The Golden Age Nursing Home Fire

By Ernest E. Juillerat, Manager, Fire Record Department
National Fire Protection Association

During the early morning of Saturday, November 23, 1963, fire destroyed the Golden Age Nursing Home at Fitchville, Ohio, killing 63 of the 84 elderly patients. The fire, which started from a short circuit in overloaded, improperly installed wiring, spread throughout the undivided attic before it was discovered. Within a few minutes after discovery of the blaze, the building filled with killing smoke, and fire burst down from the attic to trap the victims, most of whom were still in their beds. Most of the 21 who escaped owe their lives to passers-by who stopped to help rescue them. As in many nursing home fires, those who died were victims of a lack of understanding by all concerned of the life hazards from fire in homes for the aged. Since early 1961, the Ohio State Federation of Licensed Nursing Homes and others have, by means of court actions, prevented state-wide regulations from being placed in effect that would have required automatic sprinklers or a fire detection system in the home and would have required compliance with the National Electrical Code.

The Building

The nursing home was in a remote country area about ten miles south of Norwalk and about 50 miles west of Akron, Ohio. The nearest fire department was in New London, 7.6 miles away. The closest neighbors were a farm family about a hundred yards from the nursing home.

The building was about 15 years old and had originally been a toy factory. It was sold in 1953 and remodeled into a home for the aged. Eight years later the home was purchased by a group of investors and further remodeled to accommodate a maximum of 86 patients. There were 84 patients in the home at the time of the fire. Approximately 80 per cent of them were wards of the state or county and most were bedfast patients. Some of them were mild mental cases.

The original nursing home owner was quoted as saying after the fire, "That home was supposed to be fireproof. I can’t understand how it happened. Everything is concrete block." The president of the group that owned the home at the time of the fire was quoted as saying, "That place had every bit of fire protection for a 1-story building, except that it was located in the coun-
try.” Professional fire protection people would take a dim view of these statements.

The approximately 186-foot by 65-foot 1-story building was constructed mostly of concrete block walls and interior partitions with concrete slab floor and wood-joisted roof (see diagram above). A 2-room wing that had been added in recent years had aluminum siding on wood frame walls. The interior finish of the wing was plywood as was also the wainscoting in the central corridor and in the lobby. Windows were three-pane, awning-type, about four feet above floor level. Ceilings consisted in part of noncombustible and in part of combustible fiberboard acoustical tile attached to a former combustible ceiling. A central corridor about 6 3/4 feet wide ran from the center of the lobby at one end of the building to the wing on the opposite end of the building where there was a 5-foot-wide exit with double doors opening directly to the outside. There was one other exit from the corridor directly to the outside. It was a 3-foot-wide door in the passageway between the main building and the added wing. This door opened into a 12-foot-wide area between the wings. The building’s fuel oil tank stood in this area. At the other end of the building, the corridor opened into the main lobby. Exit was through the lobby to a vestibule at the front of the building and out through the main entrance which consisted of two doors having a total width of six feet.

No Fire Protection

The building had no automatic sprinklers or fire detection system. There was no local manual alarm, no emergency lighting, and there was no water supply for fire fighting. The previous owner had dug a small reservoir in front of the building and filled it with water for fire protection, but the present owners filled it up because of the danger that some patient might fall into it. There were three portable fire extinguishers. There were no specific, written emergency procedures, although the manager said she had shown all the patients where the exits
were. The home had been inspected by state authorities in March of 1963 and approved for safety in compliance with existing state laws.

The unincorporated township of Fitchville had no fire department, and the trustees of the township had contracted for fire protection with the towns of New London, 7.6 miles east, and Greenwich, six miles south. The New London volunteer fire department, which got most of Fitchville’s calls, had conducted no drills at the home and had never been inside the building before the fire. The New London fire department had a mutual aid agreement with the town of Wellington, but the agreement was to respond only inside the limits of the two towns and did not include Fitchville.

Night telephone calls to the New London fire department were received at the local funeral home. The funeral director would take the call, turn on the siren, and call the chief. He and another man on duty at the funeral home would then each telephone ten of the 20 volunteers. Response to Fitchville usually took ten to twelve minutes.

The Fire

Three attendants were on duty when the usual 4:00 A.M. bed check was made. It was customary to plug in an electrically heated rolling steam table at a 240-volt outlet in the corridor at 4:45 A.M. The breakfast would be hot by 5:00 and the rolling steam table would be rolled up and down the corridor to

Ray Mutjasic

This is all that remained of the home for the aged that was described by its owners as “fireproof.” The main entrance lobby was at the left end. The aluminum-clad wooden wing was on the right end of the building. Fire was first seen breaking through the roof at the eaves over the lobby (arrow).
feed the patients in their wards. The steam table had malfunctioned on previous occasions, but on the morning of November 23 nothing unusual was noticed when the connection was plugged into the outlet. Investigation after the fire revealed many violations of good practice in the building's electrical wiring.

Shortly before five o'clock, an attendant in the lobby noticed a flash of light through the main entrance doors and thought it must be an automobile turning into the driveway. She decided to look outside, and when she did, she noticed flames at the eaves at the corner of the lobby section where the building's electrical service entered. She ran into the office just off the lobby and tried to telephone the fire department but found the phone dead. The telephone wires, as well as the electric wires, ran overhead near where the fire was seen. At about the same time, four passers-by (three truck drivers and a student) stopped.

They went inside and found the attendant trying to use the phone. They told her to get the people out. They grabbed two portable fire extinguishers and ran outside to try to extinguish the flames. After he had emptied his extinguisher, one man stopped a passing motorist and told him to go the nearest house and call the fire department. The call was made at 5:00 a.m. The men

Robert J. Quinlan

This was the combustible wing with aluminum siding on wood frame and plywood interior finish. Nothing whatsoever remains of the building wing except pieces of the aluminum siding (lower left) and the pipes and radiators of the heating system. Contents of the wing were also almost entirely consumed except the steel parts of the furnishings. The central corridor ran through the wing to outside doors, which were at the location indicated by the arrow. The two rooms in the wing, one on either side of the corridor, were each approximately 24 feet by 27 feet, and each contained eleven beds.
described the fire as being relatively small and said that the electrical service wires appeared to be arcing and "sizzling." By the time they emptied the extinguishers, the flames seemed to be almost knocked down. Although they did not realize it, the fire by this time had spread throughout the undivided attic probably aided by a strong wind that blew parallel to the long dimension of the building. When they went back inside, they found the building fast filling with smoke. The lights went out shortly thereafter. Fortunately, two passers-by had flashlights.

Meanwhile, the attendants had started getting up some of the patients. One of the patients, who was especially alert, managed to get himself and two or three other ambulatory patients out the corridor exit to the rear. He stated that the smoke was very thick and he got out only because he knew where the door was. The truck drivers started pulling the patients out the doors at the end of the corridor. They had to take them away from the building to keep them from going back in. Some resisted rescue; all seemed dazed and confused. In very few minutes fire began bursting through the ceiling, beginning at the end toward the lobby. Only two patients were taken out through the lobby. When the New London fire fighters arrived at approximately 5:10 A.M., the entire roof and the combustible wing were ablaze, and it was impossible to enter the building. It was all over for the 63 elderly patients still inside.

Several hours later, when the smoldering ruins began to cool, those present were presented with a sickening sight. Almost every scrap of combustible material in the building had been consumed, and a large portion of the concrete block walls had fallen. Row upon row of sagging steel bedsteads held the blackened forms of the victims, all burned beyond recognition.

Records were destroyed by the fire, and identification presented a major problem. Before any of the bodies were removed, each was numbered and the location recorded on a chart. From memory, the attendants and manager identified the bed location of each. In this manner most of the victims were identified. The few who died away from their beds were identified by other means. A morgue was set up at the Fitchville Grade School, and at 12:30 p.m. workmen began transferring the remains of the victims to the school. One body, buried in the ashes, was not found until the following day.

The State of Ohio had adopted regulations to go into effect on February 1, 1961, which would have required the Golden Age Nursing Home and similar occupancies to install either automatic sprinklers or a fire detection system. The regulations would also have required compliance with the National Electrical Code. The new regulations would have required a minimum of two attendants and two licensed practical nurses to be on duty in a home having the number of patients that were in the Golden Age Nursing Home. However, the Ohio State Federation of Licensed Nursing Homes and others decided that these regulations would pose a hardship. By means of a series of court actions, the regulations were still being held up at the time of the fire.

Although the operators of the home and many other interested parties could not believe that such a thing could happen to this apparently well-operated home for the aged, it presented nothing new to fire protection people. Similar fires in similarly constructed buildings occur almost every day. Only the great loss of life brought this fire to the attention of the entire nation.
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