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15 May 2025
Your ref: INQ/PX9929/DM
Our ref: WW/AGCH.4945
Please quote on all correspondence

Dear Mr Mackin

Re: The Summerland Fire – Application for a Fresh Inquest
Your Clients: Justice For Summerland

I understand that you act on behalf of the 'Justice for Summerland' organisation ('your client'). This is an organisation which I understand to have been established in January 2024 and which includes among its members bereaved persons associated with 30 victims of the Summerland fire of 2 August 1973.

Your client has made an application to me, dated 4 March 2025, for fresh inquests to be held pursuant to Section 6(1)(c) of the Coroners of Inquests Act 1987 into the deaths at Summerland ('the application'). Your client asserts that "*there has never been an effective investigation into the fire*" and that the inquests held in 1974 were "*ineffective and perfunctory investigations*". I note that the applicant also submits that a direction for a fresh inquest is necessary, so as to act compatibly the procedural duty within Article 2 of the European Convention on Human Rights ('ECHR').

The Summerland fire was a terrible tragedy for the people of this island and beyond and which resonates to this day. Fifty innocent people tragically lost their lives as a result of the blaze, and far more suffered serious physical and psychological injuries. The subsequent inquiry of the Summerland Fire Commission revealed, that there were significant shortcomings in the design, construction, regulatory oversight and operation of Summerland

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complex. I recognise that for those who lost beloved relatives and friends, even fifty years cannot remove the grief and loss they suffered, nor expunge their anger at the unnecessary nature of that loss. I offer my deepest condolences to all those whose lives were and continue to be affected by the dreadful events.

I am mindful of the importance and sensitivity of the case and have been careful to apply a careful analysis of the application. However, I must approach your client's request without emotion when I consider the legal basis for what is now sought, applying the law as it is understood today but in the context of the circumstances that pertained in 1974 when the first inquests were held, and taking account of any relevant matters revealed since.

I have fully considered the application and all the additional material provided in support. I explain below my reasons for declining to direct the coroner to hold fresh inquests into the Summerland fire victims' deaths. I am aware that my decision will not be welcomed by your clients, and I wish to assure them that nothing I say below is intended to add to their burden or ongoing grief and I am very sorry if it does so.

These are my reasons:

A: THE RELEVANT LAW

1. The relevant statutory provision applying to your request is the Coroners of Inquests Act 1987 which states as follows:

s.6. Duty to hold inquest:
(1) A coroner shall hold an inquest touching a death:
(a) where the body of the deceased is in the Island and the coroner has reason to believe that he died in the Island in any of the circumstances mentioned in section 2(1)(a) or (b) or (4)(d); or
(b) *[repealed]*
(c) where the Attorney General has reason to believe that the deceased died (in the Island or elsewhere) in circumstances which in his opinion make the holding of an inquest desirable, and directs the coroner to hold such an inquest.

(2) Where a coroner receives a direction under subsection (1)(c) he shall hold an inquest whether or not he or any other coroner has viewed the body, made any inquiry or investigation or held any inquest into or done any other act in connection with the death.

2. Through this provision I have the power to require a fresh inquest to be held if I consider it '*desirable*' to do so. The meaning of the word 'desirable' is not further defined in Manx case law and so should be given its ordinary meaning.

3. In considering whether it is 'desirable' to direct fresh inquests the English & Welsh jurisprudence can provide assistance in interpretation, and so when considering the application I have borne in mind the principles relied upon by the Lord Chief Justice, when allowing the Hillsborough victims' families' application for a fresh inquest in *Attorney-General v HM Coroner of South Yorkshire (West)* [2012] EWHC 3783 (Admin).

4. In that case the meaning of the phrase '*necessary and desirable*' in the very similar English & Welsh legislation was considered.[1] The Lord Chief Justice, Lord Judge, stated at §10 (with emphasis added):

> *The single question is whether the interests of justice make a further inquest either necessary or desirable. The interests of justice, as they arise in the coronial process, are undefined, but, dealing with it broadly, it seems to us elementary that the* ***emergence of fresh evidence which may reasonably lead to the conclusion that the substantial truth about how an individual met his death was not revealed at the first inquest, will normally make it both desirable and necessary in the interests of justice for a fresh inquest to be ordered****. The decision is not based on problems with process, unless the* ***process adopted at the original inquest has caused justice to be diverted*** *or for the inquiry to be insufficient. What is more,* ***it is not a pre-condition to an order for a further inquest that this court should anticipate that a different verdict to the one already reached will be returned****. If a different verdict is likely, then the interests of justice will make it necessary for a fresh inquest to be ordered, but* ***even when significant fresh evidence may serve to confirm the correctness of the earlier verdict, it may sometimes nevertheless be desirable for the full***

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[1] That is s.13(1)(b) Coroners Act 1988, which provides for a fresh inquest to be ordered if the High Court are satisfied as respects a coroner that: "(1)(b) Where an inquest has been held by him, that (whether by reason of fraud, rejection of evidence, irregularity of proceedings, insufficiency of inquiry, the discovery of new facts or evidence or otherwise) it is **necessary or desirable in the interests of justice** that another inquest should be held."

extent of the evidence which tends to confirm the correctness of the verdict to be publicly revealed. *Without minimising the importance of a proper inquest into every death, where a national disaster of the magnitude of the catastrophe which occurred at Hillsborough on 15 April 1989 has occurred, quite apart from the pressing entitlement of the families of the victims of the disaster to the public revelation of the facts,* ***there is a distinct and separate imperative that the community as a whole should be satisfied that, even if belatedly, the truth should emerge."***

5. Therefore, in considering whether a fresh inquest into the deaths at Summerland is desirable, I have borne in mind the following principles that I have drawn from the 'Hillsborough' decision:

   (a) Whether any fresh evidence has emerged since the initial inquests;

   (b) Whether a different conclusion is likely at fresh inquest and if not, whether public confirmation of earlier findings is desirable in all the circumstances;

   (c) Whether the process adopted at the original inquest has caused justice to be diverted or for the inquiry to be insufficient;

   (d) Whether the substantive truth regarding how the deceased lost their lives has been revealed;

   (e) The wishes of the bereaved;

   (f) Any distinct and separate imperative that the community as a whole should be satisfied that even if belatedly, the truth should emerge.

   In addition I have considered below some other matters that are raised in the application including the impact of Article 2 ECHR.

The Purpose of an Inquest

6. The statutory function of an inquest held under the Coroners of Inquests Act 1987 and the Coroners of Inquests Rules 1988 r.27 (as was the case under its predecessor legislation, the Coroners of Inquests Act 1961, s.18(4) & s.18(5)) is to determine five things: (i) who the deceased was, (ii) when and (iii) where they died and (iv) how they came by their death, as well as (v) the registration particulars.

7. As the English Court of Appeal stated in *Morahan*:[2]

> *"An inquest remains an inquisitorial and relatively summary process. It is not a surrogate public inquiry. The range of coroners' cases that have come before the High Court and Court of Appeal in recent years indicate that those features are being lost in some instances and that the expectation of the House of Lords in Middleton of short conclusions in article 2 cases is sometimes overlooked. This has led to lengthy delays in the hearing of inquests, a substantial increase in their length with associated escalation in the cost of involvement in coronial proceedings. These features are undesirable unless necessary to comply with the statutory scheme."* (emphasis added)

8. The coroner has wide discretion to set the scope of the inquest and determine what evidence it is necessary, desirable, and proportionate to consider by way of investigation to enable their statutory functions to be discharged. These are not hard-edged questions. The decision on scope, the breadth of evidence adduced, and the decision on which witnesses to call to meet that scope is for the coroner to make in the circumstances of each case.[3]

9. It is reasonable for a coroner to admit into the inquest as evidence relevant reports of other independent bodies (such as Accident Investigation Branches) or from related public inquiries. As the English and Welsh High Court emphasised in the *Norfolk* case,[4] it is not necessary for a coroner to traverse ground that another independent inquiry has already considered. Mr Justice Singh (as he then was) particularly noted that:

> ***"it is important to emphasise that there is no public interest in having unnecessary duplication of investigations or inquiries."***

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[2] *R (Morahan) v HM Coroner for West London and others* [2022] EWCA Civ 1410 at §7
[3] *Coroner for the Birmingham Inquests v Hambleton* [2018] EWCA Civ 2801
[4] *R (on the application of Secretary of State for Transport) (Claimant) v HM Senior Coroner for Norfolk (Defendant) & British Airline Pilots Association (Intervener)* [2016] EWHC 2279 (Admin)

10. A coroner may therefore conduct an inquest and lawfully admit as evidence the conclusions of a report from another independent inquiry. It is not a requirement of law that the coroner must re-examine all the primary evidence from that earlier inquiry again at the inquest.

11. Under the Coroner of Inquests Act 1961 s.18(1) which is the provision under which the Summerland inquests were held, the coroner's duty was to examine all persons/evidence that he considered it was 'expedient to examine'. Further, by s27 of the 1961 Act the coroner had the discretion to direct an analysis of any thing he considered necessary "for the purposes of his duties under this Act". There is a wealth of authority from coronial proceedings in related jurisdictions that it is for the coroner to decide how to adduce the necessary evidence as to death. The coroner is not required to call every witness who might have relevant evidence, but only sufficient witnesses to undertake a proper inquiry. [5]

Article 2 ECHR

12. The consequences of Article 2 of the ECHR (that everyone's right to life shall be protected by law) being engaged are explained by Coroner Needham in the *Inquest into the Death of Christopher John Burrows* (18 March 2013) and in the *Inquest into the death of Benjamin David Hall* (17 October 2014): both are available in full on www.judgments.im. Art 2 imposes negative obligations on the state not to take life without proper cause and carefully defined positive obligations to protect life. It also imposes procedural obligations, including (i) a general obligation to have in place proper systems for investigating all deaths; and (ii) in respect of certain deaths, a specific obligation to establish one or more independent investigations which satisfy Convention standards.

13. In certain cases, where the Article 2 procedural obligation to establish a Convention-compliant investigation is engaged and where that obligation has not already been discharged by procedures other than an inquest, the statutory question of 'how' a

[5] See for example: *McKerr v Armagh Coroner* [1990] 1 WLR 649, 656-657; *R (Ahmed) v South and East Cumbria Coroner* [2009] EWHC 1653 (Admin), [35]; *Mack v HM Coroner for Birmingham* [2011] EWCA Civ 712 (CA), *per* Toulson LJ at [8].

person died should be read as meaning 'by what means and in what circumstances' the deceased came to die. The coronial investigation will then need to consider the broad circumstances of the death and may also return conclusions addressing wider circumstances of death and underlying causes. [6]

14. This reading of the word "how" in coronial law arises because very often an inquest will be the only means by which the state discharges the burden of the procedural obligations that flow from Art 2. But importantly, when considering whether Art 2 mandates a fresh inquest it must be remembered that the Art 2 procedural obligation is an obligation on the state as a whole, it does not fall solely to a Coroner to meet the obligation.

15. For this reason when considering whether an inquest is required to meet the state's procedural obligation under Article 2, ECHR, one must consider the totality of state investigations and whether all the investigative procedures of the state, taken together, have collectively satisfied the requirements of the procedural obligation.[7] That totality of available procedures includes criminal proceedings, any public inquiry or other investigations, any civil claim and/or the potential for a civil claims as well as a coronial investigation and inquest where one is held.[8]

16. The Convention does not adopt a prescriptive approach to the form of the Art 2 investigation. Its requirements will vary according to the circumstances of the case under consideration, and it is for the state to decide the most effective method of investigating a death engaging Art 2 procedural obligations. However there are certain irreducible minimum standards to be met that are commonly referred to as the *Jordan* criteria.[9] These are that:

    a) the state authorities must act of their own motion;
    b) the investigation must be independent;
    c) the investigation must be effective, in the sense that it must be conducted in a manner that does not undermine its ability to establish the relevant facts;[10]

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[6] *R (Middleton) v HM Coroner for Somerset* [2004] 1 AC 182, at §20, §§35-38
[7] see *Goodson v HM Coroner for Bedfordshire* [2004] EWHC 2931 (Admin) at §59 (iv) and (vi)).
[8] see *R (AP) v HM Coroner for Worcestershire* [2011] EWHC 1453 (Admin) at §95.
[9] *Jordan v UK* (2003) 37 EHRR 2
[10] this is, as described in *Jordan,* 'an obligation of means rather than results'.

d) the investigation must be reasonably prompt;

e) there must be a "sufficient element of public scrutiny" of the investigation *or* its results to secure accountability in practice as well as in theory; the degree of public scrutiny required may well vary from case to case: and

f) there must be involvement of the next of kin "to the extent necessary to safeguard his or her legitimate interests."

17. In many, if not most, cases a coronial inquest will be the vehicle through which all those state obligations are met. But it is all the mechanisms and processes of state, taken together, that must meet the Art 2 obligations and satisfy the *Jordan* criteria. Hence, at times the state's Article 2 procedural obligations might be satisfied without any inquest ever taking place.[11]

Application of Art 2 to events in 1973

18. In this case I must also consider the additional question of whether the temporal scope of Art 2 stretches back to 1973, given that the events I am considering occurred thirty years before the coming into force of the Human Rights Act 2001, in 2003.

19. In some specific situations the Art 2 ECHR procedural duty might be 'revived' and still bind the state despite these deaths occurring before the 'critical date' of the coming into force of the relevant Human Rights Act.[12] However the Supreme Court have recently held that Convention rights do not require re-investigation of historic deaths beyond 12 years, save in extraordinary situations.

20. In *McQuillan*[13] it was made clear that for the temporal scope to be extended beyond 12 years before the implementation of the Human Rights Act, any original investigation into the triggering death would have to be seen to have been "*seriously deficient*".[14] Their Lordships went further than Lord Kerr's judgment in *Finucane* (which the application

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[11] As an example see *R(Grice) v HMC Brighton & Hove* [2020] 3581 (Admin)
[12] see Finucane's Application for Judicial Review [2019] UKSC 7
[13] *In the matter of an application by Margaret McQuillan for Judicial Review (Northern Ireland) (Nos 1, 2 and 3)* [2021] UKSC 55
[14] At §144

cites) regarding the factors required before reviving an investigatory obligation, when it was stated:[15]

> "*What is critical here is not the inconclusive nature of earlier investigations but whether there now exists such* ***weighty and compelling new evidence*** *as to require a fresh investigation."* (emphasis added)

21. An alternative basis on which the temporal scope of the HRA may be further extended established is the 'Convention Values' test. This test also relates to extraordinary situations, requiring the triggering event to be of a such a nature that it amounts "to the negation of the very foundations of the Convention". Examples given in the authorities are "serious crimes under international law, such as war crimes, genocide or crimes against humanity". [16] The seminal case of *Janowiec* being related to the massacre in 1940 of 21,000 prisoners of war. It is the gross nature of the breach of Convention rights, and not the magnitude of the loss of life, that is the touchstone for this Convention Values test.

B: THE FACTUAL BACKGROUND

22. The original inquests were opened on 9th August 1973 and then adjourned pending the outcome of the public inquiry commissioned by the Island's Lieutenant Governor (on 3 September 1973) and known as the 'Summerland Fire Commission" ('The Commission'), which conducted a full public investigation of the fire.

The Public Inquiry

23. The Commission were a wholly independent body chaired by Mr Justice Cantley. In my view the state had acted proactively and promptly in that it had set up this independent panel "to inquire into, and report on, all the circumstances of, and leading up to, the fire at the Summerland Leisure Centre...".

24. The Commission scrutinised documents and heard oral evidence in public. It commenced its public hearings on 19 November 1973 and ended its hearings on 13 February 1974 having heard from over 90 witnesses over 49 sitting days.

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[15] at §128
[16] see *Janowiec and others v Russia* EHRR [2013] at §149.

25. The witnesses were examined by leading counsel for the Commission and were subject to cross examination by counsel for the various interested parties. This included four counsel (including leading counsel) who were instructed to represent the relatives of the deceased and injured persons. The Commission also made several inspections at the site of the fire.

26. The Commission's 100 page report ('the Report') was completed and presented to the Lieutenant Governor in May 1974. The Report set out the Commission's factual findings, conclusions and recommendations. It was published and so was available for the public to see.

27. The Report covers all aspects of the fire and the relevant background to how the fatalities arose. It covers the design construction and operation of Summerland in several sections including:
    1. The concept of Summerland
    2. The architectural management
    3. The structure in detail
    4. The bye-laws and compliance with them
    5. The tenancy and fitting-out
    6. The application of the Theatre Regulations 1973
    7. Fire protection and precautions
    8. Origin and development of the fire
    9. Factors in the spread of the fire
    10. Factors in the loss of life

28. Many '*inadequacies and failings*' were identified by the Commission with several persons and organisations who were deemed to be at particular fault being named in the Report. Many specific '*human errors and failings*' with 'procedures that verged in the irresponsible' were noted in the published Report, including but not limited to the following:
    - The wrongful delegation of their responsibilities by the Douglas Corporation and the Local Government Board when Summerland was planned and constructed hence lack of client oversight and control of the Summerland project;

- Lack of scrutiny of plans offered for planning and bye-law approvals by all officials and committees concerned;
- The appointment of Mr J Phillips Lomas as architect when he only had limited experience of modest building design;
- That neither Mr Phillips Lomas nor Mr C Barnett fulfilled their expected role as project manager/ director. They had indifferent communications between them and wrongly delegated tasks to subordinates;
- The architects having little simple scientific knowledge about materials and about standard performance requirements of buildings in general;
- The architects not understanding the requirements of building bylaws and not being aware of information from British Standard tests.
- Design failures in the building particularly: its inaccessible access, the extreme expanses of acrylic on the walls and roof, the lack of compartmentation and the haphazard arrangements of stairs and exits;
- Failure to consider the kind of occupancy, usage and activities of the building during the design stage;
- Failure to consider matters of occupancy and fire precautions and escape during the design development;
- The inadequate design of the North East stair (purported to be an emergency fire exit);
- The lack of efficient design management, with panels and materials used with little understanding of their limitations;
- The particular absence of attention to the characteristics of the chosen external walls of Oroglas and Galbestos in respect of fire, heat insulation, fire stopping etc;
- The use of Galbestos and Oroglas panels that contravened the bye-law that required external walls to be non-combustible throughout, with a fire resistance of two hours;
- The Chief Fire Officer raising no objection to the suggested construction when the committee considered waiving the bye-law;
- The waiver of bye-laws in respect of the Oroglas walls by the Douglas Corporation and the local Government Board without adequate inquiries and scientific investigation;
- The overall failure to seek advice from research establishments concerning the performance of Galbestos and Oroglas building materials;

- Failure to take into account that exposed edges of acrylic were relatively easily ignited in the design of the roof;
- The 'serious breach of good building practice' by using Decalin (a form of fibreboard) for the walls internally, a material that was combustible with a rapid rate of flame spread and which created a concealed gap with a combustible surface on both sides;
- The inadequate fire stopping measures inside the wall void;
- The overall design of Summerland being vulnerable to the spread of fire without suitable compensatory protections to guard against it;
- The lack of official inspection of Summerland during the fitting out stage. By the building inspectorate of the Douglas Corporation.
- Failure of the building inspectors to ensure that the building was carried out in accordance with the plans approved by the Douglas Corporation and to the standards required by the bye-laws, regulations and codes of practise in force;
- The Chief Fire Officer failing to apply the Theatre regulations 'at all';
- The absence of the 'vital' regular inspection on behalf of the fire service once the buildings were occupied;
- House Forte Ltd.'s higher management's failure to encourage the necessary official inspections.
- House Forte Ltd.'s failure to establish and maintain a proper system of fire precautions, including checking the condition of emergency exits, testing alarms and firefighting equipment.
- House Forte Ltd.'s failure to establish a practical and well understood procedure for evacuating the building in a fire emergency;
- The absence of systematic indications of exits an escape routes and provision of defective means of escape (emergency exit doors were locked, one was padlocked and also obstructed by a parked vehicle);
- The absence of any proper system for taking overall control if a fire broke out and the lack of awareness of the General Manager of his responsibility and duties to make proper provision for dealing with a fire emergency;
- The absence of any organised system of training of Trust House Forte staff re fire precautions. In particular the control room operator and the members of the 'firefighting party' who were aware this was their role;
- That the power was switched off during the fire and the emergency lighting system failed;

- The failure to use the fire alarm and public address system to alert occupants to the fire once it emerged inside the building
- The intentional delay placed on the link of the fire alarm to the Fire Station;

The cause of the fire

29. The Report also clearly identifies the cause of the fire. Supported by witness accounts and their own counsel's formal public admission, it was determined that the fire originated shortly before 19:40 hours with a match lighted by three schoolboys in a dismantled kiosk section that was leaning against the external Galbestos wall of Summerland.

30. In very brief summary, what then followed were unsuccessful attempts made by staff members to extinguish the fire and move the burning kiosk section away from the building, however, it collapsed against the wall and the combustible Galbestos ignited. Fire rapidly entered the void between the external Galbestos and Decalin fibreboard lining.

31. Expert opinion to assist the Commission was provided by Professor Rasbash, an expert in Fire Safety Engineering at the Edinburgh Fire Research Centre at the University of Edinburgh.[17] Professor Rasbash's opinion, which was consistent with the eye-witness accounts, was that within a minute of ignition of the external Galbestos coating the internal coating would also burn. Fire had massively invaded the Amusement Arcade within about 10 minutes of the fire starting within the void and rapidly spread to the area involving the Terrace restaurant. It subsequently spread to the Marquee, Showbar level and the leisure floor level. It also went up what was referred to as the 'chimney' a gap running between the Oroglas wall and the edges of the ceiling and floor at each terrace level.

32. A considerable conflagration rapidly developed within the whole height of the building with the fire moving very rapidly. Not only were the findings regarding the path and development of the fire supported by the expert opinion of Professor Rasbash, but it was recorded in photographs in cine films taken at the time.

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[17] This is the same Fire Research Centre later led by Prof Jose Torero from 2001-2012.

33. Staff had no training at all in the evacuation of customers. There were intentional delays in attempting to alert the public to a fire commencing. The alarm was not sounded to alert the fire station until 20.05 hours, and there was no public alarm sounded to occupants. The house manager switched off the main electricity supply at 20.11 hours putting the occupants into darkness and adding to their difficulties exiting the building at a time when there was an extensive fire on all three terraces.

34. The rapid spread of the fire was due in part of the design and construction of the building: the use of Decalin 'may well have been the biggest structural contribution to the disaster'. Additionally the absence of training of staff meant they failed to promptly call the fire brigade or to take prompt and appropriate action to evacuate the building or after the discovery of the fire.

35. Flowing from their comprehensive analysis of the source of the fire and how it became fatal the Commission made 34 recommendations aimed at enhancing the safety of users of public buildings in the future.

The Inquests

36. The inquests resumed on 27th August 1974 before the coroner and a jury. They were concluded in a single day. The coroner reasonably chose not to re-investigate or direct any further analysis of the fire that had been so recently investigated by the Commission's a full and detailed inquiry held in public. Rather, Mr G Carter, the secretary to the Summerland Fire Commission, was called as a witness and he produced the Commission's Report, the findings of which were accepted into evidence by the coroner in their entirety.

37. Witness evidence was also taken from:

    (a) Inspector A Killip, who reported the fact of the conviction on 17 September 1973 of the three juveniles who had admitted their actions had started the fire and had admitted through counsel that "*the ignition was caused by a lighted match*" ;

    (b) Superintendent G Kinrade: confirming the search of the premises and the recovery of all bodies had been completed by 5pm on 5 August 1973;

    (c) Chief Inspector Crompton: confirming that all persons reported as missing had been accounted for;

(d) Dr J Ferguson, Police Surgeon: confirming his attendance and conduct of the post mortem examination of the deceased and their cause of death, and who produced copes of the post mortem reports;
(e) Statements of identification witnesses for each deceased were also read.

38. The inquests' conclusions, save for some small differences in the medical cause of death, followed a similar format for each deceased:

> *"...died on the 2nd of August 1973 at the Summerland Leisure Centre in the Town of Douglas from ...[a fire/asphyxia/CO2 inhalation associated cause of death] by misadventure on the 2nd day of August 1973 when the Summerland Leisure Centre was destroyed by Fire."*

The Hillsborough case principles

39. Turning then to consider the principles from the 'Hillsborough' case which I have set out at §5 above.

(a) Whether there is any fresh evidence

40. The central plank of the application is the assertion that:

> *"There is substantial fresh evidence, which was not heard at the original inquest or by the Tribunal, which undermines the central conclusions reached at the Summerland Commission, and which will enable the earlier inconclusive investigations to be pursued further."*

41. But the application does not set out what this unheard fresh evidence actually comprises. Nor does your client identify what they believe to be the *central conclusions* of the Fire Commission's Report that they are asserting are now *undermined* by this new evidence. The application does not particularise what "*inconclusive investigations*" are being referred to.

42. The application goes on to say that "*this fresh evidence is fundamentally fatal to the reliability of the original forensic an analysis*" claiming that "*there is fresh evidence from*

world renowned expert witnesses". Yet your client has not actually put forward any fresh scientific evidence of any sort, let alone any fresh evidence that undermines any relevant conclusion reached by the Commission.

43. In coming to this view I have considered the letter you have submitted written by Professor Torero (Professor of Civil Engineering and Head, Department of Civil, Environmental and Geomatic Engineering, University College London) dated 21st February 2025. Prof. Torero states, and I accept, that new scientific techniques of fire investigation have been developed in the past 50 years, including the development of modern approaches towards fire reconstruction.

44. That there has been evolution in forensic science over the past five decades which might allow one to conduct analysis which was unavailable at the time in 1973 is indisputable: indeed one might expect all science to have moved on in fifty years. But Prof Torero has not provided any account of how any fresh analysis or technique conducted today might change in any material way the understanding reached in 1974 of how this fire started and how it spread so rapidly.

45. Prof Torero's letter states that "*the external façade of the Summerland Leisure Complex played a significant role in the rapid growth and spread of the fire within the complex, which ultimately caused these deaths.*" This is the conclusion already reached in 1974 by the Commission, as was adopted by the coroner at the inquests.

46. Prof Torero's letter states that "*the extensive external propagation served to profoundly overwhelm other provisions for fire safety. This, coupled with management failures, created a scenario from which occupants had little chance of escaping unharmed.*" His expert comment in this respect appears to firmly endorse, rather than challenge, the findings of the Commission.

47. Prof Torero's letter raises no criticism whatsoever of the science, the logic or the conclusions expressed in the Summerland Commission's Report. There is nothing anywhere in Prof Torero's correspondence that points to any conclusion of the Fire Commission as being unlikely, unreliable, incomplete, flawed, scientifically unsound or deficient in any way.

48. Prof Torero states that "*The practice of fire investigation has also developed significantly since the Summerland Fire Disaster, moving beyond simple cause and origin investigations, and addressing the full event and matters that surround it.*" But on my reading of the Report it does address matters much wider than 'simple cause and origin'.

49. Prof Torero states that "*Modern fire investigations now seek to link all aspects of the growth and development of the fire, the regulatory environment, the actions of building operators (both leading up to and during the fire) etc. in order to identify how such adverse conditions came to exist, and how they came to exist in conjunction with the continued presence of building occupants. These protocols were not typical at the time of this fire.*" It may be that, on reflection, Prof Torero considers the protocols adopted by the Summerland Fire Commission atypical and ahead of their time, as their Report clearly does address (i) the regulatory environment and actions of the regulators (ii) the actions of the building operators (both leading up to and during the fire) and does also address how and why those adverse conditions came to exist as well as (iii) the response of the building occupants to the fire.

50. Given that many of those responsible for the adverse decisions regarding design construction and regulation of Summerland will now be deceased it is not clear what any further relevant information from Prof Torero's suggested 'protocols' might now be obtained.

51. Your client's application asserts that "*a new expert analysis of the fire may identify the cause of the fire and where it began*" and postulates that "*if the fresh analysis shows that the origin of the fire was in a different location to the kiosk, that would be an important finding of itself in part because it would show that the young people at the Summerland were not responsible for the tragedy.*"

52. However there is not an iota of evidence that the initial source of the fire was anything other than in the location to the kiosk from a match ignited by three schoolboys as the public inquiry established. I cannot identify anything in the material you have provided with the application that supports a contention that the fire began in any other way than the Report suggests. I note in particular that Prof Torero's letter certainly does not

suggest any different source for the fire nor give any support to the proposition that with further investigation a different cause would be found .

53. It appears that your submissions are largely founded on supposition rather than having an evidential base. The application puts forward a speculative assertion that a fresh investigation fifty years after these events *might* produce some new insights, but offers no evidential basis for asserting that whatever insight might arise from new scientific techniques would differ in any relevant and material way from the initial findings of the Fire Commission.

54. In saying this I note (and will address in more detail below) your contentions regarding Dr Frank Skuse's involvement in the light of his established unreliability as an expert in the detection of explosives. But the application does not put forward any evidence of the practical role played by Dr Skuse in the investigation and (whatever it was) how his actions impacted upon any of the Commission's findings. Nor does it present any evidence that there was any identifiable material shortcoming in Dr Skuse opinions or actions in respect of the Summerland investigation. It appears no more than speculation that his involvement (whatever it was) must have wrongly influenced the Commission in some way.

55. The application also suggest that new pathology evidence *might* provide causes of death for each victim that are *"more accurate".* But I note your client has not suggested any cause of death was wholly incorrect, nor presented any evidence that calls into question any identified victim's recorded cause of death. Bodies will not now be available for re-examination and it is not understood that there is any question that the victims sadly died otherwise than as a result of the fire.

56. In conclusion, I am not persuaded that there is in fact any fresh evidence currently available that would make conducting fresh inquests desirable.

(b) Whether a different conclusion is likely at fresh inquest and if not whether public confirmation of earlier findings is desirable in all the circumstances

57. I note that your client wishes to challenge the 'misadventure' conclusions reached by the jury at the inquests, their position being that:

> *"Those inquests left bland, uninformative and indeed offensive conclusions, which merely recorded the deaths as misadventure...."Misadventure, by its very nature infers a finding of risk upon the deceased."*

58. It appears that your clients' concern about misadventure being an '*offensive*' conclusion may arise from on a fundamental misunderstanding of the meaning of the term 'misadventure' in Coronial Law.

59. 'Misadventure' properly understood connotes a deliberate human act that takes a wrong turn that leads to death. The deliberate act need not be an act by the deceased. Indeed the term misadventure is frequently used by coroners where the actions of one person lead to the death of another, but where there was never any intention on the part of the first person to cause the second any harm.

60. I cannot accept the assertion that misadventure "*by its very nature infers a finding of risk upon the deceased*". In my view it implies nothing of the sort. In any event, as is well known, it is not the purpose of an inquest to attribute culpability: "*...it should not be forgotten than an inquest is a fact-finding inquiry and not a method of apportioning guilt. ...In an inquest it should never be forgotten that there are no parties, there is no indictment, there is no prosecution, there is no defence, there is no trial, simply an attempt to establish facts.*" Per Lord Lane CJ in *R v South London Coroner ex parte Thompson* (1982) 126 SJ 625.

61. A finding of misadventure differs from a finding of accident in that, for misadventure the initial (and ultimately fatal) act must have been intentional, whereas for an 'accidental death' the initial act will not have been intended. I do agree that it would be offensive if there were any suggestion made that those who died at Summerland were in any way responsible for their own deaths, but a verdict of 'misadventure', properly understood, does not suggest this. A finding of misadventure does not at all place any blame for their death upon the deceased.

62. I do acknowledge that given the change in inquest practice after 50 years a narrative conclusion might now be considered available were fresh inquests to be heard. A coroner returning a narrative conclusion might choose to describe more of the findings of the Commission Report regarding the responsibility for the numerous failures at Summerland. However I do not consider this factor would justify fresh inquests when the Report of the Commission – which formed part of the evidence in each inquest - has been available for 50 years to any person who wishes to understand the numerous serious failures in design, construction, regulation and operation that led to the fire's rapid spread, and which caused, or failed to prevent, the significant loss of life once the fire took hold.

63. In conclusion I cannot agree with the criticism that the use of the term misadventure is 'offensive' or connotes any risks being taken by the deceased. Given the existence of the Commission's report I also do not consider that fresh inquests are desirable simply so that an additional narrative might supplement the jury's findings from 1974.

(c) Whether the process adopted at the original inquest has caused justice to be diverted or for the inquiry to be insufficient

64. Your application asserts that: *There was "irregularity of proceedings, insufficiency of inquiry, or otherwise" at the original inquests. They said nothing significant about the central issues of public concern, such as the cause or spread of the fire. In a disaster of this magnitude a more informative conclusion was required in order to meet the public interest. The inquests did not record any conclusion and did not ascertain how and by what means the deceased came by their deaths. The inquests thereby failed to serve two of their purposes, to allay rumour and suspicion, and the prevention of future deaths. Their ineffectiveness is personified by the fact that whilst they were opened on 9th August 1973, all 50 inquests were held and concluded in one day collectively, on 27th August 1974.*

65. I accept that the original inquests were a brief and rather summary process concluded in one day. But as I have set out above, where I consider the English Court of Appeal case of *Morahan,* even today an inquest remains a relatively summary process, particularly so when the inquest follows a full and detailed public inquiry. A prolonged inquest was not necessary to comply with the statutory scheme following the publication

of the Fire Commission's Report and, as I have said, the coroner evidently saw no need to direct any additional analysis.

66. I note that the application asserts that "*the examinations of the case by the Summerland Fire Commission were incapable of rectifying the deficiencies in the subsequent inquests.*" I cannot agree. The coroner was entitled to, and did, admit and accept all of the very detailed evidence within the Commission Report. In the circumstances, which included there being no challenge by any interested person to the Report's findings, there was no requirement for the coroner to rehear the primary evidence or critically re-examine the Report's findings. There was no good reason to consider the Report was anything other than an accurate account of the fire. Rather, as the Lord Chief Justice of England & Wales stated in the *Norfolk* case, where there has already been a pre-inquest investigation by an independent expert body:

> *"It should not, in such circumstances, be necessary for a coroner to investigate the matter de novo. The coroner would comply sufficiently with the duties of the coroner by treating the findings and conclusions of the report of the independent body as the evidence as to the cause of the accident. ... where there is no credible evidence that the investigation is incomplete, flawed or deficient, the findings and conclusions should not be reopened."*[18]

67. Moreover, to have required the many traumatised eye-witnesses to repeat the evidence they had so recently given to the Commission at the inquests would not only have been unnecessary, but would also have been disproportionate and potentially traumatising of vulnerable people to no additional purpose. Those who had been culpable in the design construction, regulation and operation of Summerland had, only a few months before, been cross examined by leading counsel who were likely representing many of your client's core members.

68. When taken in its proper context, alongside the earlier Commission's findings which were adopted in each case, I consider that the brief inquest verdict returned following a relatively summary procedure nevertheless amounted to a sufficient process.

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[18] *R (on the application of Secretary of State for Transport) (Claimant) v HM Senior Coroner for Norfolk (Defendant) & British Airline Pilots Association (Intervener)* [2016] EWHC 2279 (Admin) at §57.

69. Indeed I note that your client appears to accept that for a coroner to repeat the same process, and to adopt the evidence or conclusions from the Commission, would be an acceptable and sufficient process today. It is said at paragraph 100 of your client's application that:

> *"Fresh inquests will be manageable. The Coroner will be entitled to take as read the uncontroversial evidence or conclusions from the Commission. .... There will be many factual areas which have already been fully explored and of which little or no further examination is required." (emphasis added)*

70. Although the application does not explain what parts of the Report your client considers to be these *"uncontroversial evidence or conclusions from the Commission"* it follows from this paragraph that your client does indeed accept and condone the process adopted by the coroner in 1974, of admitting the Fire Commission Report's evidence and conclusions with no need for further examination of them.

71. I therefore do not consider that the Coroner presiding in 1973/74 fell into any procedural error by adopting the findings of a lengthy public inquiry as he did. Fresh inquests are not desirable on this basis.

(d) Whether the substantive truth has been revealed how the deceased came by their deaths

72. The application states that *"The related inquiries were inconclusive and did not remedy the deficiencies in the inquests. The Summerland Fire Commission ...conclusion is contradictory and uninformative. It raises more rumour and suspicion than it addresses."*

73. I do not accept this assertion. The application does not identified the rumour or suspicion which it is alleged the Fire Commission Report raises, and this does appear to be rhetoric rather than a submission of any substance. As I have set out at §23-§35 above, the Report of the Commission was long and detailed and considered a wide range of factors having examined a large number of witnesses. The Report cannot be reasonably criticised as being *"contradictory and uninformative"*. Rather it provides a clear account of the numerous different shortcomings by numerous people and organisations that led to the loss of life at Summerland. The substantive truth

regarding how the deceased came by their deaths was indeed revealed by the Report, and those conclusions were in turn adopted at the inquests. They did not need to be re-investigated by the coroner.

74. Prof Torero's letter asserts "*that the Summerland Fire Disaster is worthy of a new analysis*". But this is not the test I must apply. Perhaps most investigations completed 50 years ago could be improved upon today, but the issue I must consider is whether there was sufficient investigation in 1974 such that the 'substantive truth' of how the victims tragically met their deaths has been revealed. I consider that there was.

(e) The wishes of the bereaved

75. I have borne in mind that a large number of the bereaved are aligned with your client and so support your client organisation's position, wishing for fresh inquests to be held. This is a relevant but not a determinative point in favour of this application.

(f) Any distinct and separate imperative that the community as a whole should be satisfied that even if belatedly, the truth should emerge.

76. The application states that there is "a *manifest, widespread and continuing public disquiet about the ineffective and inconclusive investigations into the Summerland fire. Where a national* disaster *of the magnitude of the catastrophe in the Summerland Fire has occurred, there is a distinct and separate imperative that the public as a whole should be satisfied that everything has been done to uncover the truth. A fresh inquest is necessary in order to assuage the deep disquiet of the public and families.*"

77. Whilst I accept there is now widespread disquiet on the part of the bereaved who are aligned with your client organisation, I am not aware of the wider community expressing any concern regarding the conduct of the inquests or the outcome of the public inquiry before 2024. I acknowledge that the separate issue of a request for an apology and a formal monument to the bereaved has been a matter of concern for some time and I am also aware that your client's objective of achieving fresh inquests does today have the support of some (local and UK) politicians and of Mr Andy Burnham.

78. But any suggestion that 'the truth needs to now emerge' must be based upon there being evidence of some continuing falsehood, and I can perceive none. Moreover, in respect of any wider community interest in holding fresh inquests, the position of the community is very different from that in the Hillsborough case, where this was a significant factor given that blame for the deaths had, for many years, been wrongly placed on wholly innocent Liverpool fans.

79. I note that it is only after your client organisation came into existence – some 51 years after these deaths that the question of holding fresh inquests has been publicly raised. I make this observation not to in any way minimise or denigrate the sincerity with which your client now holds their position. Rather, it assists to explain why I am not persuaded by your assertion that there has been "*manifest, widespread and continuing public disquiet*" regarding the outcome of either the Fire Commission's Inquiry or the inquests within the wider community, and therefore in turn, why this is not as persuasive a factor in my decision making as it might have been had there been calls from the wider community for fresh inquests over the preceding five decades.

80. In addition to the application of the principles above that I have derived from the Hillsborough case, in coming to my decision I have also noted some other potentially relevant contentions raised within your client's application which I now address below.

(g) that the families of the victims do not have any resources from the government to conduct investigations into the disaster.

81. The application asserts that I must take into account that for the families to carry out their own inquiries they would need to pay for legal or expert assistance themselves. It is said that *"In light of this lack of support, it is sufficient for the applicants to show that an earlier inconclusive investigation may, with appropriate funding and powers, be pursued further."*[19]

82. I cannot accept the submission that the impecuniosity of a party who would wish to re-investigate a matter mandates that their government should take action as an alternative.

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[19] at para 8

83. This is not a proposition of law I have ever encountered before, and the application does not provide any authority in support of this proposition. It does not, therefore, carry any weight in my decision making.

(h) Fresh inquests into the 1989 Hillsborough disaster show that a fresh inquiry may shed new light on events which took place many years ago, even where there were detailed original investigations.

84. I accept, if only as a general matter of logic, your client's assertion that "*a fresh inquiry may shed new light on events which took place many years ago, even where there were detailed original investigations*". This general proposition could, theoretically, apply to any inquest from years ago, but I must make my decision on the facts of this this case, and not on non-specific assertions.

85. The application contends that Professor Lygate's "*prophesy*" that new investigations of the Stardust fire in Dublin would "*prove worthwhile*" came true. But even if this is correct, it does not assist to establish whether there might be any value in further investigation of matters covered by the Summerland Fire Commission.

86. I am not persuaded that the speculative possibility that fresh investigation of an earlier event *may* reveal more details is a persuasive reason to now hold a fresh investigation in this particular case. In stating this I have also borne in mind the absence of any suggestion by the expert your client relies upon, Prof Torero, that the Fire Commission's findings were incomplete, flawed or deficient in any way. There is no suggestion by Prof Torero that any aspect of the Report appears incongruous in the light of current scientific knowledge.

(i) The involvement of Dr Frank Skuse

87. Your client asserts that Dr Frank Skuse: *"played a critical role in the original investigation of the Summerland disaster. As the lead forensic expert, Dr Skuse was tasked with examining the causes and dynamics of the fire as part of the official investigation.* It is suggested that it was *"Dr Skuse's findings that were crucial in understanding how the materials contributed to the (i) cause of fire, and (ii) the spread*

of the fire. His investigation revealed that the combination of highly flammable materials used in the structure, along with architectural and safety flaws (such as inadequate exits and poor emergency preparedness), were instrumental in the severity of the disaster. Put simply, Dr Skuse's findings were the primary plank upon which the various recommendations and lessons learned were adopted in the intervening period"

88. I am not persuaded that this can make fresh inquests desirable for three key reasons:

89. First, I am not persuaded by the assertion that Dr Skuse was the 'lead forensic expert' and 'primary plank' relied upon by the Commission. Although I accept that Dr Skuse must have provided some evidence to the inquiry, (as he is named as a witness in the Report's appendix) I have not seen evidence that his expert evidence had anything like the significance you attribute to it. Dr Skuse is not even mentioned in the body of the Report. Rather it appears to me that Professor David Rasbash, a professor of fire engineering from Edinburgh University was the Fire Commission's primary expert witness.

90. The Report makes no reference to Dr Skuse, but rather it is Professor Rasbash who is repeatedly referenced as an expert being relied upon and who gave his opinion regarding the cause and spread of the fire. Professor Rasbash clearly held the primary role and his expert evidence is cited in multiple paragraphs of the Report.

91. Second, I am aware that a number of criminal appeal cases since 1974 have revealed Dr Skuse's unreliability as an expert witness in respect of his purported expertise in detecting the presence of explosive residues. These cases have been specifically with respect to his flawed reliance upon the Greiss test[20] to detect handling of explosives. However, I do not understand there to have been any use of the Greiss test, or indeed any test, for detecting explosives at Summerland.

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[20] The Greiss test as I understand it was developed in the 19th century and is a presumptive test used to detect the residuals of gunpowder or explosives by detecting the presence of nitrite ions. However, it is not specific for nitroglycerine and so should only be used as a preliminary test with a positive result followed by a confirmatory test. It has now fallen out of use. (See *R v McIlkenney* (1991) 93 Cr.App.R. §§38-40, §§48-62 and *R v Ward* (1993) 96 Cr.App.R. 1 §). In the Judith Ward appeal Dr Skuse's conclusions based on the Greiss test were described as "demonstrably wrong."

92. That Dr Skuse has been shown to be an unreliable expert in one aspect of his work does not, without more, establish that any particular (as yet unidentified) aspect of his distinct involvement in Summerland was flawed or somehow misled the Commission. He is not mentioned in the body of the Report and hence it seems whatever his evidence might have been it was not particularly noteworthy or influential.

93. Third, the assertion that "*Dr Skuse's findings were the primary plank upon which the various recommendations and lessons learned were adopted in the intervening period*" is simply not supported by any evidence. Additionally, the application does not set out what, if anything, of the subsequent revisions of building and fire safety regulations, aimed at preventing similar tragedies in the future was not appropriate or was omitted due to any purported shortcoming in anything that was investigated by Dr Skuse.

94. Speculation about Dr Skuse's role in this investigation is in my view an insufficient basis to establish that new inquests are desirable.

(j) Those responsible being held to account:

95. The application suggests that new inquests are required so "*those responsible should held to account*" and that "*the new analysis may point to who was responsible for the fire, and lead to civil or criminal penalties*".

96. If you are suggesting that the three children who admitted igniting the fire (and who will now be adults aged well over 60) should be held to account at fresh inquests, I cannot agree. They were juveniles when events occurred. They were prosecuted for and convicted of criminal damage related to these events, and their convictions are now long spent. In my view it would be unconscionable to publicly reveal their identities through a fresh inquest process.

97. Those responsible for the serious failures in the design, construction, regulation, and health and safety provision, as well as the many operational shortcomings at Summerland are already identified in the Commission report and their actions and omissions and, in most cases, their names have been known and placed in the public domain for fifty years now. They have already been examined in public and counsel

acting on behalf of the bereaved have already had an opportunity to publicly cross examine them about their role and responsibilities.

98. Given that the facts regarding the main actors have been known for over 50 decades it is wholly unrealistic to suggest that a fresh inquest might now lead to criminal proceedings against any person. This is not a prospect that I take into account when making my decision. Indeed, after 52 years it might also be expected that a significant number of these persons are now deceased.

99. I also consider your client's contention that re-investigation might enable civil claims to now be brought so very long after limitation has passed to be fanciful. In any event I understand that a number of civil claims were indeed pursued after the fire against Trust House Forte Leisure Limited and its subsidiary (Summerland Limited) alleging negligence and breach of statutory duty. One of these civil claims reached a quantum hearing[21] whilst the others it is believed were settled in 1970s.

100. The prospect of future criminal proceedings or civil claims is therefore not a factor that I can give any weight to when making my decision.

(k) further lessons being learned to prevent a similar tragedy in the future.

101. The Commission's Report already made 34 recommendations many of which were acted upon after its publication.

102. Understanding lessons that might prevent future deaths is only ancillary to the main statutory purposes of an inquest and is not its mainspring. I am also not persuaded that further lessons that have not already been revealed by the more recent fire tragedies at Laknal House and Grenfell Tower will be likely emerge from a re-review of events in 1973. This is not a sufficiently weighty point to justify fresh inquests here.

(l) Art 2 procedural duty

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[21] See *Gregory v Trust House Forte Leisure* [1975] 167 Manx Law Reports 1972-1977

103. Finally, the application asserts that Article 2 ECHR makes fresh inquests "*necessary, in order to act compatibly the procedural duty within article 2 ECHR".*

104. I agree that if the deaths at Summerland occurred in similar circumstance today then, given the implementation of the Human Rights Act 2001, there would be no question that the investigative (procedural) obligation under Article 2 ECHR would be engaged. This would, at very least, be based on there having been an arguable breach of the substantive general Art 2 duty by reason of the regulatory breaches that are revealed within the Commission Report.

105. I do not accept, however, that the temporal scope of Art 2 extends to these events that occurred thirty years before the coming into force of the Human Rights Act 2001. Nor that anything that was so '*seriously deficient'* in the original investigation that it might revive an investigatory obligation now. As the Supreme Court in *McQuillan* made clear, even if there are small deficiencies in earlier investigations this is not sufficient. The key question is whether there now exists *'weighty and compelling new evidence'* that might require a fresh investigation. Your client has put forward no such evidence.

106. I have also considered the 'Convention values' test discussed by their Lordships in *McQuillan*. This relates to 'extraordinary situations' and requires a significant triggering event (such as war crimes, genocide or crimes against humanity) that is of such a serious nature that it is a violation of the very foundations of the Convention.

107. Without diminishing the terrible loss of life at Summerland and the huge significance of that loss to the many bereaved, even such a major fatal fire does not reach the level required to represent a Convention violation such as to trigger a fresh investigation under the 'Convention values' test.

108. In conclusion, I can detect nothing that would arguably revive the Art 2 ECHR procedural duty here.

109. However, even if I am wrong about this, and the state's Art 2 procedural obligation was engaged and needed to be satisfied in 1973 then, as I have set out above, where Art 2 obligations are engaged the relevant question when considering the need to hold an inquest, (or fresh inquests) is whether, viewed in its totality, the investigations to date

have met the minimum requirements identified in *Jordan* of being: sufficiently prompt, independent, effective, with sufficient public scrutiny and sufficient involvement of the next of kin.

110. No particular procedure need be adopted. The form of the investigation may vary according to the circumstances and the requirements can be satisfied by a set of separate investigations, rather than by a single, unified procedure.

111. Considering the totality of the processes instigated or conducted by the state to date (that is (1) the Fire Commission Inquiry; (2) the civil claims brought; (3) the prosecution of the youths who started the fire; and (4) the inquests) and considering whether the *Jordan* criteria have already been satisfied, my view is that they have. Proceedings were proactively commenced by the state and were sufficiently prompt concluding within just over a year of the events. There was appropriate independence in each of the processes, and with sufficient public scrutiny of both the Fire Commission and the coronial proceedings. The next of kin were supported to have full involvement in the detailed examination of witnesses at the Fire Commission's hearings. The mechanisms in place were effective in that they resulted in public findings which made it clear where responsibility for the numerous different shortcomings lay. As an aside, I observe that one of the consequences of the tragedy was the enactment of the Islands existing Fire Precautions Act 1975 (said to have been closely modelled on the UK Fire Precautions Act 1971) and intended to make better provision for the protection of people from fire risks.

112. The application cites the Ballymurphy inquests, the Hillsborough case and the Stardust nightclub fire as examples of fresh inquests being held into a number of deaths and coming to different conclusions from the original inquest. That other historical cases have been reviewed is not in my view persuasive of the situation in respect of Summerland. Those tragedies arose in different factual circumstances that are not relevant in the Summerland case (for example, in relation to the Stardust tragedy, I note that the Irish Attorney General's reasoning in directing fresh inquests included regard for there having been no sufficient investigation as to the surrounding circumstances of the disaster: " *..it does not appear that questions as to the cause or causes of the fire were canvassed to a sufficient degree, if indeed at all, at the original Inquests..*").

Conclusion

113. In summary and conclusion, I have considered your client's application and matters relied upon, I have applied the principles from the Hillsborough case to this application and I have also looked at the wider matters that are cited in support. However, I am not persuaded that individually or cumulatively the matters raised in the application make holding fresh inquests desirable.

114. Central to my finding is that your client has not presented any fresh evidence that reveals any relevant or material errors or misunderstanding in the detailed findings of the Summerland Commission Report that was appropriately adopted by the coroner. Speculation that there *might* be evidence which *might* call the Commission's findings into question is not evidence, it is simply conjecture. I do not therefore accept the proposition that "*there has never been an effective investigation into the fire*".

115. Whilst I accept that the inquests were a brief and summary process, they followed a lengthy and detailed public investigation of the cause of the fire which looked at a wide range of matters relevant to how the fire took hold and spread and how it came to be so fatal and which, in my view, constituted an appropriate, sufficient and proportionate inquiry . The coroner was entitled to admit the Commission Report and the jury relied upon it as the basis for their misadventure findings.

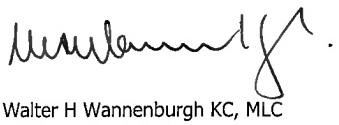
116. Your client now objects to the verdict of 'misadventure' but perhaps has misunderstood the meaning of the term and seems to believe that it is somehow offensive, suggesting risks were being taken by the deceased. But this is not the coronial meaning of 'misadventure': the verdict places no responsibility whatsoever on the deceased.

117. Whilst inquests and investigations conducted fifty years ago might no doubt be improved upon today, that is not the relevant question. I have considered whether the substantive truth of how these fifty innocent people came to lose their lives been sufficiently established, and I consider that it has.

118. The Summerland fire was a terrible tragedy, leading to immense loss of life. It should never have happened had those responsible for the design, construction, regulation and operation of Summerland properly carried out their responsibilities. However, taking all of the circumstances into account, and considering the breadth and depth of the investigation which was conducted at the time, I cannot conclude that it is desirable to now conduct fresh inquests and therefore I must decline your client's application.

I am sorry not to be able to communicate more welcome news.

Yours sincerely



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