, Phoenix Law set out their view that the following specific issues should be investigated in the inquests:

"*1. The circumstances leading to the fire, including the actions of those working for the Stardust, on 14 February 1981.*
2. Where and how did the fire start, and what was its cause?
3. How and why did the fire progress?
4. The response to the fire by those working for the Stardust and the emergency services.
5. Building design, safety and escape measures at the Stardust, and whether these minimised the risk of harm in a fire.
6. Inspections, maintenance, response to any prior warnings, and other measures which might have prevented the fire.
7. Management of the Stardust, governance and regulation.
8. Is there action which could be taken to reduce the risk of future deaths in similar circumstances?
9. What was the medical cause of each death?"

E. Submissions at pre-inquest hearing

E1. While most of the interested persons made general submissions in relation to the scope of the inquests, only Phoenix Law raised specific questions that might be addressed.

E2. In "Annex A" to their written submissions, dated 12 July 2021, Phoenix Law expanded on their earlier list, as follows:

"*1. Where and how did the fire start, and what was its immediate cause?*
2. How and why did the fire progress?
3. The circumstances leading to the fire/other contributory factors.
4. The design and condition of the building (including fixtures, fittings and installations; safety and escape measures) and whether these adequately minimised the risk of fire or harm in a fire.
5. Prior inspections, maintenance, response to any prior warnings, and other measures which might have prevented the fire.
6. Management of the Stardust 16 (including staff training and fire-planning).
7. Whether one or more of the deceased might have been saved by different actions taken before or on the night of the fire.
8. Governance and regulation.
9. The response both within the Stardust and by the emergency services, to the outbreak of the fire.
10. Whether recommendations designed to prevent further fatalities should be made, pursuant to S.31(2) of the Coroners Act 1962-2019..
11. The medical cause(s) of each death."

E3. The other interested persons broadly agreed that the above matters were relevant to the inquiries to be made, provided that no findings of civil or criminal liability were made. Some submissions were made concerning the wording of matters 4 and 7 of Annex A, and I shall return to these below.

F. Discussion

F1. It appears to me, having considered the matters raised under "Annex A" that these are broadly matters that are relevant for determination at these inquests (subject to some revision, as will be discussed below) and are not dissimilar from my initial position as set out in correspondence.

F2. Nonetheless, I am mindful of the fact that Phoenix Law, on behalf of a significant majority of the families of the deceased, had submitted to the Attorney General in 2019 that a number of matters determined at the Keane Tribunal might be 'taken as read'.

F3. This view was reiterated in their submissions dated 12 July 2021, received by my office on 14 July 2021, where they wrote, at par 6:

> "*The families seek full and fearless inquests, which are capable of revealing the truth of what led to the deaths of the 48 people who died in the Stardust fire, and of taking steps to prevent anything like this happening again. But at the same time, they recognise that some issues were fully investigated in the past and there is no reason to re-investigate them. The Coroner will be entitled, at the inquest, to read in certain evidence or conclusions from the Keane Tribunal*."

F4. Whereas I have previously given a preliminary indication of those matters that I consider to come into the scope of these inquests, I am also mindful of the fact that I have an obligation to the public to conduct these inquests in an expeditious manner, without incurring undue expense. If it is the case that there are relevant matters that have already been determined, that are unchallenged, and that do not need to be reopened, I am of the view that I should adopt these findings.

F5. In the absence of any specific views yet furnished by the interested parties in this regard and in the interests of taking the course that have been previously advocated by solicitors for the majority of the families, I will therefore take a provisional view on this matter myself, having considered the content of the Keane Tribunal report. This view will be open to revision following any submissions from any of the interested persons.

G. Some comments on the Keane Tribunal report

G1. The terms of reference of the Keane Tribunal were as follows:

> "*1. A Tribunal is hereby appointed—*
> *(a) to inquire into the following definite matters of urgent public importance:*
>
> *(1) the immediate and other causes of, and the circumstances leading to, the fire at the Stardust Club, Artane, Dublin on the 14th February, 1981,*
>
> *(2) the circumstances of and leading to the loss of life and personal injury at the Stardust Club on the 14th February, 1981,*

(3) the measures and their adequacy, taken on and before the 14th February, 1981, to prevent, detect and to minimise and otherwise to deal with fire at the Stardust Club,

(4) the means and systems of emergency escape from the Stardust Club, and their adequacy on the 14th February, 1981,

(5) the measures (including the application of the Draft Building Regulations published on the 29th November, 1976), and their adequacy, taken on and before the 14th February, 1981, at the Stardust Club to prevent and to minimise and otherwise to deal with any other circumstances that may have contributed to the loss of life and personal injury aforesaid or might have led to or contributed to the loss of life or personal injury,

(6) the adequacy of the legislation, statutory regulations and bye-laws relevant to fire prevention and safety, so far as material to the granting of planning and bye-law permission for, and the conduct, running, supervision, and official inspection and control of, the Stardust Club, and the adequacy of the application, observance and enforcement of such legislation, statutory regulations and bye-laws in relation to the Stardust Club;

and

(b) to make such recommendations as the Tribunal, having regard to its findings, thinks proper in respect of the statutory and other provisions in relation to fire, fire prevention and means and systems of emergency escape from fire, their adequacy and enforcement and any other matters that the Tribunal considers relevant."

G2. It will be observed that there is much crossover between the terms of reference of the Keane Tribunal and the matters raised at "Annex A" of the Phoenix Law submissions.

G3. I must further note that some of the determinations made by Mr. Justice Keane in his report amount to criticism of a variety of persons, and go beyond any findings that would be available to a Coroner exercising his or her powers under the Coroners Acts 1962-2020.

H. The questions raised in "Annex A"

H1. I shall therefore address each of the issues in "Annex A" with a view to considering whether any relevant previous findings in the public domain may be 'taken as read' or 'read in' at these the inquests.

1. Where and how did the fire start, and what was its immediate cause?

H2. There can be no doubt that this is a matter that needs to be re-investigated in these inquests.

H3. Furthermore, although I am not bound in law by the terms of the Attorney General's direction, I should have regard to the fact that he directed these inquests because he was of the view that there had been an insufficiency of inquiry as to the cause of the fire in the original inquests.

H4. I am therefore satisfied that this is an appropriate question for full investigation, and that none of the prior findings in this regard should be 'taken as read'.

2. How and why did the fire progress?

H5. As noted above, the cause and location of the original fire are matters that are not matters that are accepted as having been settled, whether in the Keane Tribunal report or otherwise. It is therefore appropriate to investigate in detail the question of how the fire progressed from its original location. Accordingly, I am satisfied that this is not a question that has been satisfactorily determined and that none of the findings in this regard may be 'taken as read '.

3. The circumstances leading to the fire/other contributory factors.

H6. While the question of the circumstances leading to the fire, or any contributory factors might be considered an open-ended question, I am satisfied that these are questions that should be addressed insofar as they may be directly relevant to the start and spread of the fire. They are not matters where previous findings should be 'taken as read'.

H7. However, there must be a limit on the investigation of any factors that may have indirectly contributed to the fire, and it may be that there are findings in the Keane Tribunal report that may be 'taken as read' in this regard. Some of these issues will be discussed further below.

4. The design and condition of the building (including fixtures, fittings and installations; safety and escape measures) and whether these adequately minimised the risk of fire or harm in a fire.

H8. At the pre-inquest hearing, Mr. Paul O'Higgins SC, on behalf of Mr Eamonn Butterly, submitted that this question might be too broadly formulated. It may be that this question is broader than would be appropriate for the investigation of individual deaths.

H9. I would therefore provisionally re-word this question to read:

> "*Whether the design and condition of the building (including fixtures, fittings and installations; safety and escape measures) caused or contributed to the start or spread of the fire or the deaths of the relevant individuals*."

H10. I consider this question to come into scope. However having said this, it should be noted that Chapter 1 of the Keane Tribunal report, entitled "The Scene of the Fire" addresses *inter alia* the following questions:

At II - "*The design, execution and supervision of the conversion of the building*"
At IV - "*Mechanical and electrical installations*"
At V - "*Alterations and maintenance*"
At VI - "*Means of escape from the building*".
At VII - "*Fire extinguishers and hose reels*"

H11. The chapter also addresses the relevant legislation, and the extent to which there was non-compliance by the owners of the building.

H12. Furthermore, Chapter 8 of the report, is entitled "*The Responsibility for the Disaster of the Owners and their Advisers, Dublin Corporation and the Department of the Environment*".

H13. At I, the chapter addresses "*The responsibility of the owners and their advisers*", including, at (1), "*The design, supervision and execution of the conversion*" (addressed on page 273)

H14. It would not be appropriate for me to comment on the findings made in this regard, except to say that the findings go significantly beyond any that could be made under a statutory inquest. Furthermore, there has not to my knowledge been any challenge to these findings by any interested person.

H15. Accordingly, and subject to any views of any interested persons, it may be that these are matters that do not need to be addressed in any further detail at inquest.

H16. However, because the findings of individual responsibility cannot be 'taken as read' at the inquests, I shall need to hear submissions from the interested persons as to the appropriate manner in which any findings may be adopted by the inquest or given to a jury by direction of the coroner.

5. Prior inspections, maintenance, response to any prior warnings, and other measures which might have prevented the fire.

H17.In Chapter 8 of the Keane Tribunal report, already referred to above, section II is entitled "The responsibility of Dublin Corporation", pages 279 to 289. The individual sections include:

"*(1)(i) The structure and staffing of the relevant department.*
(ii) The assessment of the applications for planning permission and bye-law approval.
(2) Enforcement of the applicable Legislation and Regulations by inspection or otherwise.
(3) Conclusions"

H18. I do not understand that there have been any challenges to the findings made, or any particular criticisms of them. Accordingly, It may be that any relevant findings can be 'taken as read' at the inquests. As already discussed, I shall need submissions as to the appropriate way that they can be adopted by the inquest or given to the jury by way of direction.

6. Management of the Stardust (including staff training and fire-planning).

H19. Chapter 1 of the Keane Tribunal report, "The Scene of the Fire" addresses, at section VIII "Ownership, management and fire safety", pages 26 to 31.

H20. Direct comment is also made at paragraph 8.34 on page 279. Again, it would not be appropriate for me to comment on these findings other than to say that they go significantly beyond findings that would be appropriate in an inquest. To my knowledge, they have not been the subject of any challenge or any significant criticism.

H21. I am therefore of the view that any relevant findings may be 'taken as read', although I shall need submissions as to the appropriate way that the findings may be adopted.

7. Whether one or more of the deceased might have been saved by different actions taken before or on the night of the fire.

H22. At the pre-inquest hearing on 28 July 2021, counsel for An Garda Siochána submitted that this question might not be appropriately worded.

H23. Having considered the submission, the question could in theory be framed as follows:

"7. Whether any actions taken before or on the night of the fire caused or contributed to the death of any of the deceased."

H24. I am conscious however that this question is in danger of contravening section 30 of the Coroner's Act 1962 – 2020, which prohibits any findings of civil or criminal liability.

H25. Furthermore, there remain unanswered questions concerning the causes of each individual death. The earlier inquests only addressed the medical causes of death, without addressing how each of the deceased met their deaths within the context of the fire.

H26. As set out succinctly in the submissions on behalf of Patricia Kennedy:

> "*We need to know when, where and how Marie died and all the relevant circumstances surrounding Marie's death so that recommendations of a general character may be made to prevent further deaths and as are necessary or desirable in the interests of public health and safety*."

H27. In the circumstances, I propose to re-frame the question in respect of each of the 48 deceased as follows:

> "*7. Where possible, given the available evidence, the circumstances in which each death occurred in the context of the Stardust fire*."

> This question will of necessity fall to be considered in conjunction with the point 11 of Annex A.

8. Governance and regulation.

H26. Chapter 1 of the Keane Tribunal report addresses at pages 26 to 31, the ownership, management and staffing of the Stardust, including the ownership of the individual shares in the relevant company (Scotts Foods Ltd). Subject to any submissions from the interested persons, it may be that the relevant paragraphs may be 'read in' to the inquests.

9. The response both within the Stardust and by the emergency services, to the outbreak of the fire.

H27. These questions were addressed in the Keane Tribunal report in the following sections:

> Chapter 2: section VI ("Raising the alarm"), p 71; section VII ("Attempts to extinguish the fire"), p 75; XI ("Conclusions") especially at p 95.

> Chapter 3: "The Evacuation of the Building.

Chapter 4: "The Rescue Operations"

H28. Again, these findings include criticisms that go beyond any findings that might be made in the context of an inquest. The findings have not to my knowledge been the subject of any challenge or significant criticism.

H29. Accordingly, I would propose that the relevant findings may be 'read in' to the inquest, subject to any submissions as to the appropriate manner in which this might be done.

10. Whether recommendations designed to prevent further fatalities should be made, pursuant to s.31(2) of the Coroners Act 1962-2019.

H30. Given that 40 years have passed since the fire itself, and that there have been many changes in legislation and regulation since that time, it would serve no purpose to review the conditions of the day. These were examined in some detail by the Keane Tribunal report, and many changes were made in response to the said report.

H31. However, if the evidence heard in the context of these inquests gives rise to concern that the current legislation or fire safety regime is inadequate to prevent a similar disaster, or any other matter arises in evidence which, if left unremedied, might lead to future similar deaths it would be appropriate to make any relevant recommendation.

11. The medical cause(s) of each death.

H33. This is an appropriate question to address and as indicated will inform any determination of question 7. Expert evidence will be called, notwithstanding that the expert will have to rely on the original postmortem records.

I. Conclusion

I1. I have outlined those issues that I consider come into scope and with which it appears interested persons are broadly in agreement.

I2. The outstanding matter relates to identifying which amongst those issues can be presented at inquest by adopting certain findings of the Keane Tribunal report.

I3. I have expressed my preliminary view of this matter however until I have received submissions from interested persons, I cannot finalise my position or indicate the manner in which the totality of evidence will be presented at inquest.

I4. If any of the interested persons has submissions or observations to make on this determination on scope, this should be indicated no later than the date of the next for mention/case management hearing on 13 October 2021.

Dr. Myra Cullinane
Senior Coroner Dublin District
13th of August 2021