

## BOOK REVIEW

BEVERLY HILLS: THE ANATOMY OF A NIGHTCLUB FIRE. By Robert G. Lawson.† Athens, Ohio: Ohio University Press, 1984.  
Pp. xii, 304. \$16.95.

Reviewed by Kathleen F. Brickey\*

On May 28, 1977, a raging fire destroyed the Beverly Hills Supper Club in Southgate, Kentucky. One hundred sixty-five people perished in the fire, all but two of them within thirty feet of an exit. What compounded this tragedy was the revelation that it could—and should—have been avoided. The fire probably would not have occurred and surely would not have been so deadly if state and local regulatory mechanisms established to protect the public against fire hazards in public buildings had worked reasonably well. But they did not, and in *Beverly Hills: The Anatomy of a Nightclub Fire*, Dean Robert Lawson meticulously chronicles the series of institutional and human failures that led to this nation's second most deadly nightclub fire.

The first part of the book sets the stage for the tragedy by tracing the events that led to the creation of a terrible firetrap. A central figure in this scenario was the building owner, who over a six-year period renovated, enlarged, and transformed the Beverly Hills Supper Club into a lavish showplace where popular entertainers drew large audiences. The building changes and additions were made in several distinct stages, and violations of applicable building and fire codes repeatedly occurred throughout the process.<sup>1</sup>

Another central figure in the tragedy was the building inspector in this small suburb across the Ohio River from Cincinnati. He was, by all accounts, a conscientious public official who through no fault of his own

---

† Dean and Professor of Law, University of Kentucky.

\* Professor of Law, Washington University.

1. On more than one occasion the building owner neglected to comply with the requirement that architectural plans for additions to the building be prepared or reviewed by a licensed architect familiar with the state's building and fire codes, that a building permit must be acquired before construction could be undertaken, and that plans must be approved by the state fire marshal. There was evidence, moreover, that the owner had instructed an electrician not to string electrical wire in metallic conduit as required by the state's electrical code. For a summary of these occurrences, see R. LAWSON, *BEVERLY HILLS: THE ANATOMY OF A NIGHTCLUB FIRE* 22, 46-47, 51-52, 291-92 (1984).

was ill-equipped to discharge the responsibilities imposed on him by law.<sup>2</sup>

The state fire marshal's office, which failed to follow regular procedures when reviewing plans for a major renovation of the building, also played an integral role in the tragedy. Although the plans obviously did not comply with the fire code, the fire marshal's office failed to halt construction on the project pending submission of modified plans, instead taking on faith the building owner's assurance that the deficiencies would be corrected.<sup>3</sup> And the field inspectors who visited the Beverly Hills to investigate and correct state fire code violations either did not detect some of the building's major hazards or did not recognize them as such.<sup>4</sup>

Suffice it to say, the net result was that a firetrap containing both obvious and not so obvious violations of the state fire code—violations that included the use of highly flammable and combustible materials, the construction of an unenclosed center stairway to the second floor of the club, faulty electrical wiring, and emergency exits that were too small, too few in number, and in some instances inaccessible—gained official approval for public occupancy.

The second part of the book chronicles the fateful evening when the fire occurred. The stage was set for a tragedy. Approximately 2,000 patrons filled the supper club that night, more than a thousand of them in the Cabaret Room where John Davidson was scheduled to perform. This room was isolated from the part of the building where the fire began, and tables and chairs had been placed in the aisles, ramps and stairways to accommodate a crowd whose number doubled the capacity of the room. Most of the fatalities occurred here.<sup>5</sup>

Despite ominous hints throughout the evening that something was amiss,<sup>6</sup> the fire smoldered undiscovered above the ceiling or between the walls of a small room at the front of the building for what must have

---

2. Like others who held positions related to fire protection in the City of Southgate, the building inspector was basically a volunteer. The building inspector had no office facilities, no resources for operating expenses, no salary, and no training. Worse, still, was that the copies of state and city building and fire codes provided by the city council had since become obsolete. The building inspector was never told that new codes had been adopted. *Id.* at 8, 17, 286.

3. *Id.* at 20-26.

4. *See, e.g., id.* at 42-45, 57-58.

5. One hundred sixty-three of the one hundred sixty-five fatalities occurred in this part of the building. *See* Diagram No. 9, *id.* at 238.

6. On at least three occasions during the early part of the evening, for example, people outside the building observed plumes of black smoke coming from the building but attached no importance to the observation. *See id.* at 70, 75, 78.

been several hours. After the fire was discovered it began to spread rapidly in three different directions, and immediate evacuation of the building became necessary. The evacuation procedure was hampered, however, by the configuration of the building's exits. Those who exited through the front of the building traversed a narrow hallway that led to two sets of double doors only six feet wide with a set of steps between them. The second set of doors then led to an above ground landing that required a left or right turn and a descent down a second set of steps. Although this design was sufficient to accommodate emergency evacuation of only two hundred fifty people, more than a thousand would need to escape through this exit on the night of the fire.<sup>7</sup>

In the Cabaret Room, an exit marked to create an appearance that it was located beyond a set of double doors actually could be reached only after making two ninety-degree turns in opposite directions within a distance of less than twenty feet after passing through the doors. Fifty patrons became lost in dense smoke while attempting to reach the exit, either because they made a wrong turn in the first instance or because they missed the second turn and wandered away from safety, futilely groping for the elusive exit.<sup>8</sup> Those who successfully reached the exit encountered yet another obstacle. Once outside they found themselves perched eight feet above ground level on a five foot square landing overlooking a steep embankment. A narrow wooden stairway led to safety on the embankment. Under these circumstances, the exit's design was sufficient to evacuate one hundred twelve patrons in an emergency, but at least three times that number headed for this avenue of escape.<sup>9</sup>

The building had no fire alarm or sprinkler system and no emergency evacuation plans. Few employees knew where fire extinguishers were located and fewer still were trained to use them properly. It was, quite simply, a worst-case scenario.

The last chapters in the book describe the aftermath of the tragedy. Here, the reader is exposed to a set of institutional responses that are at once intriguing and troublesome. Immediately after the fire the mayor of Southgate requested that the state police investigate the fire. The governor then promptly directed the commissioner of state police and the state fire marshal to coordinate an investigation that ultimately involved more than thirty detectives and three fire analysis experts. Although it quickly

---

7. *Id.* at 103.

8. *Id.* at 194-95.

9. *Id.* at 188.

became apparent to the investigative team that criminal violations of the law may have contributed to the disaster, the commonwealth attorney with authority to prosecute cases related to the fire was excluded from the investigation.<sup>10</sup> Only after the investigation was completed did the state share with the prosecutor the voluminous documentary evidence accumulated during the team's exhaustive three month investigation.

Pressured by a governor anxious to appear at a congressional hearing concerning the fire, the team hastily drafted a report that was harshly critical of both the club owner and the state and local officials charged with the responsibility of insuring the safety of public facilities. The report concluded that clear violations of applicable safety codes had occurred and suggested that possible violations of the state's criminal code also had surfaced during the investigation.<sup>11</sup> Voicing shock at the findings, the governor predicted that indictments would follow soon thereafter.<sup>12</sup>

Rather than returning indictments, however, the special grand jury convened to investigate the fire sharply criticized the state's investigation and questioned the reliability of its report. Without the benefit of testimony from any of the state's fire analysis experts, the grand jury concluded that neither the building nor its owners were responsible for the loss of life in the fire. Instead, the report asserted, the deaths were attributable to the patrons' "fail[ure] to heed a timely warning to evacuate."<sup>13</sup> The grand jury found evidence of negligence but found no criminal negligence, and its report even praised the management of the club for its efforts to comply with the law.<sup>14</sup>

The release of the grand jury report prompted the governor to appoint a special prosecutor to review the matter and to advise whether another

---

10. *Id.* at 242-45.

11. *Id.* at 254.

12. *Id.* at 260.

13. *Id.* at 271. Although many responded to the evacuation order immediately, some of the patrons in the Cabaret Room seemed to assume that the fire could be easily controlled. Their incomplete information about the danger came from a busboy who announced that there was a small fire on the other side of the building, that they should not panic, but that they should leave the building immediately. Some initially greeted the announcement with no sense of urgency and evidently were unconcerned about their personal safety. *Id.* at 161-65. But when black smoke began pouring in, panic swept the room and the instinct for self-survival transformed what had been an orderly evacuation into "a big mob of people pushing toward the outside." *Id.* at 186. Wishing to avoid blaming the victims for their own deaths, the state's investigative team did not include this information in its report. *Id.* at 253.

14. *Id.* at 271-72.

grand jury should be convened. The special prosecutor's report concluded that the evidence did not warrant criminal prosecution against any individuals except, perhaps, the owner, and that the case against him was not strong. Hence, the report recommended, no further criminal proceedings should be instituted.<sup>15</sup> The state accepted the recommendation and the case was considered closed.

Despite the magnitude of the tragedy and its attendant publicity, not a single public trial resulted from the fire. The special grand jury, curiously instructed by the prosecutor not to indict unless it found guilt beyond a reasonable doubt, exonerated all potential defendants from criminal liability.<sup>16</sup> Civil litigation against the state and some of its employees was dismissed before trial on the ground that the defendants were immune from suits based upon negligent enforcement of state safety codes.<sup>17</sup> Suits against the club owner<sup>18</sup> and the public utility that supplied electricity to the club were settled out of court.<sup>19</sup> Thus, no complete, objective public record from which reasoned conclusions about the facts and circumstances surrounding the deadly fire was created.

Dean Lawson's book admirably fulfills the need for a dispassionate historical record. His compelling account of the Beverly Hills fire is gleaned from thousands of pages of sworn statements and testimony, from personal interviews with individuals who played prominent roles on the evening of the fire or during the ensuing investigations, and from investigative reports about the causes, origins and aftermath of the fire. He refrains from injecting his personal judgments into the narrative and leaves to the reader the tasks of weighing the evidence, ascribing responsibility, and assessing the institutional weaknesses that allowed this avoidable tragedy to occur. That he could become immersed in so much

---

15. *Id.* at 281-82.

16. Under normal circumstances a grand jury would have been asked to indict upon a finding of probable cause to believe that a crime had been committed by a target of its investigation. The prosecutor's decision to require a higher standard seems to have resulted from what he believed to be his compromised position. Had the case been one with lower visibility, he would not have referred it to a grand jury. In light of the governor's prediction of criminal prosecutions, however, the case seemed destined to receive a grand jury's scrutiny. Thus, he apparently believed that he was bringing before the special grand jury an emotionally charged case supported by weak evidence of culpability. *Id.* at 264-65.

17. *Id.* at xi.

18. All of the assets of the business, including insurance proceeds from the fire and the real estate where the club once stood, were transferred to victims of the fire in exchange for a release from further liability. *Id.* at 298.

19. *Id.* at xi.

data concerning such a tragic occurrence and still present an objective and even-handed account is a remarkable achievement.

The conclusion of Dean Lawson's book also provides valuable insights into the larger context within which the disaster occurred. The state law that imposed obligations to enforce fire and safety standards, for example, did not clearly define the respective roles of state and local officials.<sup>20</sup> The City of Southgate, moreover, failed to allocate the resources necessary to provide fire protection for its citizens,<sup>21</sup> and the state fire marshal's office was poorly structured, understaffed, and undersupported.<sup>22</sup>

Of greater concern, however, is "an overwhelming, intangible factor" that played a significant role in the creation of a hazard against which the public was helpless to protect itself.<sup>23</sup>

In no part of the enforcement system was there a firm belief that applicable building and fire codes could be enforced to the letter of the law. Those responsible for enforcement of the codes, at both levels of government, sought to obtain as much compliance as possible, treated the regulatory system as one needing constant pragmatic manipulation, and expected never to make public buildings as safe as the law required. For reasons that are very difficult to pinpoint, violation of the state's regulatory procedures and of its standards of safety were accepted by officials of government as an intrinsic part of the system.<sup>24</sup>

Nowhere is this observation better illustrated than by the state fire marshal's approval of the building for occupancy on the strength of a field inspector's report that the building "is probably as good as we can expect although it does not come into complete compliance."<sup>25</sup>

It is chilling to contemplate how pervasively this attitude may influence the enforcement policies of regulatory agencies across the country. If, as one might suspect, enforcement efforts are shaped in part by the

---

20. In consequence, the law "provided a basis for the state to believe that the city, and the city to believe that the state, would look after the safety of the building, and in actual fact nothing less occurred. Both believed, and neither looked." *Id.* at 285.

21. No member of the fire department was compensated for his service, none received any training for the job, and the city did not even provide the department with copies of the building and fire codes they were charged with enforcing. *Id.* at 286; *see also id.* at 48-50.

22. *Id.* at 287-89. Some progress on this front followed the aftermath of the fire. *Id.* at 298-300.

23. *Id.* at 289.

24. *Id.*

25. *Id.* at 56. The letter from the fire marshal's office to the building owner following this report informed the owner that the building "was constructed in substantial compliance with minimum fire safety regulations," perhaps reinforcing a belief by the owner that the building was safe. *Id.* at 56-57.

belief that the law imposes impossibly high standards, governments may have dangerously lulled the public into a false sense of security. The possibility that other mass accidents since the Beverly Hills fire—accidents such as the collapse of structurally unsound skywalks in the Kansas City Hyatt Regency<sup>26</sup>—may similarly have been both predictable and avoidable is more than a little disquieting.

Thus, while this book provides a splendid historical record of the Beverly Hills fire, its contribution extends beyond its considerable value as a chronicle of the circumstances surrounding a single mass accident. It succeeds in raising larger questions about weaknesses in our legal system. These are urgent questions, and one can only hope that Dean Lawson's book will generate concern and intelligent debate about how safety regulations are and should be enforced. It should be required reading for everyone whose professional responsibilities relate to public safety, and for those who are merely concerned about their own personal safety in places of public assembly as well.

---

26. Billed as this country's worst structural failure, the collapse of the skywalks in the midst of a crowd gathered for a tea dance claimed 114 lives and left nearly 200 injured. As was true following the Beverly Hills fire, investigations into the cause of the skywalk collapse resulted in assertions that the building design approved by the city's department of public works did not comply with the city's building code. Goldberger, *Design Change in Hyatt Disaster*, N.Y. Times, Feb. 26, 1982, at 1, col. 1. Indeed, a Bureau of Standards engineer who conducted an investigation of the collapse asserted that "[a]lmost any practicing engineer could easily have seen that the walkways would not meet the Kansas City building code." *Id.*

Among other criticisms were that design changes were not subject to mandatory review, that numerous deficiencies plagued the city's inspection procedures, and that the department was severely understaffed. *Study Faults Kansas City Building Inspection*, N.Y. Times, Mar. 21, 1982, § 1, at 29, col. 1. Significantly, engineers with the International Conference of Building Officials reported that their review "disclosed a number of deficiencies which tend to weigh heavily on the negative side of a competency scale." *Id.*

