TRENDS IN LONG-TERM CARE

HEARINGS

BEFORE THE

SUBCOMMITTEE ON LONG-TERM CARE

OF THE

SPECIAL COMMITTEE ON AGING

UNITED STATES SENATE

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TRENDS IN LONG-TERM CARE

(Harmar House Nursing Home, Marietta, Ohio)

MONDAY, FEBRUARY 9, 1970

U.S. SENATE,
SUBCOMMITTEE ON LONG-TERM CARE
OF THE SPECIAL COMMITTEE ON AGING,
Washington, D.C.

The subcommittee met at 10:10 a.m., pursuant to call, in room 3110, New Senate Office Building, Senator Frank E. Moss (chairman) presiding.

Present: Senators Moss, Williams, Yarborough, Young, and Hansen.

Committee staff members present: William E. Oriol, staff director; John Guy Miller, minority staff director; and Val Halamandaris, professional staff member.

OPENING STATEMENT BY SENATOR FRANK E. MOSS, CHAIRMAN

Senator Moss. The subcommittee will come to order.

This is the Subcommittee on Long-Term Care of the Senate Special Committee on Aging.

We are here to hold a hearing this morning concerning the fire and fatalities that occurred in Marietta, Ohio.

Sitting with me this morning on the subcommittee is Senator Harrison Williams of New Jersey who is chairman of the full Committee on Aging and also a member of this subcommittee.

I am delighted to have Senator Williams here this morning.

We expect that some others of our colleagues will be able to come. The Senate is in session. If you hear those buzzers from time to time, it is because the Senate is operating and they give us various signals.

If we get a certain kind of a signal, we may have to recess and go over there for a vote and then return, but we hope that will not occur during the morning hours of our hearing.

We are pleased to have all of you here for the hearing. The purpose of the public hearing is to make the record and that is what we are going to do this morning, to get in the record all of the information that we can get concerning this event, to find out what happened, to determine what problems this poses, and from that whether there are any conclusions to be drawn for us on the Federal level, whether further legislation might be needed, or whether further regulations should be called for in the executive branch. Of course, there should be some lessons in it for local administration as well.

January 9 was the most tragic day that was burned into the history of the quiet city of Marietta, Ohio. Exactly 1 month ago today, fire,

and smoke billowed through the Harmar House Nursing Home in Ohio's oldest city while most of us were safe at home watching television programs that Friday evening.

Twenty-one persons lost their lives that night and the present death toll stands at 32 with 11 patients remaining in the hospital. Only three patients out of the 46 in the home escaped death or disabling injury.

Our presence here today indicates our belief in the perfectability of man's nature and our refusal to accept disaster as inevitable.

An accident by definition is an admission of human error. Even a cursory inventory reveals that there were human errors which contributed to the fire in Ohio. For our investigatory purposes today, we pose these errors in the form of questions which fall essentially into four interrelated categories.

The first category is marked by these questions:

How did the fire start?

Why was there such a substantial loss of life?

It must be noted that this was a new, well-constructed nursing home with large windows in patients' rooms. It had a simple one-story floor plan and the evacuation of patients should have been possible within a very short time.

The second category focuses on the Government and responsibility must fall equally upon the Congress and the Public Health Service. The question here is:

Why are there no requirements for fire safety under Medicare?

It is true that the conditions for participation in the Medicare nursing home program do make some suggestions for fire safety under section 405.1134. Regrettably, the statute spells out in unequivocal terms that the "requirements" are merely guidelines.

And, as if this were not enough, this same paragraph contains a further disclaimer that these guidelines "* * * are to be applied to existing construction with discretion in the light of community need for services."

I am asking here today that the Public Health Service tell me why there are no definite minimum fire safety requirements under Medicare.

If Public Health Service or the Social Security Administration needs more legislative authority, I will introduce legislation forthwith.

The third category of questions is related to the second because the Medicare guidelines make reference back to the State statutes. Obviously, the result could be a different fire standard for participation in the Medicare nursing home program for every State of the Union. Our concern here is with the Ohio statute.

Ohio has had more than its share of nursing home fires. Most of us will recall the Fitchville nursing home fire near Sandusky in 1963, when 63 persons perished. This committee investigated that fire and I received promises that the Ohio code would be revised so that it would be the model fire safety code for the entire country.

It isn't. Far from it. On the contrary, there continue to exist serious deficiencies. Not the least of these deficiencies is the code's failure to provide any semblance of a standard for the acceptability of carpets and curtains.

Admittedly, there is a vague reference in section HE–17–47 of the Ohio code, spelling out the requirements for interior finish and trim. The requirement is that finishing material have at least a class D flame spread resistance.

For purposes of comparison the Hill-Burton Act requires class A furnishings with a flame spread rating from 0 to 25 in corridors and exit ways; it requires a minimum of class B material for patients' rooms which calls for a flame spread rating between 25 and 75. Finishing material in the class D range have a flame spread rating between 200 and 500.

As a point of reference, class D materials will burn two to five times as fast as red oak will burn.

My questions here are:

Why do the good people of Ohio continue to tolerate these anemic fire requirements?

How many other States have statutes which are lax on fire standards?

And is the report I have true that the State of Ohio continues to have the same number of inspectors (four inspectors for 1,162 nursing homes) that they had before the Fitchville fire of 1963 in which 63 lives were lost?

My fourth category of questions relates to the Flammable Fabrics Act that was signed into law December 14, 1967. Regrettably, no new standards have been issued for any textile product under this act.

As William V. White, the executive director of the National Commission on Products Safety points out, "We still use, 2 years later, the outdated standard incorporated in the original Flammable Fabrics Act of 1953." The 1953 act allows 99 percent of all fabrics marketed to pass as acceptable for public use.

My question is: Why?

Why do we continue to be governed by the 1953 legislation?

I am sure that Senator Magnuson of the Commerce Committee, and Senator Williams here beside me, as cosponsors of the 1967 legislation, share my sense of frustration.

My next question is to ask why the Federal Government today persists in buying flammable fabrics and clothing for use in Federal offices, hospitals, nursing homes and dependents housing at military bases?

To my knowledge, a detailed recommendation was made to the Surgeon General of the Public Health Service more than 4 years ago urging that new standards and purchase specifications for fabrics used in Federal installations contain provisions to insure the degree of flame retardency required to prevent personal injury and death. No action has been taken on this recommendation to date.

I ask: Why not?

I find it significant that the Secretary of Commerce has exercised his regulatory power under the 1967 Flammable Fabrics Act in only one area. On December 17, 1969, the Secretary announced his proposed flammability standard on carpets and rugs. This standard incorporates the use of a methenamine pill as an ignition source, which, in effect, is dropped on a small piece of carpet and the spread of the flame is then measured.

My question is why did the Secretary choose this modification of the so-called "pill test"?

It is clearly obvious that this is a low and inadequate standard. The compound methenamine has been around for a long time and up until the Secretary's pronouncements its principal use was a reagent to combat urinary infections. It wasn't any good for that either. In this most

independent experts are agreed, the pill test is a test for ignition—it is not a test for flammability.

By the admission of the Department of Commerce, the test does not cover smoke emission or gases given off by burning carpet. Reportedly, it does not apply to the sponge rubber backing used with carpets.

Most significant of all, the carpet in the Harmar House Nursing Home which has received the attack of many as being the premier cause of death at Harmar House, I am told, passes the Secretary's proposed pill test.

In short, as chairman of the Subcommittee on Consumer Affairs of the Commerce Committee, and as chairman of this subcommittee which oversees the needs of our infirm elderly, I am asking the Secretary of Commerce to report to me as to why the Flammable Fabrics Act has not been implemented, and why, in the only situation where we do have partial implementation, is the announced standard so inadequate.

The reports that I received from the Secretary of Commerce, the Public Health Service* and the Bureau of Health Insurance as to the lack of any Medicare fire standards will be released to the press.

As we begin our hearing I would like to express my appreciation to the chairman of the full committee, Senator Harrison A. Williams of New Jersey, for his confidence and assistance which enabled a prompt investigation of the events of the Marietta fire.

I acknowledge what every senior citizen knows, that Senator Williams is the No. 1 man in the field when it comes to looking after our elderly. He is the model that all of us would like to emulate. Wherever I go across the country to meet with our senior citizens, I am invariably asked to convey warm greetings and thanks to Pete Williams for his efforts.

I see Senator Hansen of Wyoming is now on this panel.

I would like to ask Senator Williams if he would have some opening remarks.

STATEMENT OF SENATOR HARRISON A. WILLIAMS

Senator WILLIAMS. Thank you very much, Senator Moss. I appreciate your describing our mutual interest in the matters before the subcommittee today. I know you have a full witness list and, therefore, I will be brief.

I want to commend you, express the gratitude of myself and the rest of the committee for the many contributions that you are making to the work of the Senate Special Committee on Aging, not only through this Subcommittee on Long-Term Care that is meeting this morning and this subcommittee, but I know you have taken it to other parts of our country as well as having formal hearings here in Washington.

We are grateful, too, for the work you have done on studying the usefulness of the model cities program to older Americans.

It has not stopped there, of course. You have been very energetic in relating the problems of older people in housing to the Subcommittee on Housing for the Elderly.

Yes, you have made, and are continuing to make, an all-out effort on behalf of older Americans, on behalf of the entire committee. I just want to say, thank you very much, Senator Moss.

*See appendix A, p. 435.

Certainly, you are to be commended for seeking out the facts so promptly on the tragedy in Marietta, Ohio. It is regrettable that inquiries such as this have to be held. We in this Nation would like to think that elderly patients in institutions have maximum protection against fire and other hazards.

But, faced by headlines telling us that 32 persons died in a nursing home built less than 5 years ago, we must ask, "Why?"

Why did smoke become the deadliest killer at Marietta?

Why, if Medicare and Medicaid patients were accepted at this nursing home, did not Federal standards reduce fire hazards?

Why, since a small business loan was used for original funding, were not safety standards set at the beginning?

Staff research indicates the heavy smoke could have been caused by carpeting. And that leads to my final question:

Why did Congress vote for new amendments to the Flammable Fabrics Act in 1967 if it was not to prevent death not only from fire itself, but from the dangerous byproducts of fire?

Three years ago, when the flammable fabrics legislation was before the Commerce Committee, I made a special point of testifying because I thought that it was of special importance to the elderly. And here is an excerpt from my statement:

> Fire is a peril to everyone. To the elderly it is frequently an overwhelming disaster. Testimony before our committee has indicated that nine percent of the people are over 65, but 27 percent of those injured by fire are in this age group. I mention this to indicate that while this bill is in the interest of all, our elderly citizens have a very great stake in this important safety measure. Hampered by fading eyesight and hearing, and unable to run or even move quickly, many older persons are naturally subject to panic and particularly subject to the horrible ravages of fire.

Senator Moss, I know that you as a member of the Senate Commerce Committee and as chairman of its Subcommittee on Consumer Affairs, are deeply concerned about product safety.

I am glad to learn that you have asked a staff member of the Commerce Committee to be with us this morning and to help us determine whether the Flammable Fabrics Act may require additional revision.

Surely, our elders—when ill and institutionalized—should be as safe from peril as Federal, State, and local regulations can make them. If they are not, it is the duty of public officials to seek out the facts, which is what we here will do today.

I appreciate again the opportunity to be with you on this very important hearing.

Senator Moss. Thank you, Senator Williams.

Senator Hansen, do you have any comments you would like to make before we begin?

Senator HANSEN. I think I have none. Thank you, Mr. Chairman.

Senator Moss. Thank you very much. I appreciate Senator Hansen of Wyoming being with us. He is a most diligent member of this subcommittee and has been very helpful on the problems that we have tried to look into on this committee.

To begin today we have two gentlemen at the table. We are going to hear from Mayor John A. Burnworth, mayor of the city of Marietta; and Mr. Beman G. Biehl, the fire chief of the city of Marietta.

I would ask these two gentlemen to proceed. I suppose the mayor will proceed and then we will hear Mr. Biehl unless you have arranged it between you any other way.

Then we will hear from the fire chief.

Mayor Burnworth, we are glad to have you. We appreciate your coming here. We realize the great problem this has presented to you in your city and your citizens and your great concern with getting to the bottom of the problem and finding ways that we can be assured we will not have any repetition of the tragedy of this sort.

STATEMENTS OF HON. JOHN A. BURNWORTH, MAYOR, CITY OF MARIETTA, OHIO, AND BEMAN G. BIEHL, FIRE CHIEF, CITY OF MARIETTA, OHIO

Mayor BURNWORTH. I am going to ask our fire chief to go first to set the stage for the testimony I will give before the demonstrations.

Fire Chief Biehl.

Senator Moss. All right.

STATEMENT OF MR. BIEHL

Mr. BIEHL. Mr. Chairman, members of the committee, ladies and gentlemen, my name is Beman Biehl. I am the fire chief for the city of Marietta, Ohio. At this time I wish to present testimony to the committee regarding the Harmar Nursing Home fire.

The fire occurred on January 9, 1970, at 9:57 p.m. The building involved was a one-story modern fire-resistant structure constructed in 1965.

The west wing of the building was only completed to the outside shell at this time and six more rooms were added in 1967 and 1968.

The building is more or less shaped like a cross and is located at 117 Bartlett Street, Marietta, Ohio, in Washington County. The building is approximately 244 feet north and south, being 42 feet wide.

Senator Moss. May I interrupt. Is this the diagram of the home here?

Mr. BIEHL. That is the first preliminary diagram that we drew at the time, sir, for the identification of the patients in the nursing home.

(See diagram, p. 384.)

Senator Moss. Is that oriented as a map, north at the top, or is it some other direction?

Mr. BIEHL. North is toward you, sir.

Senator Moss. North is on the right-hand side.

Mr. BIEHL. That is right.

Senator Moss. Would you mark that with an N. Then if we get any descriptions that contain directions in them we can orient them to the building.

Thank you.

Mr. BIEHL. Would you mark the rest of them, too, Mayor, because I have east and west.

Mayor BURNWORTH. If they knew north, they can find the rest of them.

Senator Moss. West is at the top, I take it.

Mr. BIEHL. The building is 134 feet east and west, being approximately 40 feet wide. The patients' rooms were in the north, south, and west wings of the building. The east wing housed the kitchen, laundry, and dining areas.

Located in the center, where the wings came together, was the nurses' station. The interior walls were painted dry wall on steel stud beams. The paint on the walls of the original 21 patients' rooms was Sherwin-Williams Co. Super Kemtone latex wall paint. All painted woodwork was Sherwin-Williams Co. Kem-Glo. All natural finish on doors was Mobile Chemical Co. VO2 high gloss varnish and V–6 satin varnish. Stain beneath varnish is Mobil Intex stain.

The last patients' rooms, five in number, were painted with Pittsburgh Paints Wallhide latex paint on the walls and all painted woodwork was Pittsburgh Paints Lo-Luster alkyd enamel.

All natural wood coating was Vanguard V–671 sealer, V–41 gloss and V–42 satin varnish finish.

Of the original 21 patients' rooms, 10 had one wall covered with either Walltex or Textile was manufactured by Birge Co., Buffalo, N.Y., and distributed by Columbus Coated Fabrics.

The floors in the patients' rooms and the corridors were covered with Marathon 100-percent Nylor carpeting with sponge backing, manufactured by Dan River Carpets Co., Cartersville, Ga.

It was installed with Armstrong S–235 cement. Furniture and fixtures such as beds, mattresses, mattress covers, chairs, dressers, bedside stands, pillows, covers, and so forth, were purchased from Kuttnauer Enterprises, Inc., Detroit, Mich. This company sells hospital and nursing home products and the original 21 rooms were furnished from this company.

The exterior of the building was brick veneer construction with Celotex subsiding. The roof was plywood sheathing supported by metal trusses which ran from the ceiling. The roofing was asphalt shingles. The building was heated by a hot water system and also had forced air heat and air conditioning.

The occupants at the time of the fire were 46 patients, most of whom were elderly bed patients averaging 81 years of age; one licensed nurse; three nurses aides and two special nurses. Twenty-one patients were pronounced dead on arrival at Marietta Memorial Hospital. The death certificates gave the immediate cause of death as asphyxiation due to smoke inhalation. Approximate interval between onset and death, according to the death certificates, was 10 minutes.

One nurse's aide, Maysle Cozzens, was hospitalized and also one private nurse, Maude Lee, was hospitalized from smoke inhalation.

Two firemen were hospitalized, Lt. Charles Young from smoke inhalation and Fireman William McCrady from torn arm muscles. The surviving patients were taken to Marietta Memorial Hospital and Selby General Hospital. The present death toll of the original 46 patients in the Harmar House stands at 32. Most of these patients' deaths were directly related to the fire.

The first notification of the fire was received by the licensed practical nurse in charge, Mildred Hall, who indicated that she was sitting at the nurses' station working on patient charts when the buzzer from the alarm system activated the annunciator panel. A heat sensor which activated at 136° was in each room and also along the corridors.

Senator Moss. Do I understand these sensors were in every room as well as the corridor?

Mr. BIEHL. In every room as well as the corridor.

Senator Moss. Thank you.

Mr. BIEHL. The annunciator panel indicated trouble in the south end of the building. At this time, she said she sounded the house alarm and at the same time noticed smoke coming up the hall from the south end of the building.

Upon sounding the alarm, Mrs. Hall was joined by at least two aides and they proceeded in the direction of the smoke and found it was coming from room No. 104.

Doris Watts, with the aid of another employee, was able to remove Mr. Lyle Phillips from his room and take him up the hall past the nurses' station and out the main entrance of the building.

At the same time the aides were removing the patient from the room, Mildred Hall proceeded to the nurses' station to dial the fire department but stated it was too smoky to dial the phone.

She then ran out the door and across the street to a neighbor's house to call the fire department. This was later established as the Emeral Stanley residence at 205 Flint Street.

The fire department received the call at 9:57 p.m. and the officer in charge, Lt. Charles Young, dispatched two pumpers and seven men to the scene of the fire.

I was at home and heard the report of the fire over the fire department radio and immediately proceeded to the scene in the chief's car.

On my way to the fire scene I heard Lieutenant Young radio the police to call all off-duty firemen and to get all the help they could. The nursing home is in a residential area and the neighbors responded with help in removing the patients that they could.

The pumper from No. 2 station was ordered to the rear or south end of the building to start immediate attack on the fire while all other available manpower was utilized removing patients.

The driver of the truck ordered to the rear of the building stated that the smoke was so dense that he had to have two to three men on each side of the truck to guide him to the rear of the building.

I estimated the time from when the call was received at the fire department until the pumpers were at the scene to be approximately 4½ minutes. My time from home was traveled in an estimated time of 4¾ minutes.

According to witnesses, the lights failed shortly after the discovery of the fire. The electric time clock stopped at 10:02 p.m. The evacuation of the patients and a second check to make sure that all the patients were out of their rooms was completed in 22 minutes. The main part of the fire was extinguished in 12 minutes.

Immediately after the fire was extinguished, an investigation was started and witnesses disclosed that the fire had started in room No. 104.

The examination of the fire scene proved that this information was correct and the fire had started in the northwest corner of the room in a plastic waste container. Even the "V" pattern on the wall was apparent. Almost all the contents in the room that would burn were consumed by the fire.

In the northwest corner of the room where the fire started there was a plastic waste container, a bedside stand, a metal walker with a towel draped over it and a plastic-covered hospital chair. The floor was completely covered with carpet and it was all consumed by the fire.

The smoke, heat, and gasses traveled from his room into the hall and northward past the nurses' station in the center of the building and westward.

Senator Moss. Is this large photograph the room?

Mr. BIEHL. The one on the right is room 104.

Senator Moss. Thank you.

Mr. BIEHL. I would estimate that about two-thirds of the hallway area in the entire building was encompassed with the fire. The insurance adjustors estimated the loss to the building at $75,000 and loss to the contents at $45,000.

The company with which the building and contents were insured is St. Paul Fire & Marine Insurance Co., Policy No. 666N135578, and the agent is William Wiant, Marietta Insurance.

It should be noted that the majority of patients who died were in rooms where the doors were left open and that coroner stated that the cause of death was smoke asphyxiation and not actually being burned from the fire.

It is also my opinion that there was some delay in reporting the fire and also that some person or persons had departed from the south exit door leaving it open and causing the fire to travel northward at a rapid rate.

It is also my opinion that the heavy black smoke that was evident was caused by the backing on the carpet.

Although the official cause of the fire at this time remains undetermined, it is my conclusion after examining the fire scene and interviewing witnesses that the probable cause of the fire was Mr. Lyle Phillips attempting to smoke unattended or one of the aides emptying an ash tray into the plastic waste container.

Following this statement and attached hereto as an integral part of my statement, please find these items:

1. A letter from Wieser & Cawley, Inc., who installed the carpeting and also copies of the invoices for the carpeting.
2. A letter from Vernon V. Vadakin & Son, Inc., the painting contractors.
3. A letter regarding suppliers of other equipment and furnishings used in the home.
4. My statement to the State fire marshal which I made January 14, 1970, regarding the fire.
5. My recommendations regarding hospital and nursing home disasters.

Mr. Chairman, it is my desire to show you, your committee members and the others present a series of color slides taken by my staff photographer and a photographer from television station WTAP which serves the Marietta, Ohio-Parkersburg, W. Va., area.

At the conclusion of these slides, I will do my utmost to answer any questions you may have.

Senator Moss. Will those slides be on this screen here?

Mr. BIEHL. Yes.

Senator Moss. I suppose we can go around and look at the end rather than sitting here in front of them.

Gentlemen, if you can see there, all right. I am going over here so I can see better.

Mr. BIEHL. This is a picture of the building taken from the southwest corner. You will notice smoke coming out of the room. This is room 106. I think you can still see your chart over on the corner.

The second room, room 107, you notice there is no smoke whatsoever. The windows were broken out to take the patients out but the door was closed to this room so there is no smoke on the outside whatsoever.

That is the north end of the building. You see the smoke where this is about 240 feet from the fire. See where the smoke went out the door there.

There is the outside of the fire room, it is completely gutted, the fire room was.

That is another picture, not too much focus. The reason I put this picture in, if you will notice, the snow is still on the roof. This was caused mainly because the plasterboard ceiling had 4 inches of insulation on top of it. This held all your heat down and just the same as made your hallways a chimney, the same as a flue or a chimney.

There is the south door of the building, showing the smoke where it came out. Also, it was hot enough to break the windows out of the door.

There is a picture of the fire room, approximately the same one that is in black and white over on the corner there.

Now the little thing on the outside there through the window, that is a bird feeder out in the yard, that is not in the room.

Another picture of the fireroom. You will notice how the bed is warped even by the fire so you know there had to be an awful lot of fire in that room, awful hot. The sides were up on the bed as you can see. This is part of the mattress and stuffings down here.

That is the inside of the fireroom looking right over the bed and looking out. There is the door from the room. That is a brass plate on the door and only half the door is still intact there.

We set it up there to take the picture to show the door; just half of it, the rest of it was burned up completely.

That is another scene of the fireroom. There are Mr. Phillips' coats and things hanging in the closet. There is the bathroom door there, and there was a dresser setting right in this area here.

This is not a mirror, this is just a wall. You notice construction on this building, you see your steel up at the top. There was very little wood in the building. I think I have a picture of the one part where there is wood. Only in the plywood ceiling up on top of the roof.

There is another picture showing you the insulation inside the room. Now, these were also steel studs in this room and all over the building.

There is the mattress or what was left of the mattress after we put it on the outside. This was his own private chair.

Senator Moss. Plastic cover?

Mr. BIEHL. Plastic cover.

That is room 106, it is the last one on the right-hand side on the south end of the building. You can see the density of the smoke.

There is room 105 directly across the hall. It is next to the fireroom.

Senator Moss. Did it look that black or is that distorted by the picture?

Mr. BIEHL. No; distorted by the picture. The reason these pictures are not too clear, we did not have enough light. We took them with flashbulbs and the pictures did not come out too clear because it was dark in the building.

Talking about the heat sensor in each room, there is the heat sensor in that particular room.

Senator HANSEN. Has extra bedding been stripped off?

Mr. BIEHL. The mattress and bedding, yes. After we took the patient out of the bed we wrapped him in some of the bedclothing to keep him warm because on this particular evening the temperature was zero.

We did wrap some of the bedclothing around the patients and then as we stripped this off, why, we just left it as it was but most of the damage had already been done.

There is another room. You can see where the head of the patient laid on the pillow.

That is not too clear a picture, I don't know what the picture is. You can see that this back part of the wall which is all paint is all blistered off of it.

There is room 102. That is two doors from the fire scene. There was a private nurse in this room with one patient. There were two patients in the room but she was only controlling one patient.

This door was shut, she took a bath towel and wet it and put it down at the bottom of the door to keep the smoke from going in the room.

You can see there is some of the plastic wall covering that was in some of the rooms. Ten of the 21 original rooms had the plastic wall covering. Only the one wall in these rooms was covered and it was usually at the head of the beds.

There is the inside of the same room, 102, with the door closed. The only fire that got in was around the edge of the door here. It came in as fire for approximately 10 seconds, the private nurse told us, and then went to smoke and the smoke was so dense that she had to get out of it herself, even with the door closed.

She went out the window of this room, tried to get her patient out. She could not get her patient out and a nearby resident came over and he helped her take her patient and the other patient out of this room. She was too short to reach over the window sill and get the patient out of the bed.

This is approximately, oh, I would say, around 100 feet from the fire.

This is the office, you can see where the door was broken in. We could not see when were were in the hallway, could not see anything. This is the office and we broke in it in case there was anybody in there to get them out.

The furniture in this room, there was very little dust on it or anything, the door was completely closed. It is hard to see but right at the bottom is a piece of plastic that went around the light. That is the only thing that was disturbed in this room, no black smoke or anything else.

They had a copying machine sitting right behind this particular wall as you went in this door, had a plastic cover on it and it was in good shape and the plastic cover looked like it was brand-new yet.

I took this picture more or less to show the density of the smoke on white enamel. This is all white enamel here. This is directly beyond the nurses' station.

This is the annunciator panel that sits directly behind the nurses' station.

Now this had five different lights on it. There is one, two, three, four, five lights in this panel. This showed the section of the building where the heat sensor had activated and this is where the nurse knew where to go after this activated. It is just a buzzer system is all it is, and then she sounds the general alarm.

This is the scene of the nurses' station directly in the middle of the building where it crosses, the little thing over on the wall on this chart over here will indicate the nurses' station.

There is the patients' charts, right here is one of them, metal chart. They were all on the rack on this particular station. This is not a chair, this is just part of the ceiling that came down.

That is another view of approximately the same place, the nurses' station. You can see your air-conditioning and heating duct and also your metal trusses up there.

This is taken from above the nurses' station north looking south. This is approximately 150 to 160 feet from the fire room.

There is plastic in room 120. Now this is a considerable ways from the fire room. This is the only room I notice the plastic was burnt in. That is as far down as it burnt, about halfway on the wall. This is not an electric wall plug here, it is the indicator for the nurses.

This is taken from completely the northern end of the building. This was taken while the hose was laid in through the hall as you can see. There is 2½-inch hose laid through there. This is approximately 230 feet from the fire scene right here where you can see it. See how your fire went up the wall, started down here and started coming up. This is still your density or black smoke here.

There is another picture of the north end of the building, taken as far north as you can get. You can still see your fire coming up in this direction. You can see the walls how they are still all scorched from the heat when the paint was burned a good deal off of it.

That is your west wing of the building. Like I stated a little bit ago, I will show you this is about the only wood that I saw inside the building whatsoever. This is where the west wing was added in 1967–68, the six additional rooms. Now, there were five patients' rooms and one storage room added at this particular time.

This is the pop machine and a desk that was sitting in the hallway there.

This is a dining area looking west to the west corridor there. This is the staff's private dining here and back in the back part of this was the patients' dining along with this side here.

I might note that this is a fish aquarium here and the fish were still living.

This is the main entrance with the wire glass behind the doors.

This is some of the evacuation scenes.

The ambulance, taking the patients.

I might say that these pictures here show in 1968, where we did put on a nurses' evacuation and safety program for the nursing homes and the hospital program in our city.

This gentleman right here is from the State fire marshal's office, this is one of our firemen. This shows an aide or a nurse, I cannot tell you which one it is, practicing taking a patient out of a bed. It is just some few scenes.

This was taken last December, a nurses' class in a schoolhouse. This is their class. You can see with their coats on and everything, it was cold. They were still out practicing for the evacuation, fire safety.

Another evacuation showing how to take a patient out of the bed. Shows them how to use the fire extinguisher. This is the fire inspector from the State fire marshal's office.

That is it. Thank you.

(The documents referred to follow:)

WIESER & CAWLEY, INC.

FURNITURE

FUNERAL DIRECTORS

817 THIRD ST. TELEPHONE 373-1676

MARIETTA, OHIO 45750

January 13, 1970

Mr. Beman Biehl, Fire Chief
Marietta Fire Department
Marietta, Ohio

The following is information concerning the carpet which was installed by Wieser & Cawley, Inc. at Harmer House Nursing Home, Bartlett Street, Marietta, Ohio.

The carpeting was Marathon, 100% nylon with sponge backing, manufactured by Dan River Carpets Co.

On January 22, 1966, 1,028 1/3 square yards were installed in the main building and on March 2, 1968, 218 2/3 square yards were installed in the west wing.

Attached are copies of the carpet invoices from Dan River Carpet Co., stating style, color and roll numbers.

Sincerely,

WIESER & CAWLEY, INC.

Dan B. Cawley

DBC/js

enc. invoice copies

cc: file

Dan River Carpets
P O Box 249
Cartersville, GA. 30120
Invoice 041377 12/23/65

Dan River Carpets Co.
A DIVISION OF DAN RIVER MILLS, INCORPORATED

GREENVILLE, SOUTH CAROLINA 29602
P. O. BOX 1089

INVOICE NO.
35858

CODE 372-1
D-U-N-S 330-1116

SOLD TO
WIESTER & CAWLEY
817 3RD STREET
MARIETTA OHIO

207201

INVOICE DATE
12/30/67

THIS BILL IS ASSIGNED TO AND PAYABLE ONLY IN NEW YORK FUNDS TO OUR FACTORS ISELIN-JEFFERSON FINANCIAL COMPANY, INC., P. O. BOX 2974, CHURCH ST. STATION, NEW YORK, N. Y. 10008 TO WHOM NOTICE MUST BE GIVEN OF ANY MERCHANDISE RETURNS OR CLAIMS FOR SHORTAGE OR FOR OTHER GROUNDS.

TERMS
5/30 - 4/60
NET 61

DECIMAL EQUIVALENT

INCHES	FRACTIONS
1	.06
2	.17
3	.25
4	.33
5	.42
6	.50
7	.58
8	.67
9	.75
10	.83
11	.92

SHIP TO SAME

ORD NO	CUST DEPT	SALESMAN	SHIPPED AT YOUR RISK	ORDER DATE
011712		05	BELL	12/19/67

SAN	SIZE WIDTH	SIZE LENGTH	DESCRIPTION QUALITY	DESCRIPTION COLOR	COLOR NO.	ROLL NO.	SQUARE YDS.	UNIT PRICE	AMOUNT
1	1200	10050	MARATHN	CARIBEN	74130212	951229A	13400	460	616.40
1	1200	6400	MARATHN	CARIBEN	74130212	951230	8533	460	392.52
							21 933		1008.92
									40.36
							Less		968.56

1968
Hanover House

Ord 3/1/68
Inv # 32753

CONTAINING GUARANTY UNDER THE TEXTILE FIBRE PRODUCTS IDENTIFICATION ACT FILED WITH THE FEDERAL TRADE COMMISSION.

CUSTOMER

PAY THIS AMOUNT 1,008.92

THIS INVOICE ASSIGNED TO AND PAYABLE ONLY IN NEW YORK FUNDS TO OUR FACTORS ISELIN-JEFFERSON FINANCIAL COMPANY, Inc. P. O. BOX 2974, CHURCH ST. STATION, NEW YORK, N.Y. 10008 TO WHOM NOTICE MUST BE GIVEN OF ANY MERCHANDISE RETURNS OR CLAIMS FOR SHORTAGES OR FOR OTHER GROUNDS.

PLEASE NOTE

DAN RIVER CARPETS

P. O. BOX 249
CARTERSVILLE, GEORGIA 30120

PLANT
WHITE, GEORGIA

TELEPHONE
AREA 404
382-5665

372 1

INVOICE NUMBER
4323

PLEASE REFER TO ABOVE NUMBER ON ALL CORRESPONDENCE AND REMITTANCES.

SOLD TO
WISER AND CAWLEY
817 THIRD ST
MARIETTA OHIO

SHIPPED TO
HARBOR HOUSE NURSING HOME
BARTLEDGE ST
MARIETTA OHIO
(SAME AS "SOLD TO" UNLESS OTHERWISE INDICATED)

SHIP VIA	TERMS	CUST. ORDER NO.	SALESMAN NO.	INVOICE NO.	CUSTOMER NO.	INVOICE DATE
RCA-GORDONS	5%/10-4%/70-NET 71		0341	04323	20720	12/30/65

STYLE	COLOR CODE	DESCRIPTION	ROLL NO.	WIDTH	LENGTH	SQUARE YARDS	PRICE	DISC %	AMOUNT
0413	0212	MARATHON H/D FOAM -CARIBBEAN	59093A	12X	73.67	98.22 98.22	4.20		412.52
							TOTAL		412.52T
								4%	16.50
									396.02

Pd 3/10/66
Ck# 25756
JF

1966

CUSTOMER

365

IS ASSIGNED TO AND PAYABLE ON... NEW YORK FUNDS TO OUR FACTORS
ISELIN-JEFFERSON FINANCIAL COMPANY, Inc.
P. O. BOX 2974, CHURCH ST. STATION, NEW YORK, N.Y. 10008
TO WHOM NOTICE MUST BE GIVEN OF ANY MERCHANDISE RETURNS OR CLAIMS FOR SHORTAGES OR FOR OTHER GROUNDS.

PLEASE NOTE

DAN RIVER CARPETS

P. O. BOX 249
CARTERSVILLE, GEORGIA 30120

PLANT
WHITE, GEORGIA

TELEPHONE
AREA 404
382-5665

372/1

INVOICE NUMBER **4137**

PLEASE REFER TO ABOVE NUMBER ON ALL CORRESPONDENCE AND REMITTANCES.

SOLD TO

WISER & CAWLEY
817 3RD ST
MARIETTA OHIO

SHIPPED TO

HARBOR HOUSE NURSING HOME
BARTLEDGE ST
MARIETTA OHIO

(SAME AS "SOLD TO" UNLESS OTHERWISE INDICATED)

SHIP VIA	TERMS	CUST. ORDER NO.	SALESMAN NO.	INVOICE NO.	CUSTOMER NO.	INVOICE DATE
RCA % GORDONS	5%/10-4%/70-NET 71		0341	04137	20720	12/23/65

STYLE	COLOR CODE	DESCRIPTION	ROLL NO.	WIDTH	LENGTH	SQUARE YARDS	PRICE	DISC %	AMOUNT
0413	0205	MARATHON H-D FOAM/OLIVE	59001	12X	86.00	114.66			
			2576		68.50	91.33			
			1305		81.50	108.66			
						314.65	4.20		1321.53
0413	0212	MARATHON H/D FOAM -CARIBBEAN	928	12X	36.75	49.00			
			935		91.67	122.22			
			936		90.42	120.56			
						291.78	4.20		1225.48
0413	0414	MARATHON H-DFOAM/OLD GOLD	918	12X	85.25	113.66			
			933		102.25	136.33			
						249.99	4.20		1049.96
0413	0420	MARATHON H-D FOAM/HARVEST	2439	12X	102.92	137.22			
						137.22	4.20		576.32
0413	0504	MARATHON H-D FOAM/CARDINAL	59024	12X	16.00	21.33			
						21.33	4.20		89.59
							TOTAL		4262.88T

CUSTOMER

CONTINUING GUARANTY UNDER THE TEXTILE FIBER PRODUCT IDENTIFICATION ACT FILED WITH THE FEDERAL TRADE COMMISSION

Vernon V. Vadakin & Son, Inc.
Residential, Commercial and Industrial
Painting, Wall Coverings
MARIETTA, OHIO

January 12, 1970

Beman Biehl, Fire Chief
City of Marietta
Marietta, Ohio 45750

Dear Sir:

The following is a record of the surface application on the Harmar House Convalescent & Retirement Center, Harmar Hill, Marietta, Ohio.

1966 -

Room No.	Wallcovering	Paint	Doors
103	Walltex #36097	SKT	V-2/V-6
118	Textile #W3645	"	"
121	Textile #W3756	"	"
109	None	"	"
113	None	"	"
101	Textile #W3715	"	"
105	Textile #W3655	"	"
120	Textile #W3621	"	"
107	None	"	"
111	None	"	"
115	None	"	"
102	Textile #3747	"	"
119	Walltex 36097	"	"
108	None	"	"
112	None	"	"
116	None	"	"
104	Textile #W3698	"	"
117	Textile #W3696	"	"
106	None	"	"
110	None	"	"
114	None	"	"

All latex wall paint designated SKT is Sherwin-Williams Company Super Kemtone, all painted woodwork is Sherwin-Williams Company KemGlo, all natural finish on doors is Mobil Chemical Co. V-2 High Gloss Varnish and V-6 Satin Varnish. Stain beneath varnish is Mobil Intex stain.

Wall covering is Columbus Coated Fabrics Walltex or Textile as manufactured by Birge Co., Buffalo, New York.

Beman Biehl, Fire Chief
City of Marietta

January 12, 1970

1967 Addition -

Room No.	Wallcovering	Paint	Natural
151	#89469	PPG Wallhide 80 series	V-671 V-41/V-42
152	89517	"	"
153	89471	"	"
154	89523	"	"
155	89527	"	"

All latex wall paint designated as PPG is Pittsburgh Paints Wallhide latex, all painted woodwork is Pittsburgh Paints Lo-Luster Alkyd Enamel. All natural wood coating is Vanguard V-671 sealer, V-41 Gloss and V-42 Satin Varnish finish.

All wall cover designated 89____ series is Wall-O-Vin as manufactured by Columbus Coated Fabric.

Respectfully submitted,

VERNON V. VADAKIN & SON, INC.

Thomas C. Vadakin
President

TCV/wb

CITY OF MARIETTA

FIRE DEPARTMENT

MARIETTA, OHIO

OFFICE OF CHIEF
B. G. BIEHL

January 12, 1970

Harry McLaughlin Jr.,Arson Investigator
Robert Greenwalt, Arson Investigator
Arson Bureau
Division of Ohio State Fire Marshal

Gentlemen:

Following is information received from C. D. Camden Architect for Harmar House Nursing Home which was built in 1965.

Furniture & Fixtures such as Beds, Mattresses, Mattresses covers, chairs Dressers, Bed Side Stands, Pillows, Covers, etc. were purchased from:

Kuttnauer Enterprises Inc.
Hospital & Nursing Home Products
6400 Mt. Elliot St.
Detroit, Michigan 48211
Phone 313-921-7400

Their Representative at this time was:

Mr. Herbert Stielau
4700 W. 11th St.
Cleveland, Ohio 44109

In the west wing which was completed in 1966 the Beds were supplied by:

Hill-Rom Inc.
Batesville, Ind. 47006

Their Representative at this time was Robert B. Jones, Columbus, Ohio

The Chairs & Dressers were supplied by:

Will-Ross Co.
Hospital Suppliers
Cincunnati, Ohio

All Carpeting was installed by :

Wieser & Cawley, Inc.
817 Third Street
Marietta, Ohio 45750

All Painting was done by:

Vernon V. Vadakin & Son Inc.
212½ Third Street
Marietta, Ohio 45750

Submitted by: B. G. Biehl, Chief
Marietta Fire Department

CITY OF MARIETTA

FIRE DEPARTMENT

MARIETTA, OHIO 45750

OFFICE OF CHIEF
B. G. BIEHL

Following is my account of the events and procedures which were employed at the Harmar House Nursing Home on January 9, 1970. These accounts are true to the best of my knowledge.

Beman G. Biehl

B. G. Biehl, Fire Chief
Marietta, Ohio

I had just returned home from a meeting on Fire Department business and sat down to enjoy the evening paper. I had not completed the first page when I heard the radio in my bedroom. I ran back to listen and to my dismay I heard Lt. Charles E. Young report to the Marietta Police Department from Pumper # 3 that they and Pumper # 2 were making a Fire run to the Harmar House Nursing Home on Bartlett Street. I looked at my watch and the time was 9:57 P.M.

I donned an old jacket that was hanging in the closet and ran for the Chief's car which was parked outside. I could not have been more than a block away from Harmar House which is about four (4) miles from my home when I heard on the radio in the Chief's car Lt. Charles E. Young call the Marietta Police Department. "Call All Off Duty Firemen And Get Us All The Help You Can".

I arrived at the Fire scene within seconds and could see that we had a disaster. Smoke was so dense close to the home you could hardly see to drive. I could see what I thought to be a flame in the South end of the building. I immediately pulled the car to the side parking lot and jumped out and ran to a window on the Northwest side of the building and broke the window on the second room, climbed in the window and started feeling the bed for the patient. If I recall correctly, this patient had restraining straps tied to the bottom of the bed and it was difficult to get him or her out of the bed. I finally broke the strap on each side and started to lift the patient out the window to someone outside. There was no one outside at first so I called for help. I then climbed out the window and started for the next room. In this room I felt the first bed and this patient was in bed with restraining straps. I immediately broke these and passed this patient out the window. Another Fireman who I took at the time to be Howard Taylor came in the door from the hallway and helped me with the patient in the other bed.

Fire Chief B. G. Biehl
Account of Harmar House Nursing Home Fire
January 9, 1970
Page Two

Howard Taylor and myself explored the next room to no avail. Someone had removed these patients. I then went to the last room on the Northwest end of the building from Bartlett Street and checked this room. At first I could find no one but by this time I could hardly get my own breath so I got close to the floor and crawled toward the window. When I got close enough to get just a gasp of fresh air I discovered a body on the floor by the window. I immediately lifted this patient, whom I presumed to be dead, out of the window to someone outside. I could see other people trying to get the patients out of the West wing of the home so I ran around to the Northeast section of the home and after checking all the rooms I did remove one patient, from which room I cannot recall at this time.

I then could see and hear the fire was roaring just like a furnace in the middle of the building. I called for Howard Taylor to help me pull a 1½" booster line to the East side of the building and told him to start "Fire Fighting" procedures at this point. I then proceeded to the # 3 Pumper which was located in front of the building on Bartlett Street and told Harold Lamb to lay a 2½" line from the hydrant across the street, which we did. I then proceeded with the line to help fight the fire at the middle of the building but there was no water coming thru the hose. I motioned to turn the water on and asked Fireman Vermaaten to check to see what the trouble was. He found out the hydrant was frozen. Lt. Young knew what was wrong and asked if I wanted another line laid from another hydrant. I said "Yes, get one of the hydrants on Lancaster Street." -- I might say at this time that the hydrant being frozen did not have a bearing on the fire as we extinguished the fire with the water contained in Pumpers # 2 and # 3, which hold an aggregate of 1,000 gallons of water, with 1½" Live Lines and Booster Lines from Pumpers.

I helped lay part of the 2½" line to the hydrant and returned to Pumper # 3 to help Lt. Young pull off enough hose to reach the main seat of the fire. After installing the nozzle on the end of the hose I was told that Fireman McCrady was injured laying the 2½" line. I ran down to where he was. He thought he might have broken both of his arms as an automobile had ran across the hose while the truck was pulling the hose causing a sudden jolt to the hose Fireman McCrady had in his arms. I then went back to the front of the building and asked "Butch" Hadley to pick up McCrady and take him to the hospital, which he did.

Fire Chief B. G. Biehl
Account of Harmar House Nursing Home Fire
January 9, 1970
Page Three

I was about to enter the building when I noticed Lt. Young was staggering, vomiting and could hardly get his breath so I helped him into an ambulance and sent him to the hospital. I then entered the building. I asked Lt. Barker Stanley of the Marietta Fire Department, and Charles Williams, from the Oak Grove Volunteer Fire Department, and some of his men to make another thorough search for anyone who might be under a bed, in a closet or anywhere else. This was the fourth complete search I learned later.

By now the 2½" line was laid to the middle of the building but the fire was already extinguished. We used this line only for mopping up procedures. I might state here that during the short time I was away from the fire scene helping lay the line to the hydrant and performing the above duties, Pumpers # 2 and # 3 had the blaze under control. # 3 Pumper and men were coming in from the North and East end and # 2 Pumper and men were coming in from the South end. I would estimate approximately twelve minutes as the time in containing the fire. This does not mean they used water the full twelve minutes as they were told to use it sparingly.

As near as I can gather, the time of removal of all patients that were in the building when we arrived at the scene was twenty-two (22) minutes. The fire was extinguished by 10:35 P.M. I do not know how many patients were removed from the building but I do know there were many. I still cannot at this time find a correct count. If all the people I have talked to, including Firemen, took as many patients out as they say they did, the total removal would have been 133. The Home only listed 46 patients, 4 employees and 1 special nurse who was privately employed.

After the main fire was extinguished I ordered # 2 Pumper to pick up their hose, etc., and return to # 1 Station to reload and stand by in case of another alarm. I left # 3 Pumper and some Firemen to stand by for small hot spots and I took one man, Fireman Paul Hale, and proceeded to the home of Fireman McCrady to tell his wife he was injured. Upon arrival, I was told she was making coffee and sandwiches for the Firemen at # 1 Station. I proceeded to # 1 Station and found both Fireman McCrady's and Lt. Young's wives and took them to the hospital to see the condition of their husbands. Upon arrival at Marietta Memorial Hospital all you could see were bodies lying in the rooms by the emergency room and in the

halls. I found out McCrady was on the third floor and that Lt. Young was taken to Selby General Hospital. I then took both wives to their husbands and returned to the "Scene of the Disaster".

I ordered the rest of the Firemen at the scene to take up the line to the hydrant and prepare to move # 3 Pumper to Engine House for reloading of hose and water. I then started the investigation of the fire and had just found where I thought to be the origin of the fire when I received word that the Mayor would like to have me in his office so we could prepare a statement to release to the press as he was receiving calls from all over the country. There were quite a few reporters at the City Hall for a news release.

I ordered Assistant Fire Chief Dale Taylor and Assistant Inspector William Eagleson and Fireman Richard Clatterbuck to secure the building and allow no one in as I was going to call for a full investigation from the State Fire Marshal's Office.

After the news release was prepared and the news conference was over I returned to my office to call the State Fire Marshal and was told that Frank Jewell had called and I was to call him back. I was in the process of calling Frank Jewell when Harry McLaughlin, State Arson Investigator, walked into my office. He stated there were more coming to investigate.

The Investigation as it now stands is in the realm of the State Fire Marshal's Office and the Marietta Fire Department and is not completed.

At the time of this report 27 people have lost their lives in this disaster and three more are on the critical list.

I hope that this full investigation will in some way prevent a disaster of this kind from ever happening again anywhere.

January 14, 1970

Beman G. Biehl

Beman G. Biehl, Fire Chief
Marietta, Ohio

CITY OF MARIETTA

FIRE DEPARTMENT

MARIETTA, OHIO

OFFICE OF CHIEF
B. G. BIEHL

Recommendations for Hospital and Nursing Home disasters

I. Have Hospital and Nursing Home evacuation program training for all Nurses, Nurses Aides, etc. The correct timing of these procedures is one of the most important facets of this program. By this I mean someone should be responsible for calling the Fire Department immediately. I personally think in our disaster; there was a delay in the calling of the Fire Dept.

II. To stress in the training to close the doors to all rooms especially the room where the origin of the Fire is. As the pictures of our disaster will show the comparison of the rooms of the doors being shut and the doors being left open.

III. Keep all outside doors closed if at all possible as this will help keep the Fire from spreading so quickly especially if the Fire is in a hallway. An open door will act the same as a damper in a flu or chimney.

IV. Set up an "Emergency Disaster Program",such as extra ambulance service from near by town or communities. Have all phone numbers readily available.

V. Have Police keep area open for the ambulances to come and go. If at all possible keep area secluded from all traffic. We did have some difficulty of traffic congestion in the immediate area.

VI. It is a good policy where there are homes in the immediate area of a Hospital or Nursing Home to "Pre-Plan" and ask the neighbors if a disaster should hit the hospital or home if you could use their home to keep the patients out of the elements of the weather until you can transport to a hospital. We had done this in our small town and it proved very beneficial.

VII. Visit your Hospitals or Nursing Homes often enough to know the building. I do not mean just the inspectors but all Firemen. It will prove to be tremendous help if the building is filled with smoke. It might even prove to save your own life.

CITY OF MARIETTA

FIRE DEPARTMENT

MARIETTA, OHIO

OFFICE OF CHIEF
B. G. BIEHL

Recommendations for Hospital and Nursing Home disasters continued

VIII. Either have Firemen help teach the Hospital and Nursing Evacuation Program or have this program in your own Dept.

IX. Set up programs and show films of Hospital and Nursing Home Disasters to the faculty and employees.

X. Inspect the Hospital or Nursing Home often and make sure the oxygen is handled according to the Code.

January 15, 1970

Respectfully submitted,

Beman G. Biehl

Beman G. Biehl, Fire Chief
Marietta, Ohio

Senator Moss. Thank you, Chief Biehl. We appreciate that.

I want to note that the senior Senator from Ohio, Senator Young, is here with us now and saw some of the slides that you showed. He has been most concerned naturally, this being a problem that arose in his home State.

I do believe that we might have some questions. However, I think we might go on with the mayor since you both are sitting at the table here and then we can ask questions of either one of you when you have finished.

I would like to hear now from Mayor John A. Burnworth of the city of Marietta.

Will you proceed, Mr. Mayor?

STATEMENT OF HON. JOHN A. BURNWORTH

Mayor BURNWORTH. Thank you, Mr. Chairman.

Ladies and gentlemen, as mayor of a small city, approximately 18,000 persons, one becomes heavily involved in the hour-to-hour, day-to-day operations. Thus, it is that I have in my home, my automobile, and my office, radio monitors on the police, fire, and general operational radio frequencies, of our city.

On the evening of January 9, 1970, I was sitting at my desk in my home doing some paperwork when I heard the fire truck from our No. 1 station radio the police department that they were on the way to a fire at Harmar House located on Harmar Hill.

Instantly, the police dispatcher radioed instructions to police cruisers. I heard the police cruiser leaving zone 1, which is our business district, advise the police dispatcher that he could see the fire from the business district.

I immediately grabbed the phone, dialed the police department, advised the dispatcher that I was aware of the fire and, to save the dispatcher time, that I would advise our safety-service director, Mr. L. R. Weber. As I phoned Mr. Weber, my wife got my coat and boots. I completed the call and left instantly for the fire scene.

I followed the first ambulance to the fire and arrived moments after the two firetrucks were on the scene fighting the fire.

Knowing that the facility housed elderly persons I knew the main problem would be rescue. Running to the building, I saw neighbors assisting firemen by carrying patients from the building and taking patients out of firemen's arms as they were brought to windows on the west wing of the building.

I saw Fire Chief Beman Biehl assisting with evacuation of persons from the room at the end of the north wing on the west side. Asking what help was needed, he advised, "Evacuate patients."

I, with the assistance of several others—neighbors, spectators, ambulance drivers arriving at the scene—started breaking out windows on the west side of the building and removed patients.

Patients who were in beds just inside of the windows were relatively easy to remove but great difficulty was encountered in getting persons out of the beds that were adjacent to the inside wall.

The first room I crawled into to get the second patient was the third room from the north end and one of the furthest points from the fire.

However, the smoke was so heavy, so thick, black, and toxic, that my heavy-duty 9-volt light was totally ineffective and, even getting down on my hands and knees on the floor, I was unable to breathe and had to crawl back out.

It was at this point that Mr. Charles Sellars went in on his hands and knees and removed this patient.

We then were able to get assistance from a fireman with an oxygen mask who removed the patients from the next several rooms from the inside wall as we evacuated those along the windows. Having completed evacuation of this area, I turned my attention to other matters of coordinating the total efforts of our various departments.

By this time, traffic officers were in place, ambulances were flowing fairly smoothly between the rest home and the hospitals so I assisted the safety-service director to the Marietta Memorial Hospital for coordination of the activities and for the purpose of getting us factual information about the conditions of persons involved.

I held a brief meeting at the scene with Sgt. Frank Stevens of the Ohio National Guard who offered the armory facility as a temporary morgue, then assigned the Police Chief P. K. Gramkow to coordinate and oversee the morgue activities.

Following extinguishment of the fire, removal of all persons and employees, I toured the inside of the facility and proceeded to the hospital and the Ohio National Guard Armory for firsthand reports of what was taking place.

By this time, we were being confronted by many press people for information so I returned to my office at the Marietta City Building and coordinated the activities which led to a 3 a.m. press conference which was held to clarify those things that had occurred.

In looking back on those things that occurred at the scene of the fire, I can only reiterate that I have never been to a fire before where the smoke was such a ghastly problem.

I was a commercial insurance agent for 10 years, a "$1 a year" special deputy for several years, in addition to being mayor of our city for 4 years, and let me assure you, though I may not be a professional firefighter, it is my layman's observation that the smoke and heat from this fire were unusually bad.

For the record, I heard no screams or outcries from patients. Everyone at the scene who assisted, officially and unofficially, did a tremendous job evacuating patients from this convalescent home.

The only criticism I have had and will continue to have regarding this matter was the age-old problem of sightseers and spectators converging on the area, which creates traffic problems and unnecessary chaotic conditions at the scene of any tragedy.

The first responsibility we have as officials is to save lives—then protect property—then enforce the law. These things were done.

At this time, Mr. Chairman, I would like to pause in my statement to play for you a tape recording which was made in my office on Wednesday afternoon, February 4, 1970. The female voice you are going to hear is that of Miss Doris Watts.

Miss Watts was one of the nurses' aides on duty at the time of the fire. She resides at 609 Sixth Street in Marietta and is 19 years of age. Miss Watts was the first person to reach the door of room 104 and was

instrumental in the removal of Mr. Lyle Phillips, the occupant of the room where the fire started.

Incidentally, Mr. Phillips is still alive.

(Transcription of tape transcript follows:)

[Interview made February 4, 1970, by Marietta, Ohio, Mayor John A. Burnworth with Fire Chief Beman G. Biehl and Miss Doris Watts, a nurse's aide, at the Harmer House Rest Home regarding the activities at the rest home on the night of January 9, 1970, when Harmar House burned.]

(Taped by request of Senator Frank E. Moss, Chairman of the Senate Subcommittee on Long-Term Care of the Special Committee on Aging.)

Mayor BURNWORTH. Would you tell us in your own words just what you were doing prior to the fire and how you learned about the fire and what happened afterwards? Then Fire Chief Biehl who was present at the fire and at your deposition when it was taken can ask you some questions that may help refresh your memory.

Would you go ahead, please?

Miss WATTS. All right.

About ten minutes of ten I went in the office, it is right behind the desk, the nurse's station, and I called my mother, and close to ten I heard a crash and Mrs. Hall hollered. I threw the phone down and ran out in the hall and Mrs. Hall said something to the effect that there was a fire, and I could see that it was down that way and she took off that way herself and so did I. I ran down and I could tell the smoke was coming out of 104, Mr. Phillips' room.

I ran in, I got him out from the right side of the bed because I couldn't from the left—the left it would have been faster but that was where the fire was, in the left hand corner of the room. I got him out, drug him half way up the hall and then I couldn't any more, I got a lot of smoke and I just couldn't. And Masell helped me then and we drug him about up to the nurse's station and then I thought of the fire extinguisher and I went and got it, started back down the hall.

By that time the smoke was all over the hall and I think the fire was even out in the hall, I am not sure because the smoke was so heavy. But I could not go back, I could not go back down near the room. I started down and got half way down the hall, half way to his room. So I threw the fire extinguisher down and I started back up and we carried Mr. Phillips out the front door. We put him in Mrs. Ples' car. At the same time we went out, I think Mrs. Hall did—yeah, she went over to the Stanley residence to call the Fire Department because you could not see the telephone to dial.

Mayor BURNWORTH. Doris, let me ask you, did you hear any of the other patients yelling for help?

Miss WATTS. No.

Mayor BURNWORTH. Did you think the fire smoke had reached them at this point?

Miss WATTS. Well, no. I have thought so much that I must have awakened like Miss Richards, she has her mind. She was right next to Mr. Phillips' room. And I remember out in the hall, I am not sure but I think I was hollering or something. I just—I remember hoping I didn't wake any of them up but I didn't hear any of them awake. Mrs. Hall might have closed those doors. I think she may have because I did not hear anyone hollering.

Mayor BURNWORTH. Did you go back into the building after you left it?

Miss WATTS. We tried. We couldn't.

Mayor BURNWORTH. Beman.

Mr. BIEHL. I think you stated that you took another woman out, I think it was Margaret Flynn.

Miss WATTS. Yes.

Mr. BIEHL. When did you take her out?

Miss WATTS. Oh, this was long after, I wandered around uselessly for so long and then finally I did think, you know, but a lot of people, most of them were out then.

Mr. BIEHL. Let me ask you a question here. You said you could not get back into the building after you went out. Now the fire had progressed some——

Miss WATTS. It was down the hall then.

Mr. BIEHL (continuing). And became larger.

Miss WATTS. The fire was at the nurse's station.
Mr. BIEHL. How could you go in afterwards to get Margaret Flynn out?
Miss WATTS. We went in through the window.
Mr. BIEHL. You went in the window.
Miss WATTS. Her room was in the north. We went through a window.
Mayor BURNWORTH. Doris, while Beman is thinking of another question I just thought of one. Do you have any idea what made the fire travel so fast after it came out of the door of Room 104?
Miss WATTS. No, but I have heard that the front door was open and that's what did it, it helped.
Mayor BURNWORTH. What do you mean by the front door, the street?
Miss WATTS. The one we took Mr. Phillips out; the vestibule, the main entrance. Right there where the glass is; you know, the glass.
Mayor BURNWORTH. That would be on the Flint Street side?
Miss WATTS. Yeah. Un-huh.
Yes, I think we left that door open. I am not sure but I think we did. I know now we shouldn't have.
Mayor BURNWORTH. Doris, I don't want to be repetitious but there has been quite a lot of talk on the cigarette lighters and different things in Mr. Phillips' room. I think you said before that there were two cigarette lighters in there that you remember of.
Miss WATTS. Un-huh.
Mayor BURNWORTH. And an ashtray.
Miss WATTS. Un-huh.
Mayor BURNWORTH. Was there anything else in there? Was there any other lighters or matches or anything?
Miss WATTS. Not that I knew of. I knew of the desk lighter, it was on his dresser that night, I used it to light the cigarette. I knew of his Zippo lighter, you know, that kind. It had been there the night before and I had used it but it wasn't there that night. I noticed because, you know, the night before I had used it because the table lighter had not been working. But I picked it up to see if it would work that night and it did, someone had refilled it.
Mayor BURNWORTH. To your knowledge there was not anything in the room except the two lighters.
Miss WATTS. Not to my knowledge.
Mayor BURNWORTH. Did you light any cigarettes for Mr. Phillips?
Miss WATTS. No, I always let him light them.
Mayor BURNWORTH. He could light them himself?
Miss WATTS. What I mean is I let him—you know, I put it in his mouth, I lit it.
Mayor BURNWORTH. You lit it?
Miss WATTS. I lit it. I struck the lighter. I never let him do that but, you know, I let him puff on it.
Mayor BURNWORTH. You would put it in his mouth, he would puff on it and you would put the fire to the end of it and he would start the thing burning?
Miss WATTS. Yeah, un-huh.
Mayor BURNWORTH. One other question here I might ask. Do you think in your own mind that he could have lit his own cigarette?
Miss WATTS. Well, I don't think so, no. But then I never thought a certain patient up there could walk and yet at night she would get out of bed and walk. I don't know. I've thought about this, you know. I have, I really have. I don't think he could but, you know, I never gave it to him to see if he could so I really don't know. I don't think he could.
Mayor BURNWORTH. Well, the reason I was asking this, you mean he didn't have enough strength in his hand to hold the lighter?
Miss WATTS. I just don't know. His doctor—He could hold a glass.
Mayor BURNWORTH. And drink?
Miss WATTS. Un-huh.
Mayor BURNWORTH. He could hold a cigarette then?
Miss. WATTS. Occasionally. Occasionally. Sometimes, you know. They have good days, bad days. Some days he couldn't hold a glass, you know, he would spill it and other days he could.
Mayor BURNWORTH. Could he walk?
Miss WATTS. He pranced like a horse but you had to be there. You had to be there. He couldn't walk.
Mayor BURNWORTH. Doris, let me ask you——
Miss WATTS. This is not relevant, I just thought of it.

Mayor BURNWORTH. Doris, you mentioned the heavy, thick, black smoke.
Miss WATTS. Yes.
Mayor BURNWORTH. Do you think you might have an opinion for the committee on what caused the smoke? What do you think was causing the smoke?
Miss WATTS. Well, I've heard everyone say it was the carpet. I don't know. I don't have an opinion; no, I don't.
Mayor BURNWORTH. What would you say——
Miss WATTS. Plastic, does it make black smoke?
Mayor BURNWORTH. It makes black smoke.
Miss WATTS. Well, there was a plastic chair in that corner, it was burning.
Mayor BURNWORTH. And there was a plastic wastebasket.
Miss WATTS. Plastic wastebasket.
Mayor BURNWORTH. Both of them were burning, you saw them burning?
Miss WATTS. Both of them was burning, un-huh.
Mayor BURNWORTH. Did you happen to see if the carpet or floor was burning?
Miss WATTS. No, I didn't happen to but the flames were all over that corner. Now I don't think they were up the ceiling, no. I was asked that. You know, I really didn't know; I couldn't think. But if they had been up the ceiling, I would have noticed it, I think. But I do know that they were there at my level anyway, almost at my level.
Mayor BURNWORTH. Do you know of anything else in the room other than a possible accidentally disposed of cigarette that may have caused the fire?
Miss WATTS. You see, there was no electrical outputs.
Mayor BURNWORTH. Nothing that you would know of?
Miss WATTS. Nothing that I would know of.
Mayor BURNWORTH. Beman, do you have anything else?
Mr. BIEHL. The only other question I wanted to ask you would be, how long from the time that the fire first started was it until the Fire Department was notified? In other words, Mrs. Hall called——
Miss WATTS. Can you tell me, was Mrs. Hall the first call that you got?
Mr. BIEHL. We understand that's it, yes.
Miss WATTS. Okay.
Mr. BIEHL. See, you stated she went down the hallway.
Miss WATTS. Yes, she went down the hallway, I think.
Mr. BIEHL. See, she would not have been able to call the Fire Department then.
Miss WATTS. No.
Mr. BIEHL. She would have had to go back up the hall and outside the building.
Miss WATTS. Un-huh.
Mr. BIEHL. Can you give us any approximate time on that?
Miss WATTS. Four, five minutes. I don't know. Four or five minutes.
Mayor BURNWORTH. Let me ask you one other question.
Miss WATTS. Was the fire drill, you know, the sensors that sounded what she touched off when she knocked that metal casing off, was that automatic? I mean I always thought that that notified you.
Mr. BIEHL. The sensor was in the middle of the room, it detected heat; it went off at 136 degrees. It worked fine.
Miss WATTS. What I mean was, did it notify you guys?
Mr. BIEHL. No.
Miss WATTS. See, I thought it did. I don't know if she did or not.
Mayor BURNWORTH. Doris, one final question that I am sure the committee is concerned with. Do you think that by the time the fire occurred that most of the people were sleeping?
Miss WATTS. Yes. Yes.
Mayor BURNWORTH. Because they were in bed for quite a while before the fire occurred.
Miss WATTS. Yes.
Mayor BURNWORTH. Because of some people's condition you would give them sleeping pills?
Miss WATTS. Un-huh.
Mayor BURNWORTH. So your opinion is most of them were asleep at the time of the fire.
Let me ask you an opinion from just having been up there in direct relationship. Do you think that very many of the people woke up, or do you think they probably got the smoke in their sleep?
Miss WATTS. I think they must have gotten it in their sleep because I have heard the morgue say that they never got a more relaxed bunch of corpses. As far as I was concerned, you know, I really would not know if they were all asleep but usually at that time of night most of them were asleep.

Mayor BURNWORTH. The reason I raised the question was because you had said you could not get back in because of the heavy smoke and you heard no screams.

Miss WATTS. No, I didn't hear any screaming. I screamed.

Mayor BURNWORTH. We have not been able to find anybody that did.

Miss Watts. I screamed.

Mayor BURNWORTH. One thing I would like to point out in reference to the tape, Senator.

The young lady stated that she thought that the fire sensor was hooked to the fire department by direct communications and we were amazed to hear this. But we recorded the tape because I was doing a little thinking later that had she thought this she may never have called herself, you know. I will be very brief in concluding.

As you gentlemen know by this time, nursing homes in the State of Ohio are licensed by the State. For that reason, Fire Chief Biehl called in the State fire marshal personnel immediately to investigate this fire.

Personnel from the State fire marshal's office were on the scene by 2 a.m., Saturday morning, January 10, 1970. Results of their investigation are being made available to you and are attached to the end of this statement so I will not go into that matter.

Let me go now to my conclusions. There has been a fire and a high loss of lives and now our challenge is to learn from the fire all that we can and share this with others in the hope of preventing a recurrence of this type of tragedy anywhere in our great Nation or in the world.

I feel that the challenges we face are to realistically look at the facts which are being brought together by many agencies, evaluate this information and the findings, and apply what we learn to not only nursing homes but to other types of operations, such as hospitals and so forth, where similar circumstances might prevail.

To say the least, we have been visited and contacted by more than our share of experts and have been the recipient of many dozens of suggestions from those very capable people who possess outstanding 20–20 hindsight.

I have received letters, phone calls, and personal visits from individuals, associations, industrial representatives, and many others concerned with the construction materials, equipment, and supplies which were used in the nursing home. Many of these merit consideration.

While it is true that we are living in a day and age of accelerated technical knowledge, I feel it is sometimes ever so easy to overlook the obvious.

While it is true that perhaps a sprinkler system could have stopped the fire and perhaps door-closing devices would have saved lives, and further, perhaps a better quality of materials could have been used which were more fire resistant, I submit to you that it is my firm opinion this tragic fire did occur in a very new, modern, well constructed, excellently managed convalescent home which proves to me that we must consider the fact that human error played an important part in this tragedy.

I urge this committee of our Federal Government, our Congress, and our State legislatures throughout the country to, based on study, do everything in their power to pass laws which would bring about higher standards dealing with the construction, the equipment,

materials and supplies, furniture and fixtures, maintenance and operations dealing with nursing homes.

However, now let me get to the root of the problem. I submit to you that, had smoking not been permitted in this nursing home, this fire would not have occurred. I strongly urge that laws be enacted which would prohibit any type of smoking in nursing homes, hospitals, or, for that matter, any place that houses persons who are totally or partially immobile except in areas specially designed and set aside for the purpose of smoking.

It is my opinion that no employee, patient, or visitor should ever be allowed to smoke in a patient's room, under any circumstances.

Providing a specially designated area for smoking conveniently located within these types of facilities should not, in my opinion, be excessively expensive.

Further, I believe a designated smoking area could be equipped with furnishings that would be less flammable. Also, I think the room could be equipped with automatic sprinkling devices and door-closing devices in the event an accident allowed a fire to occur.

One thing we must bear in mind when we talk about upgrading facilities is cost. The cost of the facility has a marked effect on the cost of patient care.

It would seem to me that we could provide specially equipped smoking facilities which could greatly reduce the possibility of fire at less expense than would be required to virtually fireproof every room.

Let me then, in closing, urge you to look at this part of the problem. I hope that regulations can be formulated and laws passed to prohibit smoking as aforementioned.

Now, gentlemen, I wish to show to you an enlargement of a drawing which is a facsimile of the Harmar Nursing Home floor layout.

I will also mark on it for you X's for those who died at or as a result of the fire, and O's for those patients who have thus far survived.

The following attachments include a more accurate drawing developed for this presentation.

Then, Senator Moss, and Senator Williams, we would like to burn some of the carpeting and furnishings. I would like you both to come down to the floor.

One thing that Fire Chief Biehl has stated, to the State fire marshal, is that the doors being open and closed has a great deal to do with whether or not people survive.

The X's are those who are deceased, the O's are persons who lived. I think when we get them on the map you will get some general idea.

Now, this is Mr. Phillips' room, the fire room. He is living. Next to him two patients died. The registered nurse who was in this room sealed the door and took the patients out the window, they both lived.

This lady was taken out the window and lived.

This is the area over here I am most familiar with, this is the area I was working in at the time of the fire.

As I said, originally, I will reiterate, that the patients by the windows were very easy to get to. Another problem that was faced in the fire which you will hear later today is the problem created by strapping patients in bed. Of course, I think we must recognize that patients in some instances must be kept in bed.

Now, as you can see, the fire occurred here. We had deaths all around this immediate area for the heat immediately went into what we considered to be open doors.

Right here where the nurse closed the door apparently, either was shut or closed on the way out, these people lived. This is a long way off, yet it was extremely hot.

Our firemen converged from here and here in this area to get at the fire.

Now I would like to show you what we feel, Senator. If you and Senator Williams will come down here, for the benefit of the committee, this is a certification that this piece of backing was actually taken from the home. This even has the cement on the back of it. We scraped it away from the carpeting and this is actually a piece of the carpet backing.

You can see how the two are bonded together. If you will hold one, Senator, and you will hold one here, Senator, please.

Now, if you will hold that on an angle, I don't want you to burn your fingers.

This is the backing because we have peeled away. See, this was actually cemented to the floor and this is the carpet.

Now, what we will do, we will let it burn very briefly because it will put out enough of a problem. Then we will drop it in the can and extinguish it.

Now remember, at the time of the fire, ladies and gentlemen, there was air current going through the area.

Turn that around, I believe, Senator. See how the cement is burning good.

Turn it around one more time. You better drop that.

Now let me show you. If you turn it over, let the heat come to this side of it, see the carpeting will burn. Now, the problem is not the carpeting. You can smell it where you are standing when the carpet is melting. This is 100-percent nylon. The rubber is burning good.

Don't open the can the rest of the day.

The CHAIRMAN. That was just one match?

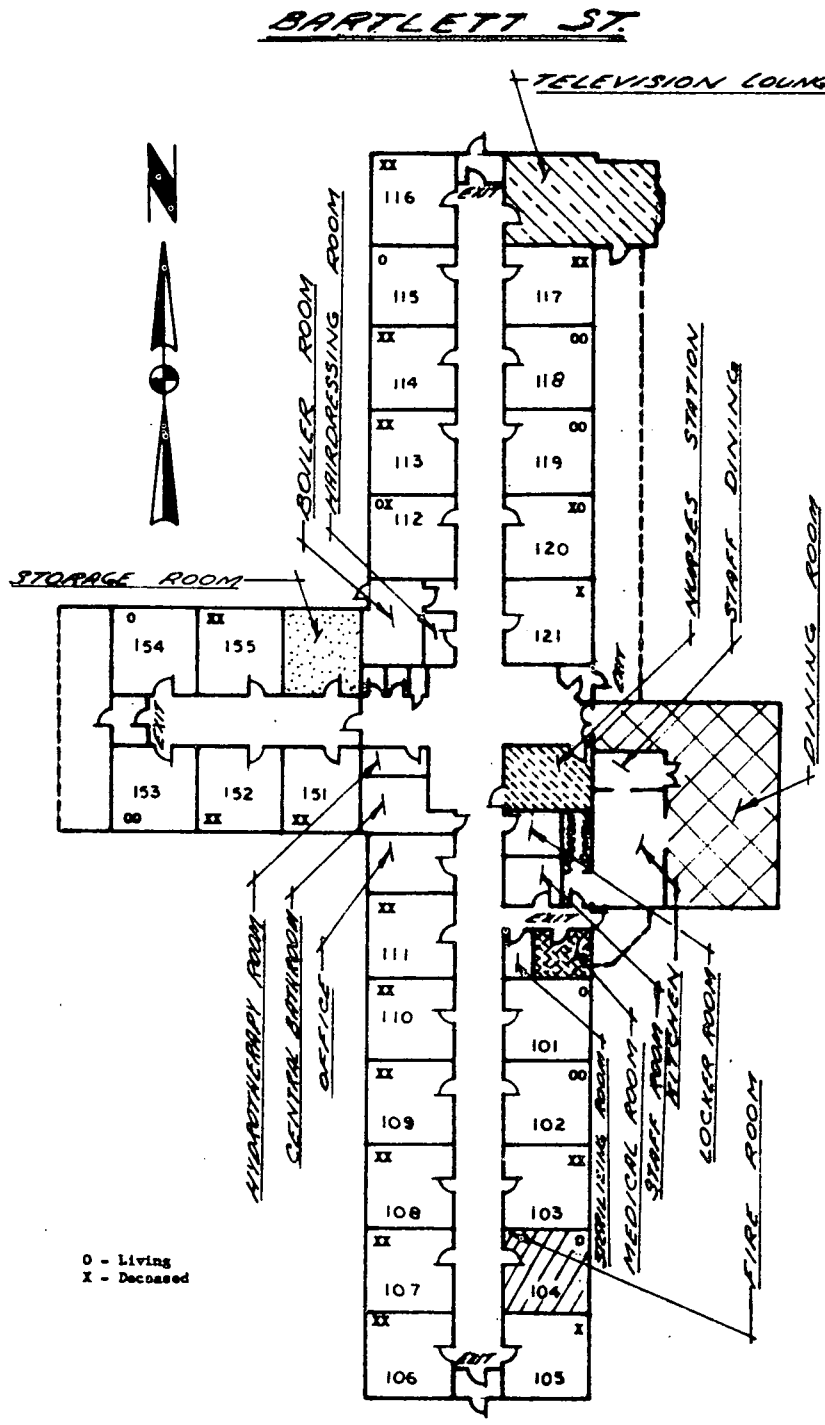
Mayor BURNWORTH. Just one match. I will show you, just watch this.

Better put it out.

Gentlemen, following my testimony there are a number of attachments. The attachments do include, Mr. Chairman, an actual map of the floor layout which we have taken from the plans which your committee can supply at a later date.

That concludes the testimony of the city of Marietta. We would be glad, within our ability, to answer any questions you may have.

(The documents referred to follow:)


BARTLETT ST.
TELEVISION LOUNGE
BOILER ROOM
HAIRDRESSING ROOM
STORAGE ROOM
NURSES STATION
STAFF DINING
DINING ROOM
EXIT
116
115
114
113
112
117
118
119
120
121
154
155
153
152
151
111
110
109
108
107
106
101
102
103
104
105
HYDROTHERAPY ROOM
CENTRAL BATHROOM
OFFICE
SERVING ROOM
MEDICAL ROOM
STAFF ROOM
KITCHEN
LOCKER ROOM
FIRE ROOM
0 - Living
X - Deceased

Current Status Harmar House Occupants February 4, 1970

101 Edna Gray (SGH)
102 Ellen Kast (Home) (MMH)
" Gertrude King (MMH)(R 1/22/70 Arcadia Nursing Home)
103 Anna Richards (DOA)
" Aurilla Johnson (DOA)
104 Lyle Phillips (MMH)(R 1/12/70 Sistersville, W. Va. Hosp.)
105 Bessie Greenlees (DOA)
106 Cora Haas (DOA)
" Evaline Mills (DOA)
107 Clarence Chandler (MMH) (D 1/19/70)
" Jesse Blair (MMH) (D 1/24/70)
108 Clara Theis (DOA)
" Gertrude Kerwood (DOA)
109 Ethel Flynn (DOA)
" Blanch Lawrence (DOA)
110 Julia Ogdin (DOA)
" Sabra Bergen (DOA)
111 Lydia Parks (MMH) (D 1/11/70)
" Anna Zimmer (DOA)
112 John West (DOA)
" Casper Berg (MMH)(R 2/1/70 Arcadia Nursing Home)
113 Myrtle Robey (MMH) (D 1/12/70)
" Grace Brigham (MMH) (D 1/13/70)
114 Margaret Flynn (MMH) (D 1/16/70)
" Mabel Hubbell (MMH) (D 1/12/70)
115 Mason Carpenter (MMH) (R 1/28/70 Christian Anchorage)
116 Hattie Middleswart (DOA)
" Helen Weber (MMH) (D 1/11/70)
117 Anna Bergen (MMH) (D 1/24/70)
" Rose Krabill (DOA)
118 Herman Masters (MMH)
" Charles Strauss (MMH)
119 Harry Boomer (MMH) (R 2/1/70 Home)
" Phillip Case (MMH)(R 1/13/70 Home)
120 John Noe (MMH) (R 2/1/70 Resthaven Nursing Home)
" Lewis Byers (MMH) (D 1/30/70)
121 Fred Garman (DOA)
151 Louise Boeshar (DOA)
" Martha Sturbaum (DOA)
152 Mae Tresch (DOA)
" Katherine Gandee (DOA)
153 Frank Tornes (MMH) (R 1/28/70 Clegg Nursing Home)
" John Ring (MMH) (R 1/14/70 Christian Anchorage)
154 Jane Zogg (MMH)
155 Mary Smithey (DOA)
" Mary Plageman (MMH) (D 1/10/70)

MMH - Marietta Memorial Hosp.
SGH - Selby General Hospital
D - Deceased
R - Released

PRESS RELEASE 3:00 A.M. January 10, 1970

HARMAR HOUSE CONVELSCENT HOME

Bartlett & Flint Streets, Marietta, Ohio

First report received at 9:47 P.M., January 9, 1970

No. 2 and No. 3 Pumpers and Chief responded to call.

Upon arrival at the scene all fire and police units were called out. This consisted of 24 firemen and 24 regular and auxiliary policemen.

Excellent response and back-up was received from area Departments. Among those identified were Emergency units from Belpre, Warren, and Oakgrove, Ohio, and Williamstown and Vienna, W. Va. Warren Ambulance Service, Parkersburg (W.Va.) Ambulance Service and Miller Ambulance Service (Vienna, W. Va.). Units were equiped with resusitation equipment and oxygen equipment. All area funeral homes responded with full equipment. City Water and Street Departments responded as well as emergency units from Bell Telephone, River Gas and Monongahela Power.

Chief Biehl made the following statements:

Building is in the shape of four wings forming a cross. Fire appears to have started in the second room from the end of the south wing on the east side. Flames were involved in 2/3 of the building. At the present time there is no idea as to the cause. This is still under investigation. Four men from the State Fire Marshal's Office are on the scene: 2 from the Arson Bureau, 1 from the Fire Prevention Bureau, and 1 from the Inspection Division.

The building has been sealed off and is being guarded by Police and Fire Department personnel.

At the present time it appears there were 46 patients housed in the facility and four female employees. As of 3:00 A.M. there were 21 deceased with 25 hospitalized. Six are listed as being in critical condition. Two firemen have also been hospitalized: Lt. Charles Young, smoke inhalation and exhaustion, and Fireman William McCrady, smoke inhalation, exhaustion and injuries to his arms. One of the hospitalized was an employee of the Home.

Mrs. Mildred Hall, in charge of the Home at the time of the fire, made the following statements to Fire Chief Biehl: The fire sensors, located in the hallways, sounded. Mrs. Hall immediately went back to Room 104 and saw the room was on fire. The aides pulled the patient out of the room and Mrs. Hall immediately pulled the fire alarm. She then went to the office to call the Fire Department but the smoke was so dense she could not see the telephone. She then left the Nursing Home to go to a nearby residence and called the Fire Department. Mrs. Hall further stated that after she went back to the Home there was a sound like a roar and smoke filled the entire building.

City personnel on route to the scene saw the fire from a considerable distance.

Evacuation Operations:

Evacuation was instant and immediate by all personnel and private citizens at the scene and resulted in expedient removal of patients. Patients in obviously good condition were moved into adjacent homes. Those in critical condition with burns and obviously suffering from smoke inhalation were given ambulance priority. A constant flow of ambulances and emergency units arriving from Marietta and surrounding areas transported all 46 patients regardless of their condition to both Marietta Memorial Hospital and Selby General Hospital. Ambulances stood by after the evacuation operation both at the scene and at the hospitals for the later removal as required to either the temporary morgue which was established at the Ohio National Guard Armory or hospitals or funeral homes as required.

All deceased were identified by 1:30 A.M. Identification was made at the hospitals.

Fire fighters at the scene were under the direction of Fire Chief Beman G. Biehl. Assisting with evacuation were the Police Chief and Service Director at the scene. Following the evacuation Police Chief P. K. Gramkow, in cooperation with Sgt. Frank Stevens, of the Ohio National Guard, established a temporary morgue and Service Director L. R. Weber handled identification operations at Marietta Memorial Hospital.

Patients at Harmar House

Room	Name	Date of Birth	Nearest of Kin	
112½	Berg Mr. Casper	7-3-1877	Mr Floyd Berg	Marietta
110 2	Bergen Mrs Sabra	2-17-1879	Mr. Don Davis	"
117 2	Bergen Mrs Anna	12-30-1885	Mr. Richard Bergen	"
107 2	Blair Mr Jesse	9-22-1872	Mr. Carl Blair	Beverly O
151½	Bochar Mrs Louise	4-12-1875	Mr. Frank Bocher	Marietta
119½	Boomer Mr Harry	3-16-1890	Mrs Robin Baker	"
113 2	Brigham Mrs Grace	1-23-1892	Mr Lawrence Penrose	"
120½	Byer Mr Lewis	12-5-1889	Mr. Harold Byer	"
115½	Carpenter Mr Marion	10-31-1886	Mrs Lola Carpenter	"
119 2	Case Mr Philip	5-3-1891	Mr. P.B. Case	"
107½	Chandler Mr Clarence	1-7-1897	Mrs Lloyd Lukens	"
109 2	Clynes Miss Ethel			
114½	Clynes Miss Margaret	12-3-1889	Mrs Mary Oldsberger	Belle Rouge Louisiana
152½	Candee Mrs Katherine		Mr Richard Graham	Marietta
101	Corman Mr Fred	7-6-1887	Mr Paul Nieb	"
101	Gray Miss Edna	10-21-1895	Mr Hayward Strecker	"
105	Greenlee Mrs Bessie	7-27-1885	Mr. Hayward Strecker	"
106½	Haas Mrs Cora	3-13-1885	Mr. Lou Haas	"
114 2	Hubbell Mrs Mabel	3-12-1891	Mr Preston Hubbell	Fitzgerald Ga.
117½	Kraighill Mrs Rose	8-14-1895	Mrs Robert Roberts	Belpre O.
102½	Kast Mrs Ellen	-1876	Mrs Harriet Rahn	Marietta
108 3	Kenwood Mrs Gertrude	2-26-1893	Mr Gaston Simmons	St Marys W.Va.
103 2	King Mrs Gertrude	11-4-1892	Mr David King	Ravenswood W.Va.
109½	Lawrence Mrs Blanche	5-30-1898	Mrs. Stanley Warren	Marietta
118½	Masters Mr Herman	11-1-1899	Mr Carl Masters	"
116½	Middlesworth Mrs Nettie	8-6-1887	Mr. Charles Middlesworth	"
106 2	Mills Mrs Evaline	8-20-1877	Mrs Alfred Strong	"
120 3	Noe Mr. John		Mr. Lester Noe	"
111½	Ogden Mrs Julia	3-18-1873	Mr Orrin Ogden	Parkersburg W.Va.
111 2	Parks Mrs Lydia	4-27-1884	Mrs Glen Roberts	Elizabeth W.Va.
104	Phillips Mr Lyle	9-20-1901	Mr James Phillips	Lewisville W.Va.
155½	Plagneman Mrs Mary	3-26-1897	Mr Lee Plagneman	Marietta
103½	Richards Miss Anna	8-19-1878	Mrs Priestley White	"
153½	Ring Mr John	6-22-1893	Mrs Margery Hogan	"
113½	Roby Mrs Lila Mayrate	8-8-1896	Mr Paul Johnson	Belmont W.Va.
138 2	Spindler Mrs Mary	9-1-1890	Miss Isabella Cargill	Charleston W.Va.
119 2	Strauss Mr Charles		Mr Robert Lorenz	Marietta
151 2	Sturhahn Mrs Martha	2-22-1912	Mrs Clifford Spindler	"
109½	Theis Mrs Clara	6-10-1882	Mrs Grant Edwards	"
153 2	Torres Mr Frank		Mrs Sarah Ley	"
157 2	Trisch Mrs Mae	10-21-1880	Mrs Floyd Henderson	Cadwell Ga.
112 2	Weber Miss Rosa Helen	3-27-1877	Mrs Charles Weber	Marietta
102 3	West Rev John	10-18-1887	Mrs E.L. Roush	Parkersburg W.Va.
111½	Zimmer Mrs Anna		Mrs Vera Hartshorn	Lowell O.
105	Zogg Mrs Jane	5-19-1886	Mrs Ralph Brown	Charleston W.Va.
103 3	Johnson Mrs Aurilla	8-11-1884	Mrs Harold Bartmus	Marietta

Harmar House Employees

R.N.	Abbott Mrs. Esther 07-18-66	929	Brown Ave	Belpre Ohio
Aide	Ash Miss Elizabeth 11-3-68	R# 2	Marietta	Ohio
Aide	Baier Mrs. Judy 08-23-67	114	Riverview Dr.	Marietta O.
Maid	Board Mrs. Ruth 02-26-68	R# 5	Marietta	Ohio
Maid	Bonnet Miss Janet 08-26-69	420	Bellevue St.	Marietta O.
Aide	Clark Mrs. Mary 04-03-67	R# 3	Mt. Cumberville	O.
R.N.	Coultrus Mrs. Ann Jane 03-22-66	334	Muskingum Dr.	Marietta O
Cook	Casto Mrs. Wilda 09-17-69	702	Lancaster St.	Marietta O
Aide	Cozzens Mrs. Margie 6/27/68	101	Leland Ave.	Marietta O
R.N.	Dilley Miss Elizabeth 01-17-66	1210	20th St.	Vienna W. Va
Aide	De Long Mrs. Marie 7/3/68	R# 1	Williamstown	W. Va
Aide	Eddy Miss Josie 11-01-69	R# 6	Marietta	Ohio
Cook	Garfield Mrs. Garnet 03-25-67	113	Victory Place	Marietta O
R.N.	Fearing Mrs. Clarya 08-13-69	9	Valley View Dr.	Vienna W. Va
Aide	Hackathorn Mrs. Lynn 05-26-69	120	N. 7th St.	Marietta O.
L.P.N.	Hanes Mrs. Frances 02-15-66	R# 3	Marietta	Ohio
L.P.N.	Hall Mrs. Mildred 02-12-68	R# 6	Marietta	Ohio
Aide	Kern Miss Tillie 10-01-66	467½	Sixth St.	Marietta O.
Laundry	Kerns Mrs. Ruth 04-24-69	R# 2	Marietta	Ohio
L.P.N.	La Fabre Mrs. Catherine 06-06-67	R# 6	Marietta	Ohio
Aide	Lewis Mrs. Dorothy 01-17-66	419	Columbia Ave	Williamstown W. Va
R.N.	Lowe Mrs. Patricia 09-02-68	901	W. Third St.	Williamstown W. Va
Maid	Mayberry Mrs. Mary 03-15-67	R# 6	Marietta	Ohio
Aide	McClung Mrs. Roy 08-27-69	R# 1	Box 85	Williamstown W. Va
Aide	McGuire Mrs. Eudora 08-26-68	202	2nd St.	Williamstown W. Va
Cook	Miller Mrs. Sylvia 10-24-68	R# 3	Marietta	Ohio
Cook	Morgantern Miss Connie 09-11-68	R# 1	Whipple	Ohio
L.P.N.	Morrison Mrs. Florence 04-10-66	R# 2	Stockport	Ohio
L.P.N.	Morris Mrs. Vesta 02-03-66	718½	Front St.	Marietta O
Housekeeping	Purr Mrs. Howard 11-14-66	718	Lancaster St.	Marietta O.
Aide	Jones Miss Marsha 05-17-69	324	Oakwood Ave.	Marietta O
Aide	Sattler Mrs. Barbara 06-16-66	807	Zugsey St.	Marietta O.
Maid	Schilling Miss Edith 06-19-69	617	10th St.	Marietta O
Cook	Sparks Mrs. Wanda 05-28-69	R# 1	Marietta	Ohio
Aide	Starkey Mrs. Lenora 07-24-69	412	Lord St.	Marietta O.
Aide	Watts Miss Doris 6-1-68	609	Sixth St.	Marietta O
Hsg.	Woods Mrs. Dorothy 09-12-69	119	Alta St.	Marietta O.
Hsg.	Rutter Mrs. Marilyn 5-1-67	R# 3	Marietta	O.
Aide	Woodruff Mrs. Patricia 03-23-68	1313	16th St.	Vienna W. Va
Cook	Wright Mrs. Helen 04-10-67	334	Pike St.	Marietta O.
Aide	Nelson Mrs. Helen 03-01-67			

Stock holders of Corp.

# Shares		# Shares	
10	David H. Strecker 135 Strecker Hill Marietta, Ohio	10	John J. Dempsey 206 Chamberlain Drive Marietta, Ohio
10	Sue Strecker 135 Strecker Hill Marietta, Ohio	10	Homer A Dempsey 206 Chamberlain Drive Marietta, Ohio
10	David & Ann Brawdwell 125 Strecker Hill Marietta, Ohio	20	C. Carl Groff Longaberger Dr #1 Marietta, Ohio
30	H N Shirby Co. 17 Iles Way Marietta, Ohio	10	James A Ackerman 320 Fourth Street Marietta, Ohio
30	Kenrick E. Bennett 412 Fourth Street Marietta, Ohio	20	Bessie R. Greenlee 730 ½ Third Street Marietta, Ohio
30	Richard R & Anita L Hill 332 Muskingum Drive Marietta, Ohio	10	Mary C. Mc Mahon 726 Lancaster Street Marietta, Ohio
30	Kranich Co & Mary L Owen Longwood Road - Rt #6 Marietta, Ohio	20	Burgan Brothers, Inc. 309 Third Street Marietta, Ohio
30	Preston M & Nancy H Mead 150 Seneca Drive Marietta, Ohio	30	Edwin B Strecker 200 Buchanan Street Marietta, Ohio
30	Chester D & Dorothy M Cramer 804 Colegate Road Marietta, Ohio	10	Ford B. Eddy 814 Colegate Road Marietta, Ohio
30	Teresa J. Dawson Seneca Drive Marietta, Ohio	12	Harriet Rohr 504 Masonic Park Rd. Marietta, Ohio
20	Mary P Strecker 114 Pike Street Marietta, Ohio	10	William A. Fields 523 Second Street Marietta, Ohio
5	John A & Eleanor C Hickle 603 Masonic Park Road Marietta, Ohio.	5	Roy J. Donnelly 720 Third Street Marietta, Ohio

# Shares		# Shares	
15	Lee Woodward St. Marys, W. Va.	5	John W. & Mabel R. Heath Route #1 Marietta, Ohio
30	Donald E. Fleming Vincent, Ohio	30	Robert E. & Joan Ley Waterfield Road Marietta, Ohio
20	Guathal P. & Judith Ann O'Meille North Hills Marietta, Ohio		
20	Hiser & Cawley, Inc. 817 Third St. Marietta, Ohio	Total Shares 647	
20	Donald P. Mintar 431 Fourth St. Marietta, Ohio		President: K.E. Bennett V. Pres.: R.R. Hill Sec.: C.D. Camden Treas. Haywood Starcher
20	Richard N. Smith 900 Colegate Road Marietta, Ohio		
10	Frank E. Barden 625 Third Street Marietta, Ohio		
30	Geo. E. & M. Kathleen Thatcher 819 Third Street Marietta, Ohio		
5	Berry-Haas Insurance Agency, Inc. 324 Third Street Marietta, Ohio		
5	William T. Hiark 308 Washington St. Marietta, Ohio		
5	C. Edgar & Miriam Northrup North Hills Marietta, Ohio		
10	Pickering Elec. Co. Inc. Route #1 Marietta, Ohio		

Form AB-24 PRELIMINARY INVESTIGATION REPORT

(First report on investigation of the cause of a fire loss. Form to be mailed to Columbus Office within 24 hours after beginning investigation)

1. Owner: Health Services, Inc. (name) Bartlett & Flint Streets (address) Marietta (city)
2. Occupant: Harmar House Convelescent Home, Bartlett & Flint Sts. (name) (address) Marietta (city)
3. Suspect: (name) (address) (city)
4. Date of fire: January 9, 1970 5. Time: 9:57 P.M.
6. Location of fire: Bartlett & Flint Streets (Street) Marietta (City or Village) Washington County (Township) (County)
7. Investigation requested by: Beman Biehl, Fire Chief, Marietta Fire Dept. 8. Date: 1-9-70
9. Company in which building is insured: Agent: Bill Wyant, Marietta Insurance Policy Number: 666N135578 St. Paul Fire and Marine Insurance Co. 10. Amount $ 265,000
11. Company in which contents are insured: St. Paul Fire and Marine Insurance Co. 12. Amount $ 45,000
13. Type of building: Brick, one-story nursing home. (frame - brick; dwelling - commercial; etc)
14. Loss to building: 75,000 15. Loss to contents: $40,000
16. Names of persons contacted or to be contacted:

(name)	(address)	(phone)
Mildred Hall	Route 6, Marietta	373-2689
Maysle Cozzens	101 Leland Avenue, Marietta	
Marie DeLong	Route 1, Williamstown, West Va.	428-6955
Doris Watts	609 - 6th St., Marietta	373-5697
Lyle Phillips	333 Flint St. Marietta % Marietta Memorial Hospital	
Charles Strauss	% Marietta Memorial Hospital	
Maude Lee	% Selby General Hospital	
Annabel Budgett	623 - 8th Street, Marietta	

17. Fire believed to be caused by: Undetermined (accident, incendiarism, undetermined)
18. Reasons why fire should be, or should not be, further investigated: More witnesses to be contacted and more investigation anticipated.
19. Date of investigation: 1-9,10,11, 1970 20. Date of this report: 1-14-70
21. (Signed) Robert T. Glenn
Harry M. Laughlin

(Use reverse side for additional information)

PRELIMINARY INVESTIGATION REPORT

Harmar House Convalescent Home
Marietta, Ohio

This is a preliminary field report of the Harmar House Convalescent Home fire in Marietta, Ohio.

Attached are the following enclosures:

1. The complete plans and specifications of the building.
2. A set of blue prints.
3. A report of Vernon V. Vadakin & Sons, Inc., Marietta, Ohio, relative to paint and wall coverings.
4. A report of Weiser & Cawley, Inc., Marietta, Ohio, carpet installers.
5. A report from Fire Chief B. G. Biehl, Marietta, Ohio, relative to information furnished by C. D. Camden, architect, relative to furniture and fixtures.
6. Report from Dr. Kenneth Owen, Washington County Coroner, containing census of home and diagram of home, showing location of occupants relative to their rooms as to survival or loss of life.
7. Death certificates of all deceased.
8. Transcribed statements.
9. Set of complete photographs of fire scene.
10. Items removed from building for examination.

The following items were removed from room 104 for examination:

1. Carpet from closet.
2. Electrical motor from bed.
3. Section of dry wall from area at head of bed.
4. Electrical wiring, switches and outlets.
5. Heat sensor.
6. Top drawer of bedside stand which contain a Kleenex box and a penny box of matches inside the Kleenex box, not ignited.

Other items collected:

1. Heat sensor from undamaged room.
2. Carpet from hallway in front of room 106.
3. Carpet from room 107.
4. Paint sample which had been flaked off by heat from wall of hall near room 113.
5. Section of dry wall near floor level in hall in area of room 113.
6. Plastic waste can from room 107.
7. One pillow from room 107.
8. Section of mattress from room 107.
9. Section of mattress cover from room 107.
10. A section of chair and chair covering from room 107, similar to the one which had been located in the northwest corner of room 104.

The fire occurred on January 9, 1970 at 9:57 p.m. The building involved is a one-story modern fire resistant structure built in 1965. The building was in the shape of a cross and is located on the southwest corner of Bartlett Street, which runs east and west, and Flint Street, which runs north and south in Marietta, Washington County. The building is approximately 244 feet north and south, and approximately 134 feet east and west. The patients' rooms are off the north and south corridors and off the west corridor. The east wing was the kitchen and dining room areas. The center where the wings come together was the area of the nurses station. The interior walls were painted dry wall on steel stud beams, however, one wall of each room was wallpapered. The exterior of the building was brick veneer construction with a cel-o-tex subsiding. The roof was plywood sheathing supported by metal trusses which run from the ceiling. The roofing is asphalt shingles.

The occupants at the time of the fire were 46 patients, most of whom were elderly bed patients, 4 regular employees and two special nurses. Twenty-one patients initially lost their lives and 6 have died since, todate. The death certificates as to the cause of death with names and addresses of the deceased are attached to this report, one employee, Maysle Cozzens, was hospitalized. Maude Lee, a private nurse, was hospitalized from smoke inhalation. Two firemen, Lt. Charles Young, was hospitalized from smoke inhalation, and fireman William McCready was hospitalized with torn muscles.

The surviving patients were taken to Marietta Memorial Hospital and Selby Hospital. The patient census notes which hospital each patient was taken to.

The first notification of the fire was received by the licensed practical nurse in charge, Mildred Hall, who was sitting at the nurses station in the center of the building when the heat activated the alarm system. The alarm system indicated the fire was in the south wing. At this time she rang the house alarm and noticed that the smoke was coming from the south end of the building. Upon the sounding of the alarm Mrs. Hall was joined by the other employees, Doris Watts, Maysle Cozzens, and Marie DeLong, in the area of the nurses station. At this time they all went in the direction where the smoke was pouring from, room 104. Miss Watts, with the aid of the other employees, was able to remove Mr. Phillips from the room and took him up the hall.

The employees described the fire as burning on the floor in the northwest corner of room 104, which was occupied by Mr. Lyle Phillips. The room was heavily charged with smoke and the employees took Mr. Phillips into the hall. Heavy smoke and heat followed them up the hall. Mrs. Hall said that by the time she got back to the nurses station, smoke was so dense she could not see to dial the fire department. She was forced to leave the building and go across the street to the Emeral Stanley residence, 205 Flint Street, where she burst into the house and dialed the operator for help. It was established later that special nurse Annabel Budgett dialed the operator at the nurses station and reported the fire as Mrs. Hall was leaving the building to report the fire. According to witnesses the lights failed shortly after the discovery of the fire. The electric time clock stopped at 10:02 p.m. The nursing home is in a residential area and neighbors immediately converged and started to remove patients even before fire apparatus arrived. The alarm was first answered by apparatus from the west side station under squad leader Donaldson Metcalf, who said the smoke outside the building was so heavy, when the fire trucks arrived on the scene a police officer with a flashlight had to guide the trucks to the rear of the building through the heavy smoke. The fire was first attacked through the window of room 104 and the fire was quickly knocked down with the next application of water being into the hall from the south door. The fire was knocked down within approximately 10 minutes with less than 1,000 gallons of water being used. Hydrant water was used in the mop up operations. After the fire was extinguished and the victims removed, the fire and police personnel sealed the building and stood guard until the investigation was completed.

Chief Biehl described the fire scene to these investigators as the fire appearing to have started in the second room of the south wing on the east side. Flames, heat, and smoke involved two-thirds of the building. A temporary morgue was set up at the National Guard Headquarters Building for the deceased. The county coroner, Dr. Kenneth Owen took charge of this operation. All deceased were identified.

The examination of the fire scene shows the fire originated in room 104 in the northwest corner of that room at a low level. It should be noted that the carpet of that room, which had a rubber back base on a concrete floor was almost entirely consumed as well as the rest of the contents of the room. The smoke, heat, and fire gases traveled into the hall from this room to the center of the building and then went east and west and traveled north to the approximate location of room 114.

Investigation indicates that the point of origin was in room 104 in the northwest corner at a point four feet six inches from the north edge of the entry door and two feet from the northwest corner of the room. This is the area as indicated by the V pattern on the wall and the deepest charring of the baseboard. It appears that the fire started on or near the floor at this point and spread upward and outward from this point. It has been established that in this area was a wooden night stand, a plastic wastebasket, a metal walker, and a wood frame vinyl plastic upholstered chair. There was a possibility of a blanket spread over the metal walker. There were no electrical outlets or switches located in this area of the point of origin.

It appears that the patients' rooms, where the doors were open, were the rooms where fatalities occurred. From the description of the fire it appears that the fire spread and production of dense smoke was very rapid, the heavy black smoke forcing the personnel from the building. The carpet in the hallway was almost entirely destroyed as far as the area of rooms 113 and 114 in a northward direction from the point of origin of the fire. Heavy destruction from heat and smoke occurred to the wall covering in the west wing, to the areas of rooms 152 and 155. The east wing, being the kitchen and dining room area, was damaged by heat and smoke. The only location where the fire made an exterior exit was through the large glass window in room 104. There was no basic structural damage to the building.

Interviews were made and statements were taken from the following persons: Mildred Hall, Licensed Practical Nurse in charge; Marie DeLong, nurses aide, Doris Watts, nurses aide; Maysle Cozzens; Maude Lee, special nurse; Annabel Budgett, special nurse; Mr. Lyle Phillips, occupant of room 104; and Charles Strauss, a surviving patient.

Formal statements taken by court stenographer Hazel Benford, 706 - 7th Street, Marietta, Ohio, will be transcribed and incorporated with this report. Mildred Hall told these investigators that she worked the 4-12 shift. Her duties were to set up medications for patients and help the aides feed. The last medication being around 9:15 p.m. on the evening of the fire and the lights being turned out at this time. She returned to the nurses station approximately 9:40 p.m. to work on the patients' charts. During this time the complete nursing home was very quiet. The alarm went off indicating there was a fire in the south wing. At this time she sounded the house alarm and she and the other aides started for the south wing and saw smoke coming from room 104. Mrs. Hall at this time started to close the door to room 111 and then went to the telephone located at the nurses station, but by this time the heavy black smoke was too dense for her to see to call the fire department. She then left the building and went across the street to the Stanley residence where she herself notified the telephone operator that there was a fire at the Harmar House.

Marie DeLong told these investigators that she was in the kitchen and dining area having a cup of coffee when the alarm sounded. She had helped Doris Watts put Mr. Phillips in room 104 to bed and she and Doris had left Mr. Phillips' room about 9:30 p.m. Marie said that she had supervised Mr. Phillips smoking a cigarette before going to bed and the cigarette was put out in an ashtray. Also, Mr. Phillips' door was left open about three

inches. Upon being notified of the fire she looked into Mr. Phillips' room and the heat and smoke soon drove her out of the building. She does not remember seeing flames coming from Mr. Phillips' room, but heavy black smoke billowed out in the hall when she went to the door. However, it may be noted that her hair was singed.

Doris Watts said she and Marie had put Mr. Phillips to bed and she was the last to leave the room about 9:30 p.m. She had supervised Mr. Phillips smoking a cigarette before going to bed. She said the cigarette was put in the middle of the ashtray and the ashtray was put on the dresser, which was to the foot of the bed on the south end of the room. She had lit his cigarette with a table model cigarette lighter, which was on the dresser at the south wall and Mr. Phillips' cigarettes were kept in the drawer of his nightstand by the side of his bed. She said that Mr. Phillips had recently been given a pocket lighter and the night before the fire she had remembered seeing both cigarette lighters on the dresser but there was only one lighter in the room the night of the fire. His own personal pocket lighter was missing. Doris was in the nurses lounge talking to her mother on the telephone when the alarm sounded. She ran to the south end of the building with the rest of the aides and pushed the door open to Mr. Phillips' room and saw fire burning to her immediate left on the floor, which would be in the northwest corner of the room. She said the smoke and heat was heavy and she went to the east side of the bed by instinct and was able to carry Mr. Phillips to the door where some of the other aides helped take him up the hall. Doris said that she took Mr. Phillips part way up the hall and stopped and she obtained a small red fire extinguisher from the kitchen area and was going to go back down the hall, but by that time the heat and smoke was so heavy she couldn't get into the room. They got Mr. Phillips out of the building and she remembers seeing Mrs. Hall leave the building to call the fire department at this time. Doris also described the contents of the northwest corner of the room and it should be noted that she noticed several bottles of baby oils and body lotions on top of the wooden bedside stand located by the side of Mr. Phillips' bed. She said Mr. Phillips' bed was not on fire at the time she removed him from the bed. The wooden bedside stand she remembered did contain cigarettes and Mr. Phillips' eyeglasses. She said Mr. Phillips in the last week had been in better shape physically and mentally than he had been for a long time. Doris was very much upset over the fact that she did not remember to close the door after she removed Mr. Phillips from the room. When Doris was asked whether she believed Mr. Phillips could have obtained a cigarette from the night stand by the side of his bed, she said she believed it could have been possible.

Charles Strauss of room 118 who was interviewed by these investigators was an amputee in a wheelchair. He heard the fire alarm and got out of his bed to get into his wheelchair and went into the hall and saw smoke coming from the south end of the building. The first thing he thought of was Mr. Phillips had been smoking in bed, because there was a rumor among the patients that Phillips would smoke while unattended. Strauss then returned to his room in his wheelchair and exited through the window. He described the hallway as being a solid wall of fire and smoke from the floor to the ceiling.

Mr. Phillips was interviewed twice, the first occassion was 2:30 p.m. on January 10 at the Memorial Hospital, room 220. Phillips was asked whether he knew about the fire at the nursing home. He said yes, he did. He was asked if he knew where the fire started. He said yes, in his room. He was asked what time the fire started. He said about 10:00 p.m., about one-half hour after he went to bed. He was asked where the fire started in his room. He said to the right of his bed on the floor in a waste can. He was asked which was his right hand. He raised his right arm partially. He was asked why he did not report the fire or sound an alarm of some type. He said he thought the fire burned itself out. He described the waste can as being a tall round plastic ice cream can. He was asked if it was similar to the waste can in his room which was to his left side at this time, sitting on the floor approximately six feet from his eye level. At this time he turned slightly in bed, glanced down at the can and said it was not like that one. He was asked whether he was smoking in bed and he said no. He was also asked if he had smoked earlier that night and he said yes. He was asked who lit his cigarette and he said he did.

On January 11, 1970 at approximately 6:00 p.m. recorded statement was taken from Mr. Phillips in room 220 at Marietta Memorial Hospital. In this statement he again remembered the fire starting in his room and that the fire did start in the wastebasket, first saying it was to the left side of the bed and then changing his statement, stating it was on the right side of the bed. He was asked if he had smoked that night and he replied that he had. When asked how he had disposed of his cigarette he said he stomped it out on the floor. Mr. Phillips was very irritable and told the investigators that he had been bothered enough.

It was also learned that Mr. Phillips had been interviewed on the same afternoon by Columbus Smith of the Dayton Daily News. Smith, while at the Marietta fire house attempting to seek information in reference to the fire, told these investigators that Phillips had told him that the fire had started in his room and in the waste can. In a dictated statement by Maysle Cozzens, which is attached to this report, Maysle Cozzens describes the fire as being in the northwest corner of Mr. Phillips' room. She stated that the chair was on fire when she looked in.

In a statement taken from Annabel Budgett it was learned that upon hearing the house alarm, she left her patient which was in room 154 in the west wing, and went to the central nurses station where she saw the other aides in the south end of the building and smoke coming from that direction. She said Mrs. Hall came up the hall to the nurses station but by that time smoke was getting very heavy and nurse Hall said she could not see to dial the fire department and started to leave the building and Annabel picked up the phone and dialed "O" and told the operator there was a fire at the Harmar House. She then went back to her patient's room and started to get her ready to get out. By that time smoke was so heavy in the hall that she and her patient had to be evacuated through the window. Room 154 is the last room on the north side of the west wing next to the exit door.

Maude Lee was the special nurse who had two patients in room 102, which would be the second room north of the room of origin, stated she was in the nurses lounge when the alarm sounded. She went to her patients'

room and saw that there was smoke in the south end of the building. She closed the door to her room and placed a wet towel across the bottom of the door and shortly after that smoke and small flames came from around the crack of the door across the top and part way down the sides. She said the flames soon went out and smoke seeped in. She and the two patients were evacuated through the window of that room. Most of the surviving patients were evacuated through the windows.

Complete photographic coverage of the building was made by fire prevention specialist Frank Jewell.

INVESTIGATORS CONCLUSIONS:

The fire originated in room 104 in the northwest corner at a very low level. It appears that the heat and smoke was building up rapidly upon discovery and when the door was opened to remove Mr. Phillips, it allowed the fire to escape into the hall and increased the burning in the room. It seems that the fire spread very rapidly and it is the feeling of these investigators that the carpet and the rubber backing on the carpet contributed to the spread of the fire and the cause of the heavy dense smoke. It seems that there might have been a delay in transmitting the alarm to the fire department because of attempts to evacuate the patients. The construction of the building contained the fire gases and smoke and it was concluded that the opening and closing of doors and the breaking out of windows during the early evacuation of patients helped to create a draft and helped spread the fire up the hall. Again, it should be noted that the majority of those who died were in rooms where the doors were open and the coroner stated that the cause of death apparently was from smoke asphixiation and those who were deceased were not burned sufficiently to have caused death. It is our recommendation that a provision for automatic transmission of fire alarms to some central alarm monitoring station such as American District Telegraph. Also, a thought should be given to a provision for automatic closing of doors including patients rooms and elimination of all combustible floor coverings. Also, installation of approved automatic heat and smoke detecting devices.

Although the official cause of the fire at this time remains undetermined, it is the conclusion of these investigators after examining the fire scene and interviewing witnesses that the probable cause was Mr. Phillips attempting to smoke while unattended.

Robert T. Greenwalt

Robert T. Greenwalt, Investigator

Harry McLaughlin

Harry F. McLaughlin, Jr.,
Investigator

Senator Moss. I notice that when you put the marks on the plat the X's were those who died and the O's were the ones who survived.

Does that account for the ones who died sometime after, a day or two or so after the fire as well?

Mayor BURNWORTH. Yes; for your benefit, as of last Friday, included as an attachment you will find a list of the patients, the date they were deceased or if they were removed to another rest home, and those that remained in the hospital.

Senator Moss. And there are some still remaining hospitalized. Were any of them considered to be in critical condition or likely not to survive?

Mayor BURNWORTH. There are still, to the best of our knowledge, one in Selby General Hospital, and three in the Marietta Memorial Hospital still questionable and they are still having the actual effects from the smoke.

Senator Moss. Is their problem respiratory?

Mayor BURNWORTH. Yes; most of them had tests done on them and they have respiratory problems.

Senator Moss. Now this was, of course, a very dramatic demonstration of the black smoke that came from the carpeting or the backing on the carpeting.

Is this type of carpet generally used in public buildings in addition to nursing homes?

Mayor BURNWORTH. Based on the information we have at this time from a thorough examination of public facilities in our community, we find Selby General Hospital and Marietta Memorial Hospital have similar carpeting.

As I understand from the architects who designed this building, this is a better grade of carpeting than they have in the other two facilities we are concerned with.

The college dormitories, sororities, the library of the senior high school, all have quantities of carpeting in them as does my office. We have lots of carpeting nowadays.

Senator Moss. I should have brought a strip of my carpeting down here and see what would happen to it from this demonstration.

Mayor BURNWORTH. It might scare you to death.

Senator Moss. Of course, based on such a serious tragedy as this, it gives me great concern.

Either you or the fire chief testified that there was this vinyl covering on the walls.

Did that play any part in the combustion here that in your opinion—I guess the fire chief could answer that.

Mr. BIEHL. In my opinion, no, it didn't have any bearing on the fire whatsoever. It was in room 104, which was the fire room, but in my estimation, there was no bearing on the fire.

Senator Moss. The fire was so hot, I take it, in 104, that you never have been able to determine definitely the cause, the ignition, how it started, is that right?

Mr. BIEHL. No, it is still undetermined, sir.

Senator Moss. Now, this sensor was not connected in any way with the alarm system that went directly into the fire department?

Mr. BIEHL. No, sir.

Senator Moss. Prior to the phone call?

Mr. BIEHL. We have no nursing homes or hospitals that directly have a direct line into the fire department.

Mayor BURNWORTH. We have Memorial Hospital working on a direct line to our fire department. So from a signalization standpoint, we do have at this time, as a result of the fire, the phone lines direct to their hospital which we can get to them or they can get to us quickly in the event of an emergency, including one at their location.

Senator MOSS. This is an open line, a hot line as we have learned to call them, now?

Mayor BURNWORTH. Yes, direct dial capacity to any one of their departments, pick it up, push one button and have our fire department or police department.

Senator MOSS. What is your best estimate of the time that it took for you to get the warning? You were talking about listening on your radio. From the time it was known that there was a fire there until the fire department had warned you, do you have an estimate of the lapse of time?

Mr. BIEHL. I have an estimate. I don't know how true it would be. I would say around 8 to 10 minutes before the fire department was notified of the fire.

Senator MOSS. Yet it seems to me, I remember in your testimony you said it was only about 12 minutes after you got there that the fire was primarily under control—maybe not totally, but primarily.

Mr. BIEHL. No, I don't think I stated that. I said it took us 12 minutes to extinguish the fire, the main part of the fire. We did the mopping up afterwards but it took us 12 minutes to actually extinguish the blaze that was in the hallway after the main blaze in room 104 had been put out.

In other words, this was approximately at 10:35 when we got the fire completely out, the evacuation of the patients and the fire out.

Senator MOSS. That seems like an awfully short period of time to me, a layman. If you can put a fire out that fast, it seems astonishing that you could have the number of fatalities we had.

Mr. BIEHL. I can explain that, sir. Technology of the fire department today and everything else, if you use fog in an enclosed area such as this was, it turns to steam and automatically puts your fire out.

Now, this is only my opinion. I am not an expert on it but I have been on the fire department for 23 years. I have been chief since 1965, and this is my opinion. We used fog in the building. It was more or less concealed in the hallway because of the insulation up on top, it had no place to go so it was more or less just one room. By putting the fog in from the hose it automatically put the fire out with steam.

Mayor BURNWORTH. I might say Senator, from having been there, the fire was out but the smoke was still tremendous. Of course, the smoke was in the rooms and nothing, water or anything else, would remove that smoke. It takes its natural course to the higher elevation. The fire was out and we were evacuating patients.

Senator MOSS. How far did the fire spread? Did it burn that record section, for instance, where the patients' records were?

Mr. BIEHL. It burned up to approximately 113 feet on one side and up to 118 feet on this other side. You could see the actual fire burning up in there and where it blistered the walls and everything.

The main part of the fire after it was knocked out of the fire room, 104, the main part of the fire that we could see at this time was right in the middle of the building around the nurses' station.

I think that was where most of the combustibles were such as the nurses' station had a formica top and had some wood in it and everything.

Senator Moss. Did the patients' records burn up?

Mr. BIEHL. Yes, sir. The patients' records that the nurse had on her station did but they had records in the office that are still intact, they were not damaged.

Senator Moss. The office records survived all right?

Mr. BIEHL. Yes.

Senator Moss. In fact, I think from the slides you showed the office was not damaged at all, really.

Mayor BURNWORTH. The door was locked and those records were salvaged as quickly as possible and taken to the hospital so they would have the pertinent data on the patients and their medications.

Senator Moss. Did the carpet then stop burning on its way down the hall by reason of this fog you said that was injected in there?

Mr. BIEHL. The carpet stopped burning at approximately room 113, and then it burned in a direct V.

Senator Moss. So it was burning on a point, sort of leading the flame down there.

Mr. BIEHL. Yes; that is right. You had a perfect V where the carpet stopped burning. The carpet burned all the way up here and clear from here.

Mayor BURNWORTH. One thing that might be of value, Senator, in a convalescent home they keep the temperature very high and it was above 80 on most thermostats. When the doors were opened by the employees taking out Mr. Phillips and others, this created quite a draft. It was zero outside and 80 or better inside.

We feel the doors being opened caused this surge of air through which carried the flames very, very quickly.

Mr. BIEHL. I might state that I think the wind velocity that evening was around 6 to 8 miles an hour. Now, up on top of the hill I have no idea what it would be but it would be more; so, I would say it was anywhere between 10 and 15 miles per hour.

With the south door being opened—there was a double door. For some reason, both doors were open, just the same as giving a flue right up through there like a chimney with a damper on it.

Senator Moss. I believe you had a question, Senator Williams.

Senator WILLIAMS. I just had one question.

You say that approximately the interval between onset and death was 10 minutes.

I just wondered, the onset, was that the smoke reaching the room where a patient died?

Mr. BIEHL. I took this off the death certificate, sir. This is the coroner's estimate on death.

The CHAIRMAN. What does onset mean, when the smoke did reach the patient's room?

Mr. BIEHL. I would say from the time it hit the patient, that is right, 10 minutes until death.

Mayor BURNWORTH. Sir, if I might supplement that. Dr. Owen was instrumental in making this facility possible in Marietta. He felt that from their first breath, 10 minutes would be the most they could handle this type of smoke. He considered it very, very toxic.

Senator WILLIAMS. As I understand it, many of these patients were in restraints in their bed. Now we saw the sides on the bed in the fireroom, as you say. Were there other restraints being used and, if so, wouldn't that just plainly complicate matters?

Mayor BURNWORTH. Yes; Senator Williams it did because we have depositions which have been provided to you where our rescue people had a difficult time getting the straps that were holding the patients in bed loose so they could get the patient out.

These straps, we don't question the wisdom of using them, because of the patient, but they certainly did create a rescue problem that coupled with the fact they could not see even with bright floodlights, the firemen cut the straps with knives and in one case literally ripped them off the bed to get the patient out.

The rails were up on all the beds, there was no way to figure out a way to get them down.

Senator WILLIAMS. Do you know what procedures have been applied there for fire drills for the patients and the staff?

Mayor BURNWORTH. I pass to the expert.

Mr. BIEHL. They have had fire drills at the building, sir, as late as, I think it was April of last year they had one. We inspected the building in October.

The only thing that they have ever had anything in this particular nursing home whatsoever was from the health standpoint was the water fountain did not come up high enough so the patient could drink out of it.

This was the only order that was ever put on the building since it was built in 1965 from the fire angle or the health angle.

Senator WILLIAMS. I have no further questions.

Senator MOSS. Senator Young, do you have a question?

Senator YOUNG. Yes; I do, Mr. Chairman.

You stated you understood there was a fire drill in the preceding October, in other words, about 3 months before the fire?

Mr. BIEHL. No; I believe I said April, sir. I think the fire drill was in April before.

Senator YOUNG. April.

Mr. BIEHL. We had inspected the home as late as October.

Senator YOUNG. I see. In other words, about 10 months before, is that correct?

Mr. BIEHL. Approximately, yes.

Senator YOUNG. Do you know anything about the nature of that fire drill?

Mr. BIEHL. No, sir; I do not.

Senator YOUNG. Now, I noticed this Harmar Nursing Home statement of the fire chief says "a modern fire-resistant structure."

What is the meaing of that? What sort of a structure was it? Was it a frame structure?

Mr. BIEHL. Brick veneer, gypsum board, fire resistant. I think the fire rating was approximately an hour or hour and a half or more. I don't know what it does have, your gypsum board, but it had plasterboard which has, I think it was $^{13}/_{16}$-inch thickness which has a rating of approximately an hour and a half, or something like that.

Senator YOUNG. The exterior in some parts of this nursing home is that brick you are saying.

Mr. BIEHL. All the outside was brick. The only wood that was actually in the nursing home was the plywood sheathing underneath the roof and it had been treated for fire resistance.

Mayor BURNWORTH. It did not burn.

Mr. BIEHL. It did not burn, had no effect on the building whatsoever, because the insulation on top of the ceiling they had anywhere from 4 to 6 inches of insulation there which held the heat down, would not let it up to the plywood.

Senator YOUNG. About how old a building was this?

Mr. BIEHL. Built in 1965, and an addition put on in 1967–68. Now, by addition, I mean the outside shell was all built in 1965 but there were six additional rooms put on in 1967–68 on the inside of the shell. There were five patient rooms and one used as a storage room.

Senator YOUNG. This was a private nursing or convalescent home, was it not?

Mr. BIEHL. That is right.

Senator YOUNG. Operated privately?

Mr. BIEHL. It was stockholders, mostly doctors, lawyers in our city.

Senator YOUNG. Are you able to say about how many employees immediately tried to remove the patients?

Mr. BIEHL. There were four regular employees and two private nurses there and they all worked diligently to get the patients out. There were six in all.

Senator YOUNG. And are they the ones who left the double doors open?

Mr. BIEHL. That I do not know. They said they didn't but the doors were open when we arrived there at the south end of the building.

Senator YOUNG. Well, it was zero weather outside. It is not probable the doors were open before the fire.

Mr. BIEHL. No, they stated that that door to the south end of the building was always locked. Now, by being locked, it was locked by anybody coming from the outside in. The patients could go out, from the inside out, but coming into the building they could not.

Senator YOUNG. Now, the fact that the doors were left open as I understand it from your testimony, that brought in the zero weather outside and 80° inside and that brought in a tremendous draft and contributed to the fire.

Mr. BIEHL. That is my opinion, yes.

Senator YOUNG. In other words, was there not negligence on the part of some employee or employees, in all probability, in leaving those doors open?

Mr. BIEHL. Negligence, you might call it human error. I would not know which to call it. The girl even stated that she knows she did wrong when she did not shut the patient's room but she said in her

excitement of getting the patient out and everything she stated that she got the patient out of the bed and drug him up partway in the hall until another aide helped her with this patient.

She says she knows they didn't shut the door and she was wrong in this, she erred here, but in the excitement she just didn't think of it.

Senator YOUNG. Whether negligence or whether it was poor judgment, it was carelessness, was it not?

Mr. BIEHL. It would have to be.

Senator YOUNG. And that contributed or, in fact, caused some of the deaths, isn't that a fact?

Mr. BIEHL. I would say so, in my own opinion.

Senator YOUNG. Now, in this one room there was only this one man in that room, isn't that correct? Room 104, I believe.

Mr. BIEHL. That is right, that was a single patient room.

Senator YOUNG. Was it the same size room as the room next to it?

Mr. BIEHL. Yes, they were all the same sized rooms.

Senator YOUNG. And those two in the next room died, either burned to death or smoke?

Mr. BIEHL. That is true.

Senator YOUNG. But the man in this room who perhaps caused the fire, he is still alive?

Mr. BIEHL. That is right. He is still alive.

Senator YOUNG. Now, has the county prosecutor had an inquiry made in this, to your knowledge?

Mr. BIEHL. Not to my knowledge.

Mayor BURNWORTH. Senator Young, under the Ohio law this would be up to the fire marshal and State attorney general. The fire marshal's office has had a consultation with our prosecuting attorney and there is no basis.

Senator YOUNG. As a lawyer—it happens that I have been a lawyer for many years and I have also been chief prosecuting attorney in Cuyahoga County. Anyway, I assert that the county prosecuting attorney did have authority to have a grand jury investigation if he chose to do it.

Was there such an investigation?

Mayor BURNWORTH. No. There was a meeting regarding it and he found no evidence that would give him the need for holding one.

Senator YOUNG. He recorded that?

Mayor BURNWORTH. Yes, this is recorded and Senator Moss has a copy of the statement regarding these matters.

Senator YOUNG. Is the report of the fire marshal in your records here in the committee?

Mayor BURNWORTH. Yes. Our statements contain copies of all of those matters and the fire marshal is going to testify. We sent Senator Moss a deposition from all of the employees.

Senator YOUNG. And how many lives were lost?

Mayor BURNWORTH. Thirty-two, sir.

Senator YOUNG. About how many in all?

Mayor BURNWORTH. Forty-six, plus the four employees and two special nurses.

Senator YOUNG. But none of the employees or nurses died as a result of smoke or fire?

Mayor BURNWORTH. No.

Mr. BIEHL. I might say there, Senator Young, that one of the patients that did die was in room 107 and the doctor gave as the cause of his death coronary occlusion. I asked him if he had any effect whatsoever from the fire and he said no.

Mayor BURNWORTH. We have provided death certificates [1] to Senator Moss.

Senator YOUNG. But, anyway, no one knows whether he would be living or dead now except for the fire, isn't that a fact?

Mr. BIEHL. I only have the doctor's opinion on it.

Senator YOUNG. Shock, sudden shock causes coronaries sometimes, does it not?

Mr. BIEHL. This happened approximately 20-some days after the fire.

Senator YOUNG. Was he injured in the fire?

Mr. BIEHL. No.

Senator YOUNG. Now, was that double door closed at any time 10 minutes after you got there, to your knowledge?

Mr. BIEHL. Not that I know of, for the simple reason that they fought the fire in the fire room from the outside because the window was already out and they proceeded from there through that room and then took another line from the south door to fight the fire in the hallway.

Senator YOUNG. Do you know how many of the 46 patients were strapped in bed?

Mr. BIEHL. I have no idea. I believe it was five that I took out myself and there were three of those strapped in bed. But as I understand it from talking to the personnel at the hospital, that was a majority of them, the rest of them were not.

Senator YOUNG. Well, of course the administrator or the personnel would know the number who were strapped in the bed, would they not?

Mr. BIEHL. That is right. We could almost tell for the simple reason the straps were still on the bed after we took them out.

Senator YOUNG. How many were there?

Mr. BIEHL. I would say there were seven at the most.

Senator YOUNG. Seven of the 46?

Mr. BIEHL. Seven of the 46 patients; yes.

Senator YOUNG. Of those seven who were strapped in bed, did any of them survive?

Mayor BURNWORTH. Not that I know of.

Mr. BIEHL. Yes, there is still one living in room 115. I know that that person—I could not tell at the time, and still I would have to look at the chart, whether it was a man or woman, but 115 is living and I took that patient out myself.

Senator YOUNG. In addition to that one in 115, do you know if some of the six others survived?

Mr. BIEHL. We can look on the record here and see. I have it here.

Mayor BURNWORTH. It was a man, Senator, in room 115, who lived. Mason Carpenter. An attachment to the testimony shows all the patients, their current health and those items. His condition at this time, Mr. Carpenter in room 115, as of last Friday he has been moved to the Christian Anchorage Home in good condition.

Senator YOUNG. Then the remaining five have survived of those who were strapped?

[1] Retained in committee files.

Mayor BURNWORTH. He is the only one of those strapped that survived. He is the only one, sir, of those that were strapped in that survived.

Senator YOUNG. One of them died 22 days later?

Mayor BURNWORTH. Yes, he did.

Senator YOUNG. That is not attributed to the fire or smoke?

Mayor BURNWORTH. According to the doctor, his death was not attributed to the fire; the other 31 were directly attributed to the fire.

Senator YOUNG. Is this nursing home in operation now?

Mayor BURNWORTH. No, sir; it isn't. All the materials inside have been removed and they are now studying the possibility of rebuilding it. The cost of the sprinkler system and certain changes in the contents, materials, and so forth, would go into it if it is reconstructed.

Senator YOUNG. In other words, if any part of the shell of the building is used, they will be compelled to make major changes in the construction of the building before they may operate a nursing home again; is that correct?

Mayor BURNWORTH. The kind of people who own the nursing home will comply with the laws. Under present laws we cannot require higher than a one-story building to have a sprinkler system, if they do rebuild the inside and operate it. The entire exterior of the building, roof and all, is in excellent condition and the interior will have to be completely redone.

I am sure in talking to their architects and directors of the facility that they will build it to the highest standards if they rebuild it at all.

Senator YOUNG. And there was no sprinkler system in it?

Mayor BURNWORTH. No, sir. A one-story building did not require it.

Senator YOUNG. Perhaps ordinary care would have required it, isn't that correct?

Mayor BURNWORTH. Yes. We discussed this possibility and I think we come back again to the cost of buying a Cadillac, how many extras can you put on it and still afford it.

All these things cost money and I think that is the evaluation you will all have to get into.

Senator YOUNG. However, to be honest about it and make an honest statement on the subject, in buildings of this sort should not a sprinkler system be in operation at all times?

Mayor BURNWORTH. I think that this would be a very excellent addition to any facility handling people convalescing.

Senator YOUNG. Have there been any lawsuits for damages charging negligence filed by any relatives of these people?

Mayor BURNWORTH. There has been no litigation, or to the best of my knowledge, inference of litigation, none.

Senator YOUNG. All of these 32 who died, did they have close relatives who lived in Ohio?

Mayor BURNWORTH. We were able to identify all the deceased within an hour and a half after the fire and they all were claimed by relatives. All the people were from the immediate area. That includes Ohio and West Virginia, Senator.

Senator YOUNG. Yes.

No other questions.

Senator Moss. Senator Hansen.

Senator HANSEN. Thank you very much, Mr. Chairman.

Mayor Burnworth, how long have you been mayor of the city of Marietta, Ohio?

Mayor BURNWORTH. Four years and 9 days.

Senator HANSEN. I am sure you would be familiar, then, with the construction to some degree and certainly the way public buildings may be furnished or finished within that city.

Assuming that you are, are there a number of other public buildings that have carpeting of the type that you found used in the nursing home?

Mayor BURNWORTH. Yes, both Selby General Hospital and Memorial have this type of carpeting in it and both of them are very vitally concerned about the results of it possibly being involved in a fire.

Senator HANSEN. Insofar as you know, has there been evidence of problems in other public buildings as arose in this instance, I mean, has the kind of carpeting been a serious factor in lost life?

Mayor BURNWORTH. We have no problems in our area at all, Senator. This is the first fire that I can recall in the years I have lived there, in 20 years, where there have been any deaths and the first one involving a heavy loss due to what we consider to be the problem of backing more so than the carpet.

Senator HANSEN. I think you testified that with the benefit of hindsight that makes us all pretty wise that your first recommendation was that smoking be prohibited in this type if institution. Am I right about that?

Mayor BURNWORTH. Yes. I have been through this thing with many people since it occurred and it just occurs to me that smoking was the root of the problem, and I think the fire marshal in Ohio will testify to the fact.

It seems to me when you are dealing with people who are immobile, we should eliminate anything that even resembles bringing about a danger.

I just feel that this fire would not have occurred based on our information, had there not been for the smoking.

Senator HANSEN. As I recall the statement of the young nurse—I have forgotten her name.

Mayor BURNWORTH. Miss Doris Watts.

Senator HANSEN. She was not certain that this one patient in whose room the fire apparently started would have been able at all times even to have lighted his own cigarette. Is that what she said?

Mayor BURNWORTH. She said she placed it in his mouth and he puffed it and she lit. She didn't hand him the light. There was a statement in the fire marshal's report that a box of matches was concealed in the Kleenex box by the patient.

Senator HANSEN. In your opinion, if a person was that incapacitated as her statement would indicate, would it be fair to assume that such a patient might drop a cigarette on the bed and in the sheets and on the mattress and if there had been no carpeting on the floor at all that the results might have been rather serious?

Mayor BURNWORTH. Yes; I think the pateint was actually either way creating a problem with cigarettes in bed. We have had fires

since this fire in a private home caused by a cigarette dropped in a chair. No one was killed but the cigarette seemed to be the basis for the fires.

I think our main concern here is we are dealing with a group of people who are very elderly and in poor condition and though most people don't like to say it, most of them are there for the rest of their years to be made comfortable.

I am not opposed to having carpeting in nursing homes, I think it makes it more homey, I think the patients would like to have it.

I think our challenge is to use our technology to develop a carpet that will not burn.

Senator HANSEN. Would it not be probable to assume that if there were no carpeting in a home for elderly people, people whose physical abilities are certainly very restricted, that there could be other accidents that might occur from slipping and breaking hips and that sort of thing on a floor that would be uncovered?

Mayor BURNWORTH. I agree with you, Senator. I think when you get the time to read the various depositions of the State fire marshal's investigation, plastic waste baskets had to be a factor.

In the preliminary report between Mr. Phillips and the State fire marshal he knew it was in the waste can, he thought it would burn out. That is in the record.

Had it been in a metal waste can, perhaps it would have burned out, but it certainly didn't burn out in a plastic waste can.

The plastic industry is growing so rapidly and there are many fabrics and things I don't believe in all honesty that the fire departments in large or small cities are familiar enough with the result of the burning.

The other concern we have had, Senator Hansen, is that what does the combination of things burning cause in the way of toxic gases?

We hear about mixing alcohol and tranquilizers and you get results that blow your brains out, but what about the gases that mix from various types of materials burning?

I think this is going to involve a lot of study by the types of laboratories that have the types of equipment to do so.

Senator HANSEN. One factor that I think you touched upon with Senator Young was the cost, and I believe you said, that nursing homes could be equipped with all sorts of safety devices and sensor mechanisms that would add to the safety.

I suppose sometimes, and I suspect this is more often than not generally true, it is important if we are going to provide adequate housing and care for our elderly citizens to keep those costs down as much as we can.

Will you agree with that statement?

Mayor BURNWORTH. Yes, Senator; as I understand, the minimum cost per month in this facility was $500 a month, $6,000 a year.

I think we have to have safe facilities, certainly, but we have to have reasonable costs so average people can afford to put their parents there when they are in such physical condition we cannot help them.

If we don't, we are going to have to see more and more Federal subsidizing which runs our tax bill up.

So I think cost is a very important factor but safety must come first.

Senator HANSEN. In your judgment, Mayor, what percent of our elderly population in need of this type of facility would be able to afford $500 a month charge?

Mayor BURNWORTH. Well, in our areas, sir, very few. We are in Appalachia. We are not proud of it, we don't have the economic problems that many areas around us have. I still think this is relatively high. I would say a very small percentage, although I could not provide you a figure. Mr. Halamandaris did provide information on this.

Senator HANSEN. I want to commend you for what you have done out there and how you demonstrated your concern and your interest in what goes on in your city and your moving right out there to find out what happened in this particular instance.

Would you think that the recommendation you made that smoking be prohibited in nursing homes except in areas specifically finished and furnished in order to assure maximum safety for those persons who do want to smoke would be the No. 1 recommendation you would have to make on the result of your investigation of that accident?

Mayor BURNWORTH. After consulting with all the experts, hindsight of all these people, I still think this would be the most expeditious thing we could do. I know it sounds difficult and tough to take an elderly person's smoke away from him but there has got to be a way of coping with it, sir; there just has to be.

I think in this instance, if you read the depositions you will find that the nurses while assisting this man, or while monitoring smoking actually smoked themselves. The more cigarette butts you have out in an ashtray that gets dumped the more chances for fire. We are concerned. We are concerned with their safety to the point of preventing it by these drastic means or we are not, and I am.

Senator HANSEN. Thank you very much, Mr. Mayor.

Thank you, Senator.

Senator Moss. Senator Yarborough.

Senator YARBOROUGH. Mayor, that $500 a month provides what we call pretty plush care for the elderly, does it not? It takes persons in pretty affluent circumstances to afford it.

Mayor BURNWORTH. These doctors primarily constructed the facilities for the purpose of making available facilities that would accommodate their loved ones when the need was there. I would say, though, that that cost is very realistic in reference to the other homes in our community.

Senator YARBOROUGH. People who were paying that for a mother or father to stay there would expect that they were receiving good and sufficient care.

Mayor BURNWORTH. They were, yes, sir.

Senator YARBOROUGH. Most families would be making a real sacrifice to pay that for care.

Mayor BURNWORTH. Yes.

Senator YARBOROUGH. Paying that much they think they had a right to put their relatives in prime top care for nursing homes.

Mayor BURNWORTH. They felt so as much as the day before. Our city council clerk had her husband up there and, unfortunately, he passed away a few days before the fire and she said to me later there could not have been a nicer place to put her husband to be cared for.

You would not have believed it, sir, if you had been in there the day before the fire. You could not conceive this could happen.

Senator YARBOROUGH. Have we had in the record yet whether or not they had fire drills and how often?

Mayor BURNWORTH. Yes; I think the State fire marshal will speak of this today, also.

Senator YARBOROUGH. He will cover that?

Mayor BURNWORTH. Yes.

Senator YARBOROUGH. Are there any regulations for the State of Ohio or by the city of Marietta locally requiring fire drills in this type institution?

Mayor BURNWORTH. Yes.

Senator YARBOROUGH. How often do they require fire drills?

Mayor BURNWORTH. I yield to the chief.

Mr. BIEHL. Highschools, any of the schools, have a fire drill every month.

Senator YARBOROUGH. What about nursing homes?

Mr. BIEHL. Nursing homes, we have at least twice a year. Hospitals, the one hospital to my knowledge has never had one. The other hospital, Selby General Hospital, has had as high as three in the last year even to evacuate some of the patients on practice. We even as much as took a garbage can such as sits in front of us here and built smoke, put a piece of paper in it and had smoke in it at the end of the hall so that the aides and nurses and everything would even think that it was real fire. They had no knowledge of the fire drill whatsoever, only the hospital administrator, the janitor, and myself had any knowledge of the fire drill.

Senator YARBOROUGH. The practice of removing patients from the beds in event of fire or any other emergency, had the personnel been drilled in that procedure?

Mr. BIEHL. Every hospital, every nursing home, all the new nurses aides, and everybody has had schooling on evacuation of patients, small fire extinguishers. I had some slides, I don't know if you saw those.

Senator YARBOROUGH. I missed the slides.

Mr. BIEHL. That started back in 1968.

Senator YARBOROUGH. Had this preceded the nursing home——

Mr. BIEHL. I know of at least one of the aides that had had it. I cannot state whether all of them have had it but there were two that had had it.

Senator YARBOROUGH. I don't mean in training in school or anywhere, but had they practiced putting that into operation in that specific nursing home. Had they had any drills or practice there in trying to remove patients?

Mr. BIEHL. I don't believe they have. They had fire drills where they would know what they were supposed to do in case of fire but not in evacuating patients; no.

Senator YARBOROUGH. Do you have any city or State regulations requiring such periodic drills in nursing homes or hospitals?

Mr. BIEHL. That is handled strictly through the State, sir. I would have to yield to our State fire marshal. We in our locality do not although I became chief in 1965. The Fitchville fire was in 1963. This alarmed me. We had never had any practice of nursing evacuation or fire safety. It was put in effect as soon as I became chief and we

have had it every year, at least once, to pick up all the new nurses or aides that had been employed by the hospitals or nursing homes. We had one as late as last December 1969, approximately 20 to 25 employees at that time taking the course.

Senator YARBOROUGH. Mayor, now I notice your recommendation that you recommend that laws be enacted to prohibit any type of smoking in nursing homes, hospitals, or any place that houses persons who are totally or partially immobile except in areas especially set aside for the purpose of smoking.

Mayor BURNWORTH. Yes.

Senator YARBOROUGH. I think that is a good recommendation.

Mayor BURNWORTH. I think it is, because you know it is kind of frightening to go down the halls of a hospital to visit a friend when you have crowded conditions and have a patient out in the hall with oxygen and have somebody walking by smoking a cigar.

Senator YARBOROUGH. Of course, that is a matter of local law and not a Federal law. In your State it would be either a city ordinance—I presume it is under the city ordinances. Certainly the State could by a statewide law.

Mayor BURNWORTH. We have a statutory form of government in Ohio. Some cases where we can and cannot go beyond the State law. Senator, I believe one of the responsibilities of the Federal Government has is bringing about those things for us we cannot do ourselves, because if you try to get this in 50 separate States there are going to be 50 separate groups lobbying against it. The Federal Government can handle these groups at one time and they become binding. I don't mind Federal intervention when it is for benefit of people.

Senator YARBOROUGH. The Commerce Committee held hearings on flammable and inflammable fabrics. I have been astounded here at the lack of enforcement of the Federal officials, the lack of inspection that they are making to really determine which type of carpeting in flammable and which is inflammable.

Senator Moss. We had that question at the beginning, that is presently before us.

Mayor BURNWORTH. I agree with Senator Moss that the pile test is outdated. That test right there, if that does not convince anybody, they are blind.

Senator YARBOROUGH. Thank you.

Thank you, Mr. Chairman.

Senator Moss. Senator Young has a question.

Senator YOUNG. I have a couple questions.

You mentioned the Fitchville fire in Ohio in 1963, and perhaps my colleagues don't know about that. That occurred about 5 miles from where I was born. How many were killed, how many died in that?

Mr. BIEHL. Sixty-three, sir.

Senator YOUNG. Sixty-three died?

Mr. BIEHL. That is right. Sixty-three deaths, if I recall correctly.

Senator YARBOROUGH. It seems to me one disaster in a State is enough to alert that State, it ought to alert all 50 States.

Mr. BURNWORTH. I agree.

Mr. BIEHL. The only thing I can say, we have had inquiries from almost every State in the Union after this fire and I am sure they did after the Fitchville fire; but people forget.

Senator YARBOROUGH. Very rapidly.

Mr. BIEHL. That is right. It is up to the people right now while this situation is existing or existed to get the law formulated and put into effect now. That is my opinion on it.

Senator YOUNG. Now, there was testimony here his morning in this home they had a fire drill about 10 months before this fire.

Mr. BIEHL. That is right.

Senator YOUNG. That was the only one that year?

Mr. BIEHL. To my knowledge, yes. They may have had others I don't know of.

Senator YOUNG. At the time of this fire, how many employees and officials were on duty in this home?

Mr. BIEHL. You had one LPN which was in charge, you had three nurses aides. That was all that were employed.

Senator YOUNG. I mean how many officials and employees were living in the home?

Mayor BURNWORTH. No employees lived there.

Mr. BIEHL. No employees lived there.

Senator YOUNG. How many were there this night?

Mr. BIEHL. One LPN and three aides and two special nurses.

Senator YOUNG. And two special nurses.

Mr. BIEHL. That is right. They were hired by the——

Senator YOUNG. Were they registered nurses?

Mr. BIEHL. No; they were practical nurses.

Senator YOUNG. Practical nurses.

Mr. BIEHL. That is right.

Senator YOUNG. And the relatives of these 46 inmates paid $276,000 a year, that is $500 a month for the care of their elderly parents?

Mr. BIEHL. I don't know.

Senator YOUNG. Well, 46 times $6,000 a year would be $276,000. Isn't that correct?

Mr. BIEHL. I take it it is. I didn't make the statement of how much it cost to live in the nursing home; I did not know that.

Mayor BURNWORTH. Senator, they have had a total staff of 44 people with their registered nurses and of course they had them 24 hours a day 365 days a year. We have provided you with a list of all that.

Senator YOUNG. That is all in here?

Mayor BURNWORTH. Yes.

Senator YOUNG. How many registered nurses?

Mayor BURNWORTH. I believe there are three or four lists.

Senator YOUNG. It is in the record.

Mayor BURNWORTH. Yes, behind the testimony.

Senator YOUNG. By the way, it is a fact that our State of Ohio has had more than its share of this.

Mayor BURNWORTH. Too many.

Senator YOUNG. If we did not learn in Fitchville, let's hope we learn from Marietta.

Mayor BURNWORTH. I agree.

Senator Young. Thank you very much, gentlemen, I think we have established that there was no registered nurse on duty that night, it was an LPN, but there were registered nurses on the other shifts.

Mr. BIEHL. Five in all, sir.

Senator YOUNG. Five in all. I wonder if it is your opinion, Mr. Biehl, if the door of 104 had been shut could the fire likely have been contained to that room? What do you think?

Mr. BIEHL. My personal opinion is that if the door had been shut as soon as they took the patient out, we would not have had any deaths in the fire.

Senator Moss. Did Mr. Phillips ever admit that he was smoking that night?

Mr. BIEHL. No, sir.

Mayor BURNWORTH. No, sir.

Senator Moss. He did not.

Mayor BURNWORTH. Well, only under supervision.

Senator Moss. Well, earlier when the nurse was in, but I meant after.

Mayor BURNWORTH. You have the statement, sir, for later perusal.

Senator Moss. I join my colleagues in commending you, Mr. Mayor, for your recommendation about smoking in areas where people are immobilized and can't care for themselves. I agree we ought to take a good hard look at this and perhaps with our Federal jurisdiction because of Medicare and Medicaid patients we might get a general regulation on this that might help avert tragedy of this sort.

Well, we have taken all morning and I do appreciate very much your most excellent presentation with the slides and pictures, and the demonstration of the burning of the carpet, and the tape recording of the nurse's aide who was on duty that night. I think it has presented us with a very excellent picture. So we thank you, and you may be excused.

Mayor BURNWORTH. Thank you, Mr. Chairman.

Senator Moss. We have a problem now of the additional witnesses. We are going to proceed to hear the State fire marshal, Mr. Sides, and also Mr. Stevens and Mr. Morgan. However, it is going to be necessary to carry this over to tomorrow.

Of the others listed as witnesses, is this going to cause an insurmountable problem to come back in the morning? If so, I would like to have you talk to Mr. Halmandaris and see if there is any other arrangement we can make. As I announced at the begininng, the Senate is sitting and there may come a time very shortly when some of us will have to leave. That is the reason it won't be possible to go on through the afternoon here.

We will hear Mr. Sides, the Ohio State fire marshal in Columbus, and Mr. Richard Stevens, director of engineering services, National Fire Protection Association.

Then when we do recess today we will come back in at 9:30 tomorrow morning so that we will be able to hear the remainder of the witnesses in time to finish up tomorrow, hopefully, by noon.

Mr. Sides, will you proceed?

STATEMENTS OF SAMUEL T. SIDES, OHIO STATE FIRE MARSHAL, COLUMBUS, OHIO; RICHARD STEVENS, DIRECTOR OF ENGINEERING SERVICES, NATIONAL FIRE PROTECTION ASSOCIATION; AND WILLIAM JAMOUNEAU, ROHM & HAAS CO., PHILADELPHIA, PA.

Mr. SIDES. Mr. Chairman, members of the committee, I am Samuel T. Sides, fire marshal of the State of Ohio. Much of what I have to say here will be a repetition of what Chief Biehl has already told you.

At 2 a.m. we had four investigators from the State fire marshal's office on the scene of the fire. The next morning I met with Governor Rhodes at the scene and he ordered our office to make a complete investigation in conjunction with the Marietta Fire Department.

I believe I have provided you with a short resume of my report.[1] However, I have brought with me all of the attachments, a list of some of the same material that Chief Biehl has provided you with regarding the carpeting, a list of all patients, statements taken from the employees by a court stenographer and 8 by 10 photographs of the scene.[2]

My report was submitted to Governor Rhodes on the fire and reads as follows:

Shortly after 9:57 p.m. on Friday, January 9, 1970, fire broke out in the Harmar House Convalescent Home, Bartlett and Flint Streets, Marietta, Ohio, Washington County.

The building housing the nursing home was a one-story structure which was built in the form of a cross. General dimensions are approximately 244 feet north and south, being 42 feet wide and 134 feet east and west, approximately 40 feet wide. The building is a one-story modern fire resistant structure built in 1965. The interior walls are dry wall, painted, with steel stud beams. The exterior of the building was brick veneer construction Celotex subsiding. The roof was plywood sheathing supported by metal trusses which ran from the ceiling. The roof was asphalt shingles.

Now in the State of Ohio the responsibilities concerning nursing homes: The nursing homes are licensed by the nursing homes division, State department of health. The board of building standards adopts regulations, which are known as the Ohio Building Code. This is enforced by the division of factory and building regulations, department of industrial relations. All nursing homes are inspected by the division of factory and buildings, certified municipal building departments, State department of health, nursing home division, State fire marshal division, and local fire departments.

Attached to this report is a list of the owners and stockholders.[3] It was incorporated as Health Services.

Chief Biehl pretty much described the fire and this will probably be a little repetitious.

At the time of the fire there were 46 patients, most of whom were elderly bed patients, four regular employees and two special nurses. At the writing of this report 28 persons have died as a result of the fire. The official cause of death was listed by Coroner K. E. Owen as asphyxiation and smoke inhalation. The surviving patients were taken to the Marietta Memorial Hospital and Selby Hospital. A complete list of patients in the building at the time of the fire is attached to this report.

The first notification of the fire was received by the licensed practical nurse in charge, Mildred Hall, who was at the nurse's station in the center of the building when the heat sensor in room 104 activated the alarm, whereupon Mrs. Hall rang the house fire alarm and noted the smoke was coming from the south end of the building. All employees went in the direction of the smoke, which was coming from 104. Two of the employees removed Mr. Phillips from the room and out of the building.

[1] See p. 424. Report from Division of State Fire Marshal, to Governor James A. Rhodes, January 21, 1970.
[2] Retained in committee files.
[3] See p. 390-91.

The employees described the fire as burning on the floor in the northwest corner of room 104, occupied by Mr. Lyle Phillips. The room was very heavily charged with smoke and one employee tried to fight the fire with a fire extinguisher, but stated the smoke was too dense. The employee stated that at this time they tried to remove patients from the building with the assistance of surrounding neighbors.

On arrival of the fire department, some of the fire fighters assisted with rescue work, others attacked the fire and stated that the fire was extinguished within 10 minutes with less than 1,000 gallons of water being used from one of the pumpers.

It was thought at first that there was some delay in sounding the alarm to the fire department. This is questionable. However, investigation disclosed that one employee did use the phone in the nurses station, dialed the operator and reported the fire. We have not decided whether this call got through or not.

Examination of the fire scene disclosed that the fire originated in room 104 in the northwest corner of that room at a low level. The plastic wastebasket and the carpeting, which had a rubber back base, was entirely consumed, as well as the rest of the contents of the room. The smoke, heat and fire gases traveled into the hall from this room to the center of the building, then spreading east and west and also north to the approximate location of room 114. A diagram of these rooms is attached to this report, similar to what you see over here.

Investigation further indicated that the point of origin in room 104 was at a point 4 feet 6 inches from the north edge of the entry door and 2 feet from the northwest corner of the room. This is the area as indicated in fire terminology as the V pattern on the wall and the point of the deepest charring of the baseboard. The fire started on or near the floor at this point and spread upward and outward. In the area was a wooden night stand, a plastic wastebasket, a metal walker, and a wood-frame vinyl plastic upholstered chair. Investigators reported that there were no electrical outlets or switches in the immediate area of the point of origin.

It appears that where the patients' doors were open those were where the fatalities occurred, and it was reported that in the rooms where the doors were closed, the patients were rescued. From the employees' description of the fire it appears that the fire spread very rapidly and produced very dense, heavy, black, smoke following these employees from the building. The carpet in the hallway was almost entirely destroyed as far as the area of rooms 113 and 114, which is a northerly direction from the point of origin. Heavy destruction from heat and smoke occurred to the wall covering in the west wing in the area of rooms 152 and 155. The east wing, which is the kitchen and dining area, was damaged by heat and smoke. The only exterior fire travel from the building was through the glass window in room 104. There was no burning through of any of the walls or ceiling and no basic structural damage to the building.

The report commends the Marietta Fire Department under direction of Fire Chief Beman Biehl for the rescue operations and extinguishment of the fire in such efficient manner under such perilous conditions. Statements were taken from Chief Biehl and the firemen responding to the fire and are attached to this report. In addition to the statements from the fire department, statements were taken from all

of the employees of Harmar House and special nurses who were on duty. Also a statement was taken from Mr. Lyle Phillips, occupant of room 104, and Mr. Charles Strauss, a surviving patient. In addition to the statements attached is a complete list of all the Harmar House employees, a copy of the specifications and blueprints of the Harmar House, provided by C. D. Camden & Associates, architects and consulting engineers, Marietta, Ohio. Also, report of the carpeting installed in patients' rooms and hallways. Also a report of the paint and wall-tex used in Harmar House. Other additions attached to this report are the fire casualty reports, certificates of deaths, and the fire report provided by the Marietta Fire Department. Complete photo coverage was made of the interior and exterior of the building by one of our specialists, and are attached to this report.*

Investigators removed from the scene for laboratory analyses the following items: (1) Carpeting from the closet in room 104, (2) electrical motor from the bed in room 104, (3) section of dry wall from area at head of bed, (4) electrical wiring, switches, and outlets from room 104, (5) heat sensor from room 104, and (6) top drawer of bedside stand containing a Kleenex box and a penny box of matches inside the Kleenex box, which were not ignited.

Other items collected for laboratory analyses include: (1) Heat sensor from undamaged room, (2) carpet from hallway from in front of room 106, (3) carpet from room 107, (4) paint samples from the hall wall near room 113, (5) section of dry wall near floor level from hall in area of room 113, (6) plastic waste-basket from other rooms, (7) one pillow from room 107, (8) section of mattress from room 107, (9) section of mattress cover from room 107, and (10) a section of chair and chair covering from room 107, similar to the one in 104.

Participating in the investigation were State Arson Investigators Chief Eugene L. Jewell, Robert Greenwalt, Harry McLaughlin, Jr., and Frank Jewell, State fire prevention specialist, who also took the photographs which are enclosed. All investigators concur that the fire originated in room 104 in the northwest corner of the room at a very low level. It appears that the heat and smoke was building up very rapidly when discovered and when the door was opened to remove Mr. Phillips it allowed the fire to escape in the hall and increase the burning in the room.

The fire spread very rapidly and it is the feeling of the investigators that the carpeting and the rubber backing on the carpeting contributed to the spread of the fire and was the cause of the heavy, dense, black smoke.

As Chief Biehl stated, the construction of the building was such that it contained the fire gases and smoke and it was further concluded that the opening and closing of doors and the breaking out of windows during the early evacuation of patients helped to create a draft and helped spread the fire along the hall. The investigators also concur in the fact that had the door of room 104 been closed after the removal of Mr. Phillips the fire might possibly have been contained in the one room.

The items removed from the premises for testing have been transmitted to the Chemical Engineering Laboratory of Ohio State University and the Underwriters Laboratory at Northbrook, Ill. I just received the report and Mr. Bono is here to testify regarding that.

*Retained in committee files.

I also just this past day had a sample of the carpeting tested for smoke and the gentleman who made that test is here and will testify to his findings.

We made personal testing of the carpeting such as you saw demonstrated here and produced heavy black smoke.

The cause of the fire is undetermined. However, in all probability the fire was caused by a discarded cigarette. Mr. Phillips gave two statements that he stamped cigarettes on the floor. It is doubtful but it was his statement.

As a result of this investigation, I recommended to the Governor that an approved automatic sprinkler system be installed in all such occupancies. This sprinkler system should be equipped with an alarm device transmitted to a central station protective signal center such as the American District Telegram System, or to the fire department alarm office where possible.

Now in the large cities the fire departments are so crowded on the switchboard they can not provide this, and that is why I recommend this. In the smaller stations they can hook right into the smaller switchboards.

Also it is recommended that smoke detectors be provided in nursing homes in addition to the sprinkler system, as these will warn of the presence of smoke before enough heat is generated to activate the sprinkler system.

An approved automatic heat actuator closing device should be installed on all doors. Also with this system could be incorporated a device for automatic self-closing of all doors.

It is recommended that an approved fire door be installed at each wing which extends from a main corridor, and an approved fire door should be installed in any corridor over 100 feet.

Now of course that is debatable but we feel in the long hallway there should be an approved fire door to stop the spread of fire.

The fire marshal's office recommends an expanded fire prevention program in all nursing homes, hospitals, and similar type occupancies. This will require additional funding. The fire marshal's office has been conducting this type of program to the best of our ability and we are also attaching to this report a list of suggestions for fire safety in nursing homes and hospitals.

We also recommend that an additional member be appointed to the Ohio Board of Buildings Standards who shall be a member of the fire service with recognized ability and broad training in the field of fire protection, suppression, and extinguishment. This member would be familiar with the problems faced in fire fighting and extinguishment which is sometimes overlooked by people in the architectural fields.

Respectfully submitted, Samuel T. Sides, State fire marshal.

Now I have also brought along the rules regarding the nursing and rest homes by the Ohio Department of Health.[1]

I also would like to call to your attention another nursing home fire that we had since this fire. This occurred in Clermont Nursing and Convalescent Home, Milford-Goshen Pike, Milford, Ohio, on January 31, 1970 at 7:50 p.m.

This building is very similar to the building we are talking about, the Harmar House. I have this preliminary investigation report that I would like to read, it is very brief. Attached are the following

[1] Retained in committee files.

enclosures: [1] (1) Diagram of building, (2) List of all patients residing in the nursing home, (3) List of employees on duty at the time of the fire, and their statements, and (4) Statements from Fire Chief Richard Bevke and Assistant Fire Chief Harold Faulkner.

The following items were taken for examination: (1) Sample of carpet from the C wing, (2) Television set that was involved in the fire, and (3) Metal formica-covered nightstand which television was sitting on.

The fire occurred on January 31, 1970, at approximately 7:50 p.m. The building involved is a one-story modern fire resistant structure completed in November 1966. The building is built in the form of an H, with an L-attached wing to the northeast side. The building is approximately 236 feet in length east and west, and approximately 170 feet in width north and south. Located in the center of the H is the dining room, kitchen, boiler room, laundry and storage areas, and the nurse station. The L-attached wing to the rear does not contain living quarters for patients, but are working areas for personnel and treatment rooms.

At the entrance to each wing there is a steel A label fire door. The hallway north and south contain B label wood doors for the purpose of closing off the hallway. The floors are tile except for the C wing, which is carpeted. The ceilings and hallways are drop-type acoustical ceilings. The interior walls are painted. The railings in the hallways are of steel.

There are pull-type fire alarms located in all halls and a central alarm at the nurses station. The walls of the residential area are plaster over 4-inch cement blocks. The L-attached wing to the rear is frame work, rock lath covered and plastered.

The exterior walls are of 8-inch cement block covered on the outside with brick. The building is a one-story in height with frame trusses supporting an asphalt shingle roof. There are outside exit sliding patio doors from the rooms in the center part of the H.

At the time of the fire there were 106 patients, three nurses and five aides and one maintenance man in the building. There was no loss of life and only a few of the personnel complained of smoke congested lungs.

The fire developed in room A12, located on the southwest corner of the building. The room was occupied by Emma Harvey and Rose Wiley. The origin of the fire was a television set sitting on a metal Formica-covered nightstand. The brand name of the television set was Sharp, made in Japan and distributed by the Sharp Electronic Corp., Carlstadt, N.J., and was purchased from the K–Mart, Beechmont Avenue, Cincinnati, Ohio. The cost was around $70 and was approximately 1 year old. The television set was owned by Emma Harvey who at this time was watching the television set and listening to it by means of earphones.

Investigation reveals that Mrs. Emma Harvey saw smoke coming from the back of the set at first and then a small glow which turned into flames from under the front and bottom. Upon observation of the television set getting afire, Mrs. Harvey yelled for Marlies Rein, who was the aide taking care of her room on this particular evening. Mrs. Rein happened to be in room A10, next door. Mrs. Rein, upon being

[1] Retained in committee files.

alerted by hearing her name being yelled by Mrs. Harvey, rushed into the room and saw the television set burning. At this time Mrs. Rein quickly removed Mrs. Harvey from the room by means of the wheelchair which she was in and located Mrs. Wiley, who was at this time in the bathroom, and moved her into the adjoining room.

Mrs. Rein then returned to the nurses station and alerted Mary DeGraw, who at once reported the television fire to the registered nurse in charge, Mrs. Martha Gillman. Mrs. Gillman called the number listed for the fire department and alerted other personnel by the means of a public address system to report to the nurses station.

During this time Mary DeGraw and Anna Luke, other employees, had returned to room A12 with Marlies Rein. The television was still burning and the room was starting to fill up with smoke. The electrical plug was pulled and Mrs. DeGraw attempted to smother the fire by putting a blanket over the television.

At this time the three employees left the room, shutting the door behind them and started working toward the evacuation of the other patients in the A wing. During this time Mr. Robert Hunter, the evening maintenance man, had been alerted about the fire and went to the room in which the fire was burning with a fire extinguisher. However, upon opening the door, the intense smoke in the room caused him to reshut the door and not use the extinguisher.

All other personnel by this time had joined in the evacuation of the patients from A wing. Some of the patients were evacuated by the means of wheelchairs and chairs being drug up the hall and in some instances, two patients were put in one bed and beds were rolled down the hallway. Some were evacuated through the double sliding patio doors and exited to the outside of the building.

The evacuation of the patients had been completed in A wing upon the arrival of the fire department and the fire was out in room A12, due to the operation of the two sprinklers located in room A12. Some of the personnel said that evacuation was almost half completed on A wing when the alarm system rang, this being caused by the sprinkler head operation from heat, which had risen to 160°, the amount of heat that it took to operate the sprinkler head. A couple of employees had heard the water start to run. The patients were evacuated to the hallway and dining room areas. The personnel say, as verified in their statements, that heavy smoke was building up into the hall in the area of room A12 by the time the evacuation was completed and all doors to all rooms were closed upon the patients being evacuated. There were visitors in the building at the time of the evacuation who were asked to help and all cooperated.

Room A12 is located in the southwest corner of the building and joins room A10, with a connecting bathroom between the two rooms. The room has a built-in frame dresser at the foot of the two beds with Formica covering. The floor is tile, the walls are painted rough plaster. The curtains to the outside windows are fiber glass and the drape dividing curtains in the room are 100-percent cotton, fire resistant treated. The room also contains two metal Formica-covered nightstands with drawers, manufactured by the Hard Manufacturing Co., Buffalo, N.Y., two metal frame chairs with bottoms and backs vinyl-covered foam rubber.

There was one overstuffed vinyl covered chair located in the room owned by Mrs. Wiley, two steel beds Formica paneled with a 4-inch foam rubber mattress covered by a waterproof ticking and one plastic waste can. The fire damage to the room was only smoke and destruction to the television set and scorching of the stand which the television was sitting on. The 100-percent cotton dividing curtains which were close by the origin of the fire, were not damaged by fire, smoke only.

The number that was called for the fire department was the Clermont County sheriff's office, who in turn alerted the fire department with a plectron alerting system. The fire chief happened to be traveling down the road approximately one-quarter mile from the nursing home when he received the alarm on his radio in his automobile. Also, the assistant chief happened to be close by in his automobile. Both were on the fire scene in a matter of minutes. All patients had been evacuated from A wing upon their arrival. The sprinkler system was still working in room A12.

INVESTIGATOR'S CONCLUSIONS

The fire originated in room A12 in the northwest corner of the room, the origin being a television set sitting on a nightstand. It is the feeling of this investigator that the reason for the minor damage was that Emma Harvey, the discoverer of the fire, alerted Marlies Rein, who quickly alerted other personnel Mary DeGraw and Anna Luke, and that these employees upon leaving room A12 shut the door behind them. This caused the heat from the burning television to be confined in the room and build up temperature to 160 degrees and activated one of the sprinkler heads located in the ceiling just inside the entrance door to the room. It may be noted that the sprinkler system was working when the fire department arrived and the fire was out in the room.

It was found that the evacuation was so orderly and quiet that other patients knew nothing about a fire.

Now I call this report to your attention because it is a direct contrast to the Harmar House incident. Here we had the patients close the doors upon the discovery of the fire, we had a sprinkler system in the room which extinguished the fire.

Senator Moss. Thank you very much, Marshal Sides. It is good to have a report of one that was properly handled and came out without any fatalities. The people there are certainly to be congratulated in the accomplishment that was made in the more recent one that you have reported.

I appreciate your giving us the recommendations which you say you have passed on to the Governor of Ohio at this point.

Mr. SIDES. Yes, Senator. Upon completion of this report Governor Rhodes appointed a committee of fire knowledgeable people to study the nursing home laws in the State of Ohio and also my recommendations and report back to him for possible legislative action.

Senator Moss. I notice one of the recommendations that all carpeting be prohibited in nursing homes, hospitals, and similar types of institutions. Do you think that is necessary?

Mr. SIDES. Senator, I think it should be prohibited except if the industry can show that this carpeting has been submitted to some nationally recognized testing laboratory and shown to be safe from fire and toxic gases.

Senator MOSS. So your recommendation is a qualified one, carpeting should be prohibited until such time as its flammability can be reduced much below what it is now required by the standards we have under the Flammable Fabrics Act?

Mr. SIDES. Yes, sir; I believe when you hear the report from the Underwriters Laboratory and from this other testing laboratory you will find this was highly smoke-producing and fast-burning material.

Senator MOSS. Is this type of carpeting rather common now in Ohio in use in public buildings?

Mr. SIDES. Senator, I am sorry to say I found it is in my own office.

Senator MOSS. Well, I think the mayor said the same thing.

Mr. SIDES. It is generally used.

I would like to add one other thing to this statement. The State fire marshal's office publishes a newsletter that goes out to all the fire departments in the State of Ohio and to the other State fire marshals and this is an excerpt from the October 1957 Ohio Fire Marshal's Newsletter:

> We have received a communication from the American Society for Testing and Materials asking us to help them to determine whether or not floor coverings constitute any particular fire hazard. They have asked for answers to the following questions and we hope that if any of you have any experience regarding these questions that you will forward the information to us so that we may help the committee with this responsibility.
>
> 1. In your opinion do floor coverings in general or does any particular type of floor covering constitute a fire hazard requiring control?
>
> 2. Do you know of any fires in which floor coverings were in any way a factor in the spread of flames, smoke or heat?
>
> 3. If you do know of any fires involving floor coverings, can you identify the floor covering by type, such as wool, nylon, cotton or other type of carpet or linoleum, vinyl, asbestos or plastic resin, flooring of any type or floor covering.

Now as I understand, as a result of this newsletter that goes to all the fire services in the State of Ohio we received two answers, one from the city of Cincinnati saying they had no problem with floor coverings and the other I believe from the city of Toledo saying they had no problem.

I understand that the society in their general survey throughout the United States only received 20 answers and none had had any particular trouble with carpeting.

Senator MOSS. They certainly had a lot of trouble in the fire we have been talking about.

What did you think of the mayor's recommendation prohibiting smoking in hospitals or nursing homes except in some room that was set apart for that purpose?

Mr. SIDES. Generally speaking, I would go along with it. We always say in hazardous areas everywhere. Now some cities have city ordinances prohibiting smoking in nursing homes and in hospitals. The city of Columbus has an ordinance that smoking must be done under supervision, the visitors can smoke only in smoking areas like in the central lobby downstairs.

I would be in favor of prohibiting smoking in these instances where people are bedfast and can't help themselves.

Senator Moss. Did Mr. Phillips ever make any statement about what that penny box of matches was doing in the Kleenex box?

Mr. SIDES. No, sir; as a matter of fact, the boys took two statements from him and in his second statement he just shut them off and said he was not going to talk to them any more.

Senator Moss. The recommendations you have, and I think I would approve of all of them with the possible exception of that on the no-carpeting at all, and you have qualified that saying that if they could get one that is substantially fire resistant you would not object. I wonder what would be the added cost that that might place on servicing nursing homes? I don't suppose you would have any way of making an estimate?

Mr. SIDES. No, sir; I would not.

Senator Moss. See, one of the problems we have, and I think my colleagues, Senator Young and Senator Yarborough, are touching on this, is that this was a rather expensive nursing home for the average older person; $500 a month is quite a high cost for care in a nursing home for an older person who ordinarily just has a little social security to try to get by on.

One of the problems we have been having, and this committee has been very concerned with, is the inadequacy of the amount of money available under Medicare and Medicaid for our older people to the point that many nursing homes will not take these patients any longer because the Federal payment is not enough to meet the cost. We are much concerned about that of course. Now with these additional safeguards, of course, it is likely the cost will be higher still and this is where we come to a point of trying to decide what we can do and what we should do about adequate facilities for these people who deserve to have an adequate home with which to live in their elderly years.

Well, I am making that more by way of observation because I am sure you are as aware of it as I. If you have any comment I would be glad to have it, but I would not expect that that would necessarily come within the range of your responsibilities as fire marshal.

Mr. SIDES. Senator, when you go into cost I realize some of the recommendations here are going to be costly; for instance, a sprinkler system. Now it is my understanding that from the Ohio Inspection Bureau who sets the insurance rates in Ohio that in older occupancy the addition of a sprinkler system will be credited against their insurance and over a period of time their insurance reductions would pay for a sprinkler system. However, I inquired as to the Harmar House type of installation and it would be costly, there would not be much difference there installing the sprinkler system because of the fire resistant construction of the building. So in a new, modern type rest home such as this they probably would not get much reduction, if any, for a sprinkler system so there would be some cost involved in both here.

Senator Moss. You referred to the Fitchville fire which was such a terrible holocaust in 1963. I think when we held our hearing then you had four or five inspectors that worked in Ohio. What number do you have now?

Mr. SIDES. Well, I am not familiar with that, Senator. I have only been fire marshal for 3 years. However, in our inspection bureau in the State Fire Marshal's Office we have a chief and assistant chief of inspection and 23 field inspectors. These are the men that inspect all the nursing homes and they are all inspected annually by our man and also by the various local fire departments. We also have four fire prevention specialists, as I said. The one you saw instructing people how to evacuate nursing homes and handle patients, this is our Fire Prevention Bureau.

Senator MOSS. Well, these 23 inspect all public buildings, not just nursing homes?

Mr. SIDES. Yes. According to the revised code we are charged with inspecting schools and we license hotels and motels and dry cleaners; we are required to inspect them. Also petroleum installations, liquified petroleum gas, and so forth. So they do have a varied type of inspection that they do.

Senator MOSS. Well, there are 1,162 nursing homes in Ohio, I am told. How often do you inspect these?

Mr. SIDES. We inspect them annually.

I might explain the type of inspection that is done in a nursing home. First of all, it is inspected by the division of factories and buildings for the construction and furnishings and if they okay it then it goes to the State department of health for an inspection; and then if they okay it, it goes to the nursing home division; and then if they okay it they request us to make an inspection. So by the time we make our inspection it is approved by the other three divisions and actually the inspection that we make from the fire marshal's standpoint is mostly a housekeeping inspection.

Senator MOSS. By housekeeping you mean what, just a cursory inspection?

Mr. SIDES. Combustibles, proper containers for rubbish, paint and metal containers. This is what we call good housekeeping. And poor housekeeping causes most of our fires.

Senator MOSS. Under your recommendation now the rubbish containers that have to be in the nursing homes would have to be metal?

Mr. SIDES. Yes, sir. We usually recommend, and we do know all State institutions require metal containers with metal lids.

Senator MOSS. Thank you, Chief Marshal Sides.

Mr. SIDES. Thank you.

(The report from the Division of State Fire Marshal follows:)

STATE OF OHIO,
DEPARTMENT OF COMMERCE,
DIVISION OF STATE FIRE MARSHAL,
Columbus, Ohio, January 21, 1970.

From: Division of State Fire Marshal.
To: Governor James A. Rhodes.
Subject: Report of Investigation of a Fire at the Harmar House Convalescent Home, Bartlett and Flint Streets, Marietta, Ohio, Washington County.
Date: January 9, 1970.

DESCRIPTION OF BUILDING

Shortly before 9:57 p.m. on Friday, January 9, 1970 fire broke out in the nursing home described above.

The building housing the nursing home was a one-story structure which was built in the form of a cross. General dimensions are approximately 244 feet north and south, being 42 feet wide and 134 feet east and west, approximately 40 feet wide. The building is a one-story modern fire resistant structure built in 1965.

The interior walls are dry wall, painted, with steel stud beams. The exterior of the building was brick veneer construction celotex sub-siding. The roof was plywood sheathing supported by metal trusses which ran from the ceiling. The roof was asphalt shingles.

RESPONSIBILITIES

Nursing homes in the State of Ohio are licensed by the Nursing Home Division, State Department of Health. The Board of Building Standards adopts regulations, which are known as the Ohio Building Code. This is enforced by the Division of Factory and Building Regulations, Department of Industrial Relations. All nursing homes are inspected by the Division of Factory and Building, certified municipal building departments, State Department of Health, Nursing Home Division, State Fire Marshal Division, and fire departments.

OWNERS

Health Services, Incorporated. A list of all owners and stockholders is attached to this report.[1]

THE FIRE

At the time of the fire there were 46 patients, most of whom were elderly bed patients, four regular employees and two special nurses. At the writing of this report 28 persons have died as a result of the fire. The official cause of death was listed by coroner K. E. Owen as asphyxiation and smoke inhalation. The surviving patients were taken to the Marietta Memorial Hospital and Selby Hospital. A complete list of patients in the building at the time of the fire is attached to this report.[2]

The first notification of the fire was received by the licensed practical nurse in charge, Mildred Hall, who was at the nurses station in the center of the building when the heat sensor in room 104 activated the alarm, whereupon Mrs. Hall rang the house fire alarm and noted that the smoke was coming from the south end of the building. All employees went in the direction of the smoke, which was coming from 104. Two of the employees removed Mr. Phillips from the room and out of the building.

The employees described the fire as burning on the floor in the northwest corner of room 104, occupied by Mr. Lyle Phillips. The room was very heavily charged with smoke and one employee tried to fight the fire with a fire extinguisher but stated the smoke was too dense. The employee stated that at this time they tried to remove patients from the building with the assistance of surrounding neighbors.

On arrival of the fire department, some of the fire fighters assisted with rescue work, others attacked the fire and stated that the fire was extinguished within ten minutes with less than one thousand gallons of water being used.

It was thought at first that there was some delay in sounding the alarm to the fire department, however, investigation disclosed that one employee did use the phone in the nurses station, dialed the operator and reported the fire.

Examination of the fire scene disclosed that the fire originated in room 104 in the northwest corner of that room at a low level. The plastic waste basket and the carpeting, which had a rubber back base, was entirely consumed, as well as the rest of the contents of the room. The smoke, heat and fire gases traveled into the hall from this room to the center of the building, then spreading east and west and also north to the approximate location of room 114. A diagram of these rooms is attached to this report.[3]

Investigation further indicated that the point of origin in room 104 was at a point four feet six inches from the north edge of the entry door and two feet from the northwest corner of the room. This is the area as indicated in fire terminology as the V patten on the wall and the point of the deepest charring of the baseboard. The fire started on or near the floor at this point and spread upward and outward. In the area was a wooden night stand, a plastic waste basket, a metal walker, and a wood-frame vinyl plastic upholstered chair. Investigators reported that there were no electrical outlets or switches in the immediate area of the point of origin.

It appears that where the patients' doors were open these were where the fatalities occurred, and it was reported that in the rooms where the doors were closed, the patients were rescued. From the employees' description of the fire it appears that

[1] See p. 390-91 for list of stock holders.
[2] See p. 388 for list of patients.
[3] See p. 384 for diagram of rooms.

the fire spread very rapidly and produced very dense, heavy, black, smoke following these employees from the building. The carpet in the hallway was almost entirely destroyed as far as the area of rooms 113 and 114, which is a northerly direction from the point of origin. Heavy destruction from heat and smoke occurred to the wall covering in the west wing in the area of rooms 152 and 155. The east wing, which is the kitchen and dining area, was damaged by heat and smoke. The only exterior fire travel was through the glass window in room 104. There was no burning through of any of the walls or ceiling and no basic structural damage to the building.

THE FIRE DEPARTMENT

The Marietta Fire Department under the direction of Fire Chief Beman Biehl, are to be commended for the rescue operations and extinguishment of the fire in such efficient manner under such perilous conditions. Statements were taken from Chief Biehl and the firemen responding to the fire and are attached to this report.[4] In addition to the statements from the fire department, statements were taken from all of the employees of Harmar House and special nurses who were on duty. Also, a statement was taken from Mr. Lyle Phillips, occupant of room 104, and Mr. Charles Strauss, a surviving patient. In addition to the statements, attached is a complete list of all the Harmar House employees, a copy of the specifications and blueprints of the Harmar House, provided by C. D. Camden and Associates, architects and consulting engineers, Marietta, Ohio, Also, reports of the carpeting installed in patients rooms and hallways. Also, a report of the paint and wall-tex used in Harmar House. Other additions attached to this report are the fire casualty reports, certificates of deaths, and the fire report provided by the Marietta Fire Department.

PHOTOGRAPHS

Complete photo coverage was made of the interior and exterior of the building and are attached to this report.[5]

INVESTIGATION

Investigators removed from the scene for laboratory analyses the following items:

1. Carpeting from the closet in room 104.
2. Electrical motor from the bed in room 104.
3. Section of dry wall from area at head of bed.
4. Electrical wiring, switches and outlets from room 104.
5. Heat sensor from room 104.
6. Top drawer of bedside stand containing a Kleenex box and a penny box of matches inside the Kleenex box, which were not ignited.

Other items collected for laboratory analysis include:

1. Heat sensor from undamaged room.
2. Carpet from hallway from in front of room 106.
3. Carpet from room 107.
4. Paint samples from the hall wall near room 113.
5. Section of dry wall near floor level from hall in area of room 113.
6. Plastic waste basket from other rooms.
7. One pillow from room 107.
8. Section of mattress from room 107.
9. Section of mattress cover from room 107.
10. A section of chair and chair covering from room 107, similar to the one in 104.

Participating in the investigation were State Arson Investigators Chief Eugene L. Jewell, Robert Greenwalt, Harry McLaughlin, Jr., and Frank Jewell, State Fire Prevention Specialist, who also took the photographs which are enclosed. All investigators concur that the fire originated in room 104 in the northwest corner of the room at a very low level. It appears that the heat and smoke was building up very rapidly when discovered and when the door was opened to remove Mr. Phillips it allowed the fire to escape in the hall and increase the burning in the room.

The fire spread very rapidly and it is the feeling of the investigators that the carpeting and the rubber backing on the carpeting contributed to the spread of the fire and was the cause of the heavy, dense, black smoke.

[4] See p. 356 for statement of Chief Biehl.
[5] Retained in committee files.

The construction of the building was such that it contained the fire gases and smoke and it was further concluded that the opening and closing of doors and the breaking out of windows during the early evacuation of patients helped to create a draft and helped spread the fire along the hall. The investigators also concur in the fact that had the door of room 104 been closed after the removal of Mr. Phillips the fire might possibly have been contained in the one room.

The items removed from the premises for testing have been transmitted to the Chemical Engineering Laboratory of Ohio State University and the Underwriters Laboratory at Northbrook, Illinois, and a report from these laboratories will be forthcoming. Personal testing was made of the carpeting by the Fire Marshal's office and was found to burn very rapidly, producing heavy black smoke, and are attached to this report.

The cause of the fire shall be listed as undetermined. However, in all probability the fire was caused by a discarded cigarette. Mr. Phillips, the occupant of room 104, admitted to the investigators that he sometimes stomped his burning cigarettes out on the floor. There was no other apparent source of ignition in the area.

RECOMMENDATIONS

It is strongly recommended by the State Fire Marshal's office that an approved automatic sprinkler system be installed in all such occupancies. This sprinkler system should be equipped with an alarm device transmitted to a central station protective signal center such as the American District Telegraph system, or to the fire department alarm office where possible.

Also, it is recommended that smoke detectors be provided in nursing homes in addition to the sprinkler system, as these will warn of the presence of smoke before enough heat is generated to activate the sprinkler system.

An approved automatic heat actuator closing device should be installed on *all* doors. Also with this system could be incorporated a device for automatic self-closing of all doors.

It is recommended that an approved fire door be installed at each wing which extends from a main corridor, and an approved fire door should be installed in any corridor over 100 feet.

The Fire Marshal's office recommends an expanded fire prevention program in all nursing homes, hospitals, and similar type occupancies. This will require additional funding. The Fire Marshal's office has been conducting this type of program to the best of our ability and we are also attaching to this report a list of suggestions for fire safety in nursing homes and hospitals.

All waste containers in patients, rooms shall be metal. Plastic type containers should be prohibited.

That all carpeting be prohibited in nursing homes, hospitals, and similar type institutions.

We also recommend that an additional member be appointed to the Ohio Board of Building Standards who shall be a member of the fire service with recognized ability and broad training in the field of fire protection, suppression, and extinguishment. This member would be familiar with the problems faced in fire fighting and extinguishment which is sometimes overlooked by people in the architectural fields.

Respectfully submitted.

SAMUEL T. SIDES,
State Fire Marshal.

Senator Moss. We will now hear from Mr. Stevens. If I have other questions that occur, perhaps I would like to refer back to you so you may remain seated there, if you will, please.

Mr. Richard Stevens of the National Fire Protection Association. I believe you have appeared before our committee before.

STATEMENT OF RICHARD STEVENS

Mr. STEVENS. That is correct, Senator.

Senator Moss. We are glad to have you again and look forward to your testimony.

Mr. STEVENS. Thank you.

Mr. Chairman, members of the committee, ladies and gentlemen, the fire in the Harmar House in Marietta, Ohio on January 9, 1970, exemplifies again the unique problem of life safety from fire that exists in this type of occupancy. The fact that this fire involved a recently constructed, one story, basically noncombustible building with a relatively high ratio of employees to patients makes it more relevant to any study of the fire problem in this type of occupancy than many other fatal fires that have occurred in similar facilities. It is more relevant because most of the fatal fires in this occupancy have occurred in buildings that did not measure up to current construction standards. Opponents of adequate measures to assure a reasonable degree of life safety from fire in this occupancy have used this fact, and others, to successfully block the adoption of code provisions which would provide that degree of assurance.

The conditions prevalent in these places, however, which make them a unique fire problem have little relationship to the construction of the building.

THE PATIENTS

Fire experience has shown that the primary problem in providing a reasonable degree of life safety from fire in this type of occupancy is the patient himself.

Tha facts show that the patient is generally incapable of any act of self-preservation in an emergency situation due either to his own mental or physical infirmities or to conditions which are forced upon him. He will frequently observe the starting and progression of a fire without taking any action of self-preservation or of sounding an alarm to alert others. The patient often will not follow verbal instructions to evacuate the building and, if forced to leave, will often struggle with those who attempt to move in. Furthermore, once evacuated, a patient is very apt to reenter the building if not restrained. This means that evacuation of these places—the usual course to follow in a fire emergency in a building—becomes practically an impossibility with the limited staff available.

In further support of this statement, I ask you to consider also the fact that elderly people are extremely susceptible to fire effects and that in this type of occupancy the patients are frequently under sedation, especially at night. In addition, many patients are strapped in their beds or otherwise restrained at night, as was the case in the Marietta, Ohio, fire.

Since many of the patients do not possess the mental and physical abilities that they once enjoyed, they are apt to be the originators of fires either through acts of carelessness, overt acts, or physical inability to deal with a situation.

It is my opinion, therefore, that the patient is the primary reason that these places are unique amongst all occupancies when considering the problem of life safety from fire. There is, however, one other reason for this uniqueness which is worthy of consideration.

THE STAFF

Having already established that it is practically an impossibility to expect the staff in this type of occupancy to evacuate the patients while an uncontrolled fire is in progress, it is relevant to point out that in the Marietta, Ohio, case there were on duty at the time of the fire

emergency four employees of the establishment and two special employees hired by patients. There were 46 patients in the building. This, I believe, is a relatively high ratio of attendants to patients.

In a hospital where similarly there are many patients incapable of self-preservation, during a fire emergency selected employees from all parts of the building immediately report to the fire area to assist the staff on duty in that area in moving patients and fighting the fire. Even off-duty employees are summoned when dormitories are a part of the hospital complex. This magnitude of backup assistance is not available in the type of occupancy being considered here.

It has been stated, authoritatively, that the employee turnover rate is very high in all institutional occupancies. This means that awareness of the procedures to be followed during fire emergencies may not be as deeply instilled in the employees as would be desirable. Therefore, human error is a distinct possibility. Even in situations where employee training is outstanding, human frailties are generally inevitable during emergencies.

Conclusion

If you agree with me that it is not possible to contemplate evacuation of this type of occupancy during a fire emergency and if you also agree that it is not reasonable to risk the lives of the patients on the actions of the staff, assuming the fire conditions are such that those acts can be performed, then I am sure you will agree that the only answer to the life safety from fire problem in this occupancy is to automatically detect and automatically control any fire that occurs.

In the present state of the art, the most practical system available to perform this function is the automatic sprinkler system. Each sprinkler in the system responds individually to fire as a detector and an expellant of water, which is the extinguishing agent. Both acts are performed automatically. There is no positive assurance that such a system would save the life of a patient should a fire occur in his room, but there is ample evidence, fortified by over 70 years of accumulated statistics, that the system would prevent the loss of life by fire of virtually all other patients in the building.

The history of fire prevention and fire protection shows that it often seems to require a fire tragedy to stimulate improvement of life safety from fire in buildings. Typical of such situations are the Cocoanut Grove fire in Boston on November 28, 1942; the Winecoff Hotel fire of December 7, 1946 in Atlanta; and the school fire at Our Lady of the Angels in Chicago on December 1, 1958, all of which led to significant improvements in required levels of life safety from fire. This reaction to tradegy as a means of improvement in code provisions is not because of a prior lack of knowledge of how to deal with the problem. Rather, it is because of public apathy and private reluctance to accept the monetary expenditure necessary to achieve what needs to be done. The fire at Harmar House in Marietta, tragic as it was, provides the opportunity to improve the level of life safety from fire in that type of occupancy all over the Nation.

Steps are now being taken within the National Fire Protection Association to amend the provisions of its Life Safety Code to raise the level of protection of institutional occupancies like Harmar House. This code is very widely accepted as suitable for governing the level of life safety in this and other occupancies. It is reasonable to expect that

the Marietta fire and the amendment of the Life Safety Code will lead promptly to widespread improvement in State and local requirements.

Thank you.

Senator Moss. Thank you, Mr. Stevens. Your recommendation that we have a sprinkler requirement similar to Marshal Sides', I wonder what your opinion is as to what the effect might have been in this Marietta fire if they had had a sprinkler system? I saw in the background that it was the dense smoke and that rubber backing which appears to have been the cause of death. Now would a sprinkler have got at that, do you think?

Mr. STEVENS. I think the sprinkler would have stopped all production of smoke and fire once it had operated in that room, plus of course when this happens that is the end of everything.

Senator Moss. Would it not have required a combination though of closing the door and the sprinkler going on?

Mr. STEVENS. Closing the door as Marshal Sides pointed out, might permit the sprinkler to operate a little more quickly than it would otherwise do because it would keep the heat within that room. I think even if the door had been open there would not have been any other fatality.

Senator Moss. Your observation and your testimony is that the sprinkler would have brought down enough water to have put the fire out on that carpet within the room before it got out of the room?

Mr. STEVENS. That is correct.

Senator Moss. That of course would have confined it if that were so. I am no expert at all, I am just trying to find my way around here. Although I would not say that rubber burned explosively, it nevertheless took off with a simple one match and burned up very readily this morning when we had that exhibition there.

What about this pile test that they talk about in testing a carpet? Can you tell me what your opinion of that is?

Mr. STEVENS. Well, my official opinion is that it is a small-scale test of very limited usefulness.

Senator Moss. Would this carpet have passed the pile test, the type of carpet that we burned this morning?

Mr. STEVENS. I would guess it would, yes.

Senator Moss. I was asking the marshal about the number of inspectors that they had. I believe when you testified on Fitchville you told me about the number of inspectors they had in Ohio, fire inspectors. Do you recall that?

Mr. STEVENS. I am afraid, Senator, my memory is not quite that good.

Senator Moss. The reason I brought that up I suppose I was under the impression there had not been any appreciable change in Ohio even though the Fitchville fire was such a terrible tragedy. I just wondered if there had been a notable change in your observation as to the inspection process there.

Mr. STEVENS. Well, from what Marshal Sides said, he has 23 regular inspectors and four that are out training people. This is certainly a tremendous improvement.

Senator Moss. Would it be adequate for the population of the State of Ohio, though?

Mr. STEVENS. Well, that is a difficult question to answer. What is adequate or what might be ideal are miles apart, I am afraid. I suspect Marshal Sides would like to have a lot more inspectors if he could get them.

Mr. SIDES. Definitely.

Senator Moss. In your details, Mr. Stevens, on the fire organization type drill that you talk about, would you recommend that this be a drill that would be repeated rather frequently in a nursing home or a place where people are incapacitated for moving around readily?

Mr. STEVENS. Very definitely. Very definitely. I have heard today that semiannually or annually. I guess I would think that monthly might be more in order.

Senator Moss. There has been testimony here, and we have heard it before, that there is quite a high turnover of personnel of people who worked in nursing homes which would mean you would always have some new ones coming on. I was thinking back to this fire evacuation drill which is just one thing. If it had been drilled into these people to close the door in that room, we might have been spared these fatalities if the fire had been contained to room 104. They did get Mr. Phillips out, and we might have had no fatalities there. So I presume part of the drill would be that to close the doors and close the windows and keep the fire contained as much as possible.

Mr. STEVENS. Very, very definitely.

Senator Moss. We have an anomaly between the two Federal statutes that we are concerned with here. One is the requirements under Medicare and Medicaid. I know there is a distinction there that escapes both people but there are two different kinds of Federal support for the elderly people. Now the Life Safety Code of the National Fire Protection Association is a required condition for people who are receiving Medicaid from the Federal Government. There is no such requirement under Medicare. Can you think of any possible reason for a distinction like that?

Mr. STEVENS. No, sir, I can not.

Senator Moss. Well, I don't think there is any reason to distinguish. Of course that is something that we have a responsibility for here, we and the Department in its regulations, putting into effect the requirements there.

Getting back to this fire drill, do you know how many of these people who were on duty there that night, marshal, who had been on duty when they had the last drill, which is about 9 months before, or something like that?

Mr. SIDES. As I recall from talking to our fire prevention man, I think two of the ones on duty had previous training along with the group from one of the local hospitals.

Senator Moss. But this was general training in what you do in case of fire?

Mr. SIDES. What you do in case of fire and how you evacuate, yes.

Senator Moss. Do you know if there was a drill on this particular home in which they were working?

Mr. SIDES. I can't answer that. I think they got all the people from the surrounding areas in one group.

Senator Moss. At a school?

Mr. SIDES. I don't think the building itself actually figured in the drill.

I would like to correct one thing that was said earlier. There is no law to my knowledge requiring drills in hospitals or nursing homes. The only law that I know of in the State of Ohio requires the school principal or the superintendent of a school to conduct a drill at least once a month and it is the school principal's responsibility. This is the only law I know in the State of Ohio requiring a fire drill.

Senator Moss. It would be a salutary rule if this were required also of the nursing home or a convalescent hospital, wherever people are there in the public charge.

The thing that comes through in this so strongly is the fact that the draft went through there, the door was left open on the outside, the door to the room was left open and then the windows were broken in as the smoke got dense. It seemed to me we just had a big chimney there with a draft through there and fanning that fire.

Mr. SIDES. What you had actually was a horizontal chimney.

In regard to what Mr. Stevens said about sprinklers, even if the fire got out of that room, if there was a sprinkler system installed and the fire got out of that room there would still be sprinkler heads in the hallway to take care of any further buildup of heat in the hall.

Senator. Moss. So if it did creep out in the hall, it would get that sprinkler activated eventually.

Mr. SIDES. Yes.

Senator. Moss. Well, I appreciate it very much, gentlemen.

Mr. SIDES. Senator, may I make a comment? I have a gentleman here from Rohm & Haas, Mr. William Jamouneau, who made the smoke test for us and I would like for you to listen to his testimony.

Senator Moss. We will hear you, Mr. Jamouneau.

STATEMENT OF WILLIAM JAMOUNEAU

Mr. JAMOUNEAU. I am William Jamouneau, associated with Rohm & Haas Co. I conducted tests on a sample of carpeting which Marshal Sides sent to our company.

The test is conducted in a 1-foot square oven which is 31 inches high and an open flame is applied to the underside of the specimen which is a 1 by 1 by ¼ inch. The smoke produced is measured by an attenuation of a light beam which is passing through the cabinet. In other words, when the material begins to smoke, the light is absorbed and this absorption is recorded on a photoelectric cell.

Now we ran several tests of this carpeting material. First we started with a red oak sample. Red oak is taken as a kind of traditional touchstone. Now two values are recorded here, the maximum smoke density which is the highest light absorption value which was recorded during the 4-minute test.

The second value relevant here is a smoke density rating which is an area under a curve during the 4-minute test. Now for the red oak we recorded a maximum smoke density of 3. When we tested the fibers alone, having scraped the fibers from the foam backing, we recorded a value of 13. When we tested an equivalent weight of the foam backing, the report was 99.

Now the smoke density rating which is the average for 4 minutes, the area under the curve for a 4-minute test run the smoke density for red oak is 0.015, for the fibers alone 10, and for the backing alone, 83.

These tests were conducted in the past few days and I sent them here in a written report.

(The report follows:)

CARPET SAMPLE CHARACTERIZATION IN SMOKE CHAMBER BY ASTM STANDARD D–2843

The Redstone Research Laboratories of the Rohm and Haas Company have performed tests on a sample of carpet as provided by Mr. Thomas Sides, the Fire Marshal of the State of Ohio in the smoke chamber specified in ASTM Standard 2843, "The Standard Method for Measuring the Density of Smoke From the Burning or Decomposition of Plastics." This ASTM test method is of considerable value in comparing the relative smoke generating characteristics of plastics under conditions of active burning and decomposition in the presence of a flame, and has been found useful in the present investigation of the smoke generating characteristics of the carpet sample. The specimens burned in the present investigation have been cut to conform as closely as possible to the size specified (1x1x¼ in.) in the ASTM standard.

Due to lack of time, the specimens were in an unconditioned state, with no prior conditioning.

The test specimens are placed on a coarse mesh screen and exposed to an open propane flame which impinges on the under surface. The smoke generated from the test is measured by passing a light beam through the smoke onto a photocell. The output of the photocell is taken as a measure of the light absorbed by the smoke. Two quantities have been used to report he results: the maximum smoke density, in percent light absorption, and the smoke density rating, which is the area in percent under the light absorption-time curve.

Specimens of carpet, fibers only, and backing only were tested. The carpet specimens were placed in the chamber with the backing toward the flame and then the next set of carpet samples were inverted such that the pile was exposed toward the flame. The test results are given in the following table.

SAMPLE[1] TEST RESULTS

Test description	Size (inches)	Weight (grams)	Maximum smoke density[2]	Smoke density rating[2]
Red oak	1 x 1 x ¼	2.60	3	0.015
Fiber toward flame	1 x 1 x 5/8 [3,4]	[5] 1.64	91	66
Backing toward flame	1 x 1 x 5/8	[5] 1.66	55	35
Fibers only [6]	(7)	1.60	13	10
Foam backing only	1 x 1.5 x ¼ [3,8]	1.64	99	83
Do	1.5 x 1 x ½	2.60	87	70
Backing toward flame	2 x 2 x ¼ [3,4]	7.35	91	52
Fibers toward flame	2 x 2 x ¼ [3,4]	7.3	100	61

[1] Samples tested as received; no conditioning.
[2] ASTM Standard D–2843.
[3] Nominal thickness of a specimen as manufactured.
[4] Carpet specimen sizes approximated to ASTM Standard D–2843.
[5] Average weight of 3 specimens.
[6] Included a small amount of backing left clinging to fibers.
[7] Ball of fibers (~1 in. diameter) made to approximate weight of carpet specimen.
[8] Specimen of backing made to approximate weight of carpet specimen.

Senator Moss. Well, thank you very much. I understand red oak is 0.015.

Mr. JAMOUNEAU. That is correct.

Senator Moss. The other numbers are all in front of the point I take it, 10 for the fibers and 83 for the backing itself.

Mr. JAMOUNEAU. Yes, sir.

Senator Moss. So the comparison there is even though it is in the abstract, and I don't relate it very well visually to smoke, I can see that the difference is just immense.

Mr. JAMOUNEAU. One hundred is taken as a maximum total smoke obscuration. Zero being the least amount, 100 being the maximum.

Senator Moss. Thank you very much. That will add to our record and be of help to us.

We appreciate all of you gentlemen coming here to be witnesses today.

We are going to have to recess now. Tomorrow we are going to hear from the carpet people and the Office of Flammable Fabrics as well as from the Underwriters Laboratory, so we have some very important witnesses to hear tomorrow.

We will reconvene in this room at 9:30 tomorrow morning.

(Whereupon, at 1:05 p.m. the special committee was recessed, to reconvene at 9:30 a.m. Tuesday, February 10, 1970.)

APPENDIXES

Appendix A

(Subsequent to the hearing, the chairman wrote the following letter to The Honorable Maurice H. Stans, Secretary of Commerce:)

FEBRUARY 16, 1970.

DEAR MR. SECRETARY: I am enclosing a copy of my opening statement delivered as we began our hearings on questions arising out of the January 9, Ohio Nursing Home fire which to date has taken 32 lives. I have two vital questions:

1. Why hasn't the 1967 Flammable Fabrics Act been implemented?
2. When will the new standard for flammability of carpets and rugs be announced to replace the ineffective "pill test" and will the new test take into consideration smoke emission?

Significantly, it is nowhere indicated in your December 14, 1969 press release that the announced standard for flammability of carpets and rugs (pill test) is of an interim or first generation nature. On the contrary, your release bears the stamp of finality with the singular exception of the word "proposed". Certainly the carpet industry, independent laboratories and Dan River, specifically, viewed the Department's proffered pill test as *the* test for carpets and rugs.

What is most important at this time is that we have implementation of the Flammable Fabrics Act immediately and the replacement of the pill test with something like the ASTM-E84 tunnel test to measure the flammability and smoke emission of carpets and rugs. I would hope you could act on these objectives at once. The safety of all Americans in our homes and schools, and especially, those who suffer the compound burdens of ill health and advanced age deserve your immediate attention to reduce the risks of injury by fire. In view of the importance of this matter, I would appreciate hearing from you as soon as possible.

Best wishes.

Sincerely,

FRANK E. MOSS,
Chairman, Subcommittee for the Consumer.

(The following reply was received:)

THE SECRETARY OF COMMERCE,
Washington, D.C., April 7, 1970.

DEAR SENATOR MOSS: This letter is in reply to your recent letter requesting information on the Flammable Fabrics Act.

In response to your first question as to why the Flammable Fabrics Act amendments have not been implemented, the following information is submitted. When I was appointed Secretary of Commerce, I immediately asked for a review of this program as I considered it to be one of the Department's most important responsibilities. This review disclosed that under the previous Administration there had been only minimal progress in implementation of the Act. During that Administration two findings of possible need for a flammability standard were made. In October 1968, there was a finding that there might be a need to revise or amend the general wearing apparel standard on flammability (CS 191-53). In December 1968, there was a finding that there might be a need for a flammability standard for carpets and rugs.

After examining the results of this review, I took the following actions:

1. The Department requested increased funds for fiscal years 1971 and 1972 for use in implementation of the Act;

2. The staff at the National Bureau of Standards working on this program was reorganized, bringing more qualified people into the program and increasing the number of personnel working on the program;

3. Action was initiated to increase the flow of data concerning deaths, injuries and economic losses resulting from the accidental burning of products, fabrics or related materials from the Department of Health, Education and Welfare that was envisioned by section 14(a) of the Act.

4. Research contracts were let by the National Bureau of Standards to supplement the research work being performed "in-house" on flammable fabrics.

5. The entire program of this Department has been reorganized to provide a systematic approach to the identification, evaluation, and testing of common problems of flammable fabrics. Examples of these problems are by-products of combustion, heat measurement from burning fabrics, investigation of the operation of flame retardants, and heat transfer from burning garments. Such research will provide for the first time methods and techniques to determine the flammability characteristics of fabrics and interior furnishings.

In addition to the reorganization of the flammable fabrics program, the Department has also proposed a carpet and rug standard and issued a finding of possible need for a flammability standard for certain items of children's wearing apparel. The more difficult area of wearing apparel in general will require extensive research to resolve the many problems presented before any meaningful revision can be made in that standard.

As to your second question regarding the proposed carpet and rug standard, the Department views this proposed standard and any standard that may issue from this proposal as a "first generation" standard for carpets and rugs. The purpose of the proposed standard is to guard against the hazard of a small ignition source such as a cigarette, ash, cinder or spark that might come in contact with a carpet or rug. The more complex problems of carpet and rug underlayment, smoke and toxic fumes from carpets and rugs, and carpets' and rugs' contribution to a general conflagration will be addressed as soon as either data or research provide us with the tools to adequately identify, assess, characterize and test the hazards in these areas.

We have been preparing facilities to make possible the development of test methods for carpets and rugs and simulate actual room conditions. We have developed the capability to measure both smoke intensity and the concentration of toxic gases in order to evaluate those hazards, and to establish appropriate test methods for future standards. It is our intention to proceed with the development of test methods and with such other research as will make possible a determination of the need for second generation standards.

You inquired specifically about the ASTM–E84 tunnel test for carpets and rugs. It is our view that this test, which exposes the product fixed to the ceiling of the tunnel to a high intensity flame source, is not representative of service conditions for carpets and rugs. Specifically we feel that a test method must, as nearly as practicable, simulate service conditions. This will be our aim as we continue the technical development of test methods and standards.

Please be assured of my continued interest in this vital program. We are doing everything possible within the limits of the Act and the existing personnel and budgetary limitations to accelerate the work in this program.

I hope that this information will be of assistance to you.

Sincerely,

MAURICE H. STANS,
Secretary of Commerce.

Appendix B

LETTERS AND STATEMENTS FROM INDIVIDUALS AND ORGANIZATIONS

ITEM 1. EXCERPT FROM NEWSLETTER OF AMERICAN PATIENT ASSOCIATION, DATED JANUARY 30, 1970

31 DIE IN NURSING HOME; SMOKE FROM BURNING CARPET A MAJOR CAUSE OF DEATH: FEDERAL, STATE FLAMMABILITY STANDARDS IN DOUBT

An Ohio state health department spokesman called Harmar House "one of the finest and safest homes in the United States." Then why did 31 old people perish when the nursing home caught fire on January 9? An American Patient investigation has found that Ohio standards on flammability of interior finishings, particularly the kind of carpeting that sent black smoke billowing through the home, are among the lowest in the nation. Most of the deaths were judged to have been caused by smoke poisoning.

The fire at the Marietta, Ohio, proprietary home shows that federal fire-safety requirements are weak and weakly enforced. Owned by Health Services, Inc., a group of investors numbering five physicians, Harmar House was a Medicare facility and the holder of a Medicaid vendor number.

As a result of the fire, the U.S. Community Health Service (part of HEW's Public Health Service) began circulating a Januray 16 memorandum to state agencies and to Medicare officials warning that "certain types of carpet have a high flame-spread rating" and, with rubber or rubber-coated backings, have performed poorly in flame-spread tests. "No carpet or carpet assembly presently installed or proposed for installation in a health-care facility should have a flame-spread rating of more than 75 when tested by an independent testing laboratory in accordance with ASTM E 84 61." Such safe carpeting is not hard to find, says the CHS. However, Ohio's standard is a flame-spread rating of 200 (Class D).

Medicare regulations are silent on carpeting standards. American Patient has learned that this gap in patient protection had been called to the attention of Medicare officials by fire-safety experts in the Department of Health, Education, and Welfare in the past—but no action was taken.

Hill-Burton and Federal Housing Administration standards cover carpeting, but Harmar House was covered by neither. Medicaid standards that went into effect January 1 and employ the Life Safety Code do not allow the Class D standard used by Ohio. However, half or more of the states, including Ohio, apparently do not apply the Life Safety Code, a federal official admits.

Carpeting was not the only problem. Medicare recommends—but does not mandate—sprinkler systems in boiler rooms, trash rooms, and "non-fire-resistant areas." A Medicare official in the Baltimore headquarters said that sprinklers in patients' rooms at Harmar House were not required by the regulations and that an architect's letter was on file declaring that "noncombustible" carpeting had been used.

The lack of sprinklers in the boiler room was noted by an Ohio state health department nurse on a Medicare survey; but the Baltimore official said this was not sufficient cause to decertify the home. "As far as we can tell, there were no hazardous areas in the home," said Gerald S. Sheinbach of the Bureau of Health Insurance, Social Security Administration. "It was a one-story structure with the best fire rating and plenty of exits. The furnishings were all approved according to the fire code of Ohio," he said, noting that Medicare recommends use of drapes and carpets that comply with local fire-resistance codes.

Asked if information about safety deficiencies were available to the public so that informed patient-placement can be accomplished, Sheinbach said no. "The Medicare deficiency report is restricted by SSA's confidentiality regulation

to people who must have the information. I think you can appreciate the reasons: a lay person reading these could be panicked by not understanding what they really mean."

The State Fire Marshal's office told American Patient there were no building violations. However, the Marshal does recommend in its report on the Harmar House fire that all carpeting in hospitals and nursing homes be removed.

PERSPECTIVE

A complete Fire Marshal's report is awaited. But enough is already on record to show that Medicare and state regulations have dangerous loopholes. HEW Secretary Finch has the statutory power to incorporate the Life Safety Code into Medicare as an ironclad requirement.

Mr. Finch should also immediately repudiate the ruse of "confidentiality" for barring the public from learning the truth about nursing home and Medicare certification. "Lay persons" may or may not be "panicked" by reading the reports. But 31 have already died because only Medicare officials read them—and did *not* panic.

ITEM 2. NEWS RELEASE FROM AMERICAN NURSING HOME ASSOCIATION, DATED FEBRUARY 9, 1970

The Harmar House Nursing Home fire in Marietta, Ohio, resulted in severe loss of life because of four basic factors: failure to close door to fire room; alarm system; basic building design and materials used in furnishing the facility, according to James Regan, fire safety consultant to the American Nursing Home Association.

In a brief report prepared for the association on the January 9th blaze in which 28 asphyxiation deaths were attributed to the fire, Regan said conditions he found on his on-the-spot inspection of January 12 "are still present in many health facilities throughout the country."

Among factors he listed as attributing to the heavy loss of life were failure of personnel to close door of the fire room after rescuing patient; inability of the smoke detection system to sound an automatic alarm at the fire department and the delay alarm to the department; presence of combustible carpeting throughout the building as well as the extensive use of synthetic materials in the building and the design of the building which provided for both individual corridors and lofts (above ceilings) of the one story modern facility.

Regan pointed out that ANHA's representative had supported amendments to the National Fire Protection's Life Safety Code requiring a written fire safety plan encompassing (a) use of alarms, (b) transmission of alarms to fire department, (c) response to alarms, (d) isolation of fire, evacuation of persons close to fire, preparing building for evacuation and fire extinguishment.

Other amendments supported by ANHA would require supervision of facility alarm system by outside service (fire department) and interconnection of detection and extinguishing systems to the alarm system; limiting floor covering (rugs, carpets and mats) to material having a low flame spread rate and subdivision of corridors with smoke barrier doors for each 150 feet of corridor and subdivision of open areas including lofts.

Mr. Regan, a former chief of fire prevention in New York City, said had the home conformed to these amendments the tragic fire would not have taken place.

He also took issue with present system of reporting fire deaths arguing that the terms "suffocation" and "smoke inhalation" are too broad and "do nothing to identify the gases that may be present during a fire or the materials that are capable of producing a toxic or lethal gas upon destruction by heat."

Ross Reardon, acting executive director of the ANHA, said the state fire marshal's report on the fire already had been circulated to all members of the Ohio Nursing Home Association by the state association. He added that the Ohio Executive Director Gary Shepherd had notified member homes of the identity of the rubber-backed carpeting which was used in the home and urged them to "take all precautions" with respect to carpeting as "heavy dense acrid smoke was generated from the smoldering and burning of this carpeting, creating the deadly atmosphere."

Plans also have been announced by the Ohio Association to sponsor seminars February 24–25–26, in Cincinnati, Toledo and Akron.

Both the Ohio Association and the ANHA are taking steps to improve testing and labeling of materials used in nursing homes.

The American Nursing Home Association represents some 7,372 nursing homes and related long-term care facilities, with more than 425,000 beds. Its membership includes both proprietary and non-proprietary facilities.

ITEM 3. LETTER FROM ELIZABETH DAVEY, R.N., NURSING SUPERVISOR, HARMAR HOUSE, MARIETTA, OHIO

THE HARMAR HOUSE,
CONVALESCENT AND RETIREMENT CENTER,
Marietta, Ohio, February 6, 1970.

Senator FRANK E. Moss,
U.S. Senate, Washington, D.C.

DEAR SENATOR MOSS: Thank you for your invitation to appear at the hearing of your special committee on February 9, 1970, with regard to Harmar House, Marietta, Ohio. However, I am not well and on my doctor's advice ask that I be excused from taking the trip to Washington at this time.

This tragedy has been a particularly severe shock to those of us who were concerned with the day to day operation of the home and were so intimately acquainted with those involved. We were confident that we had constructed and were operating a safe and most modern facility. One with cheerful surroundings and where the guests received thoughtful and understanding care. It just couldn't happen, but it did.

My associates and I wish to express our appreciation to you and your colleagues for your investigation and study of the problem. And that out of all this will come some good for our older people in the years that lie ahead.

Sincerely,

ELIZABETH DAVEY, R.N.,
Nursing Supervisor.

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