THE DISASTER RESEARCH CENTER
THE OHIO STATE UNIVERSITY
COLUMBUS, OHIO 43210

Research Note #8

# A Description of Organizational Activities in the Fitchville, Ohio Nursing Home Fire

By
William Anderson
E. L. Quarantelli

Department of Sociology
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## Introduction

In the early morning hours of Saturday, November 23, 1963, a fire completely obliterated the Golden Age Nursing Home in Fitchville, Ohio, killed 63 patients and routed 21 others plus a night staff of three attendants. Four firemen were injured in fighting the blaze. Only one other nursing home fire in the history of the country resulted in more victims.

In terms of its spatial impact, the event clearly was not a community disaster. Still, it seemed to the Disaster Research Center that at least on a descriptive level something could be learned in this situation about:

1. Disaster responses in an institutional setting; and
2. Organizational reactions to disasters in a non-urban area.

However, the basic purpose of the field trip was to give members of the DRC staff further experience in an actual disaster situation. Thus, the description below is the by-product of a training mission and should be treated as such.

On the afternoon of the fire, two research assistants of the DRC arrived in the area to observe the activities of organizations in this crisis. After visiting the site of the fire Saturday evening, they spent Sunday informally interviewing about a dozen individuals associated with the disaster involved agencies. An attempt was made to interview personnel in each principle organization that participated in the emergency operations. Among those interviewed were the County Coroner, a Red Cross Field Representative, members of the local sheriff's department, State Highway Patrol, and Salvation Army, as well as volunteer firemen.

This descriptive report is based on the transcribed interviews of these respondents, participant observations on the scene, newspaper accounts, a statement from the Huron County Grand Jury, the technical report of the State Fire Marshal, and the transcriptions from the official investigation of the State of Ohio. After a short account of the setting and the crisis situation, there is a description of the activities of the major organizations that attempted to cope with the disaster. No attempt is made to give an overall description or to make any systematic analysis of the specific organizational responses.

## The Disaster Setting

Fitchville, site of the Golden Age Nursing Home, is a rural village of about 200 inhabitants located in Huron County, approximately 10 miles southeast of Norwalk. The latter is a town of about 10,000 persons. The nearest large city is Cleveland, 50 miles distant.

Although Fitchville is in a rural area, all the usual disaster agencies are present in nearby Norwalk. For example, in Norwalk there is a State

Highway Patrol post, a Red Cross chapter, and a Salvation Army unit. However, they as well as the other local disaster agencies are very small in size and heavily dependent on more distant units or higher headquarters for any but the most highly restricted equipment and personnel needs. For instance, the Red Cross chapter has but one paid executive and an annual budget of around $12,000. Organizations in nearby localities are even more embryonic or informal in structure. Thus, almost all fire departments are of the volunteer type. Fitchville Township, in fact, has no fire department. The scarce resources and limited staffs which characterized these disaster organizations are probably very typical of almost all such organizations in small town and rural America.

There had been a bus accident in the area in the springtime in which around forty persons had been involved. In the main, however, there was a general lack of organizational experience with large scale crises. Various agencies, as again is usual in such localities, were mainly accustomed to being called upon for run-of-the-mill traffic accidents, house burnings, drownings, etc.

Equally typical was the lack of any overall plan coordinating the activities of the disaster organizations or guiding their inter-relations. Several years ago there had been a few meetings between representatives of different disaster agencies in and around Huron County but nothing had come from them. A few local organizations did have their own disaster plans. The Norwalk hospital, for instance, formally rehearsed a plan twice a year and had, in fact, just conducted such an exercise about a week prior to the fire. On the whole, however, it could not be said that organizations in this area had been trained or were prepared for anything but very local emergencies.

To some extent, the lack of structure and plans was partially counterbalanced by a web of informal understandings that had developed in a semi-rural tradition from the personal relations of officials of various agencies with one another. Thus, a sheriff's deputy noted that it frequently happened that a closer fire department responded to an alarm even though the fire was located within the jurisdictional limits of a more distant department. Likewise, it was a standard but unofficial routine for the police to notify the Salvation Army when they might be needed. It is to be suspected such informal understandings probably also are typical of similar types of localities in non-urban America.

The Nursing Home itself was located on the outskirts of the several scores of clustered houses that constitute the village of Fitchville. Open farming land dotted here and there by a farm house immediately surrounds the five acres of the Home. State Highway #250 passes 30 to 40 feet directly in front.

The Home was a rambling, one-story concrete structure with overall dimensions of 186 by 65 feet. Built originally in 1948 as a toy factory, it underwent several ownerships and remodeling in the decade that followed. On March 10, 1959, agents of the State Division of Factory and Building Inspection approved the structure as safe and adequate for nursing home use. It was one of almost 1,200 nursing homes in Ohio.

At the time of the fire, the Home had 84 patients, two short of its legal bed capacity. It would appear, although the DRC was unable to receive a definite figure, that a slight majority of the patients were completely ambulatory. (At one time in 1962 there had been 80 patients, of which 47 had been ambulatory, 11 bedfast and 22 helpless in various ways). Among the patients, besides the old and the infirm, were many suffering from mild mental disorders; the Home being one of six nursing homes in Ohio taking such cases. Some had been recently transferred there from a state hospital in Cleveland. About 80 percent of the patients were supported by county and state aid. In fact, more than half of the patients had no known relatives and seldom received visitors. Most were in their 70's or 80's.

To take care of this institutionalized population, there was a day staff of about 21. The night of the fire, following the usual pattern, only three staff members were in the Home. This included the night supervisor, and two nurse's aides. One of the latter was a 19 year old girl who had been on the job only three days.

The post-disaster technical investigation states that there had been a recurrent series of minor problems with the electric wiring and circuits in the building, particularly with the blowing of fuses and the burning of switches. There was no automatic sprinkler or fire detection system, local manual fire alarm, emergency lighting, or emergency water supply for fire fighting. However, according to the report of the State Fire Marshal, the Home passed inspections at different times.

One inspection in 1962, and also one in 1963 reported that there existed an established and documented evacuation plan. The post-disaster investigation, however, noted there was no specific, written, emergency evacuation procedure. In fact, according to the transcribed record of witnesses, no employee had been briefed or given any instruction on how to evacuate the building.

## The Disaster

A post-disaster investigation established that shortly after 4:45 a.m. a series of small fires ignited over a period of a few minutes and quickly merged into one overall blaze in the attic and wall areas. Apparently almost simultaneous ignition occurred at a number of points due to the inadequate and improper wiring of the electric circuits. Strong winds, some combustibles in the building and a tarred roof helped the fire to spread rapidly.

The three members of the night staff of the Home were all in the kitchen at that time. Following custom, they had started preparing breakfast. In fact, the State Fire Marshal report observed that the ignition of the fire was probably coincident with the plugging in of a heavy duty coffeemaker and an electric steam table used to keep prepared food warm. However, nothing amiss was noticed for a minute or two, and all three staff members went elsewhere in the building.

The fire appears to have been almost simultaneously noticed by passing motorists on State Route #250 and one of the staff members, who observing an unexpected light in front of the building, opened the front door to look outside. They all saw the roof area above the service entrance ablaze. This was at 4:50 a.m. At this time there was no smoke or flame inside the building, but there was great heat.

Two passing truck drivers came inside, asked for and were directed to fire extinguishers and returned outside to discharge them at the spreading flames. One of the staff members attempted to use the phone to send in an alarm, but the line having been short-circuited was dead. The electric lights in the Home by now had also started to fail. Another passing motorist drove a fifth of a mile to a nearby house, woke the sleeping householder, and had him make a call to the Village of New London, 7.6 miles away. This call reached the fire department and its chief just before 5 a.m. Thus, less than 15 minutes elapsed from the time of the outbreak of the fire to the time when the first disaster organization was directly notified.

Still another passing motorist who had stopped upon seeing the blaze offered to drive the night supervisor to a telephone. He drove her to a pay telephone at Olena, approximately 2.9 miles north of the nursing home. Uncertain what department to call, she dialed the operator who connected her with the Norwalk Fire Department. This, according to the fire department's log, was around 5:13 a.m. The supervisor was told that the nursing home was outside of the department's jurisdiction. When she said that there were patients inside the burning home, the answering party allegedly hung up. The telephone operator on her own initiative immediately called the New London Department.

However, in a later newspaper account, the Norwalk Fire Chief said that since the fire was in a jurisdiction outside his own, the call was referred to the New London Fire Department. It was said that if a call had come from the New London Department, the Norwalk Department would have responded since there is a mutual aid agreement between the two departments, an agreement not confirmed by the New London Department. But a direct request for assistance from the New London Department is first necessary. (It should be observed that at least six weeks after the fire, a UPI dispatch from Norwalk had the Norwalk fire chief stating that

his department could not answer the call because state law forbids a fire department from going into another area unless it has a written prior agreement with another community). Which, if any, of these three versions of the incident is correct, the DRC has been unable to ascertain. Nevertheless, the Norwalk Fire Department did notify the sheriff's office a little after 5:20 a.m. that it was not sending men or equipment to the scene.

Prior to the arrival of any fire equipment, the motorists who had initially stopped at the scene, truck drivers, and the two remaining staff members, attempted to evacuate the patients. Initially four patients were removed from the ward which appeared nearest the fire. The four were taken to one of the hallways near an exit and told to wait there until they could be evacuated. However, as the heat was becoming very intense, other patients were led outside and often put into the cars of motorists who had stopped.

There was considerable confusion in the attempt to remove patients. One problem was that the passing motorists who were doing most of the rescue efforts were trying to find their way around in darkness and smoke in a building unfamiliar to them. Some tried to remedy this situation by using the flashlights from their cars and trucks.

Another problem was that with an exception or two, there was little self or mutual help on the part of the patients. Would be rescuers, reported surprisingly little commotion or noise, and characterized the patients as being in a daze or immobilized. A few patients died in their beds four feet from an emergency exit, but it is possible these may have been bedridden cases. There were also several reported instances of patients who after being led outside, went back into the building. Most, however, simply were inactive, not doing anything to get themselves out of the building and eventually died from smoke inhalation. A partial explanation of the inaction, apart from the physical and mental conditions of the patients, is that around three-fourths of them were receiving medication. In fact, it was customary for some of them to be given sedatives and tranquillizers to prevent nocturnal wandering.

The half dozen or so passing motorists, plus the two staff members evacuated most of the 21 patients who eventually were saved. Apparently the time available for rescue before flame and heat prevented entry into the building was short. The New London Fire Department, for example, the first disaster organization on the scene was there by 5:10 a.m., but none of its men were able to get inside the building.

The arrival of this fire department heralded the start of a relatively large convergence of men and equipment from near and distant disaster organizations. The specific agencies that participated in the activities of the emergency period are detailed later. Those that took an active part represented a minority of all disaster organizations--many at a distance--that

offered help. In fact, in a number of respects the potential resources mobilized were disproportionate to the needs of the situation. In general, the actual organizational response was marked by a great deal of ad hoc decision making, the absence of any overall or centralized control, and considerable improvisation in intra and intergroup operations.

For instance, the first 11 survivors were piled into the private automobiles of passing motorists. A sheriff's deputy, leaving his own car, drove one of the automobiles because the civilian driver was not immediately found. It is unclear why personal rather than organizational vehicles were used. Participants reported that only two cars were used in providing this transportation, but this is probably incorrect. Of course, there was the erroneous impression that some of the rescued patients were "horribly burned." In fact, this seemed to have dictated the decision to rush these survivors to a hospital in Norwalk even while other evacuated patients were wandering around on the front lawn of the Home.

A sheriff's deputy provided an escort for the cars. The hospital had supposedly been alerted by both the sheriff's department and the Highway Patrol. However, when the first survivors arrived at the hospital--in the words of one deputy, "I had to ring the emergency button as there was no one in sight." It also turned out to be necessary to move some of the regular hospital patients out in order to admit all the survivors. (Apparently with the help of the Norwalk Police these patients were moved to other hospitals). The ambulances brought all but one of the remaining survivors to the hospital. The very last survivor, said to be in a bad state of shock and seriously burned, was rushed to the Norwalk hospital in a police car, even though there were numerous ambulances on the scene by that time.

As it turned out, except for four who were kept in the hospital until Monday, all the survivors had to be moved again later that day. A few had suffered second degree burns but there was no great need for hospital care. In addition, the hospital had no facilities for handling the mentally incapable patients who constituted a majority among the survivors. Before 3 p.m. that afternoon, with the help of volunteer drivers from the Red Cross, 17 survivors were retransferred to other rest homes in the general vicinity.

## The Post Impact Period

At the disaster site, with the survivors removed, there were only two major tasks for the array of organizational units that within an hour after the outbreak of the fire had surrounded the Nursing Home. These were: 1) to recover the bodies of the victims; and 2) to investigate the causes of the fire. Neither of these things could be done, however, until the fire burned itself out; the headway it had gotten supposedly making any attempt to bring it under control impossible. In fact, effort was directed at cooling the fire down rather than extinguishing it. Thus, most of the personnel and

and equipment of the various disaster agencies had little to do for some time after they had arrived on the scene.

While there was an increase in traffic at the disaster site, the roads around were not clogged by vehicles as is usually the case in situations of this nature. (This is probably not unrelated to the fact that Saturday was the day after President Kennedy's assassination). Nevertheless, Route #250 was blocked off and control points were manned by members of the Highway Patrol Auxilliary. The rest of the personnel from the different disaster agencies waited for about six hours before beginning their effort to recover the bodies. During that time they were supplied with coffee and food by a canteen from the Salvation Army (the supplies being donated by local restaurants), and sheltered in a tent erected by a vault company from Norwalk.

Around noon the task of recovering bodies from the ruins of the building began. The Coroner who was on the scene seemed to have taken overall charge, and was assisted by members of the Highway Patrol, the Sheriff's office, the Red Cross, as well as local firemen. Representatives of the State Fire Marshal's office also arrived on the scene.

However, as was typical in this whole disaster operation, there continued to be a mixture of formal and informal actions, of planned and unplanned activities, of coordinated and uncoordinated behavior. For instance, a volunteer fireman provided a crane and bulldozer belonging to his business firm for use in removing the debris. (He also had furnished his fire department with a tanker). The manager of the New London Telephone Company, being also a volunteer fireman, was on the scene and hooked up a telephone line for use at the site. Similarly, a high lift owned by a local power company was also brought to the scene, and used to lift cameramen from the State Fire Marshal's office to get photographs for identification. The State Patrol instructed firemen on how bodies should be exposed for photos. And firemen, probably at the request of the Coroner, used spray rather than force hoses in cooling down the ruins so that the bodies would not be too disturbed. However, in the course of digging into the wreckage, bodies were apparently moved before their spatial location had been clearly mapped.

A majority of the bodies were still on or near the crumpled frames of the beds on which they had been sleeping. This aided in identification since a floor chart had been drawn by employees of the Home locating each bed position and its occupant. However, all the bodies but one had been charred beyond visual recognition. Also, a number of the victims were away from beds, sprawled in hallways, etc. This, in combination with the movement of bodies during the debris clearance left 16 bodies unidentified at the time of recovery.

While the process of recovering bodies was underway, a New London undertaker realized the need for plastic bags in which to transport the remains. He called an Akron, Ohio funeral home which dispatched them. They

arrived in a vehicle of the Akron Post of the State Highway Patrol.

Earlier in the morning, a decision had been made to use the Fitchville Elementary School 1 1/2 miles away as a temporary morgue. It had adequate space and supposedly enough telephones (actually two other phones had to be installed later for use by the Red Cross and the mass media). A local undertaker requested the use of the building at 9:30 a.m. in a call to the Superintendent of the New London School District which includes Fitchville. The school superintendent himself helped in the conversion of the school into a temporary morgue, sharing the job with an assistant coroner. Different rooms were designated as an identification room, a press room, a reception room where relatives of the victims could speak with Red Cross officials or ministers, and a first aid room where relatives feeling faint could recover. The bodies themselves, when they arrived, were laid out in the auditorium.

In addition to the coroner's staff, the Red Cross, the Highway Patrol, and the Sheriff's Department, all had representatives at the school. The Salvation Army also moved its canteen to the school but also left several of its volunteers serving coffee at the site of the fire. Some inhabitants of Fitchville also served as volunteers at the temporary morgue. In general, there was little formal structure and many informal arrangements made between the members of the different organizations and others at the temporary morgue.

The 16 unidentified bodies were initially brought to the meeting hall of a veteran's group. There, with the help of the equipment and supplies in a van of the State Highway Patrol arriving from Columbus at 9:30 a.m. on Saturday, further attempts at identification were made during the weekend. All records of the Home had been destroyed, and fingerprints could not have been obtained from the charred remains (many hands were simply missing). However, dental charts and surgical records of the patients were found later on Saturday, apparently at a hospital in Norwalk. Through these records and the help of a nurse from the Home who knew the clothing, jewelry, etc. worn by particular patients, all bodies were identified by 7 p.m. on Sunday (for some reason, newspaper accounts reported five bodies were still unidentified as of Monday).

Relatives of the victims started to arrive on the scene, but by late Sunday only 29 bodies had been claimed (eventually 41 were claimed). These were taken away for burial by relatives to different localities. The unclaimed bodies were then taken to the veteran's groups meeting hall. (The existence of two morgues in effect meant that some bodies initially at the school were later brought to the hall, and vice versa). There seems to have been some pressure for a quick close down of the morgue in the school. While concern was expressed over the possibility that the children would be upset over their school being used for such a purpose, there also seemed

to be a fear that the prolonged presence of bodies might create a contamination problem.

Officials of a cemetery in the county offered the sheriff a plot of ground in which to bury the unclaimed. The Funeral Director took charge of the burial arrangements. Initially the plan called for a common grave but this apparently violated local burial regulations. To meet these rules each victim was put into a cloth covered casket of wood. These caskets were then laid out in a long, low trench. The State Aid for the Aged fund provided $180 for each burial. However, the original funeral scheduled for Wednesday had to be postponed until Friday because of a shortage of caskets in the Norwalk area. Thus, almost a week after the fire, the last victims were buried with the Governor of Ohio in attendance, at a 15 minute service jointly conducted by a Catholic priest, a Protestant minister and a Jewish Rabbi.

There was one other major post-impact activity in connection with the disaster. This was an investigation into the causes of the fire. Almost as soon as it was recognized that there was going to be a heavy loss of lives, various state agencies began inquiry into possible causes.

The major investigation, upon order of the Governor, was conducted by the State Fire Marshal. This inquiry conducted over a five week period culminated, after several postponements, in the issuance of a technical report on December 31, 1963. The major findings of this report were that: 1) the probable cause of the fire was extensive shorting along overfused and improperly wired electrical circuits under an overload; 2) the probable causes of the extensive fire damage was the nearly simultaneous ignition of fires at a number of different points, and delay in turning in the alarm to the fire department having jurisdiction; and 3) the probable cause of the extensive loss of life was lack of prompt evacuation based on an orderly plan since the first five minutes of any building fire are critical. The report also declared that the fire did not result from design but carelessness.

A similar finding was reached by the Huron County Grand Jury, and as a result no indictment was ever made. It too blamed the heavy loss of life on the lack of a sound evacuation plan. The jury statement also declared existing state fire inspections were valueless, and recommended legislation to tighten regulations covering nursing homes.

The owner of the Nursing Home disagreed with the report of the State Fire Marshal on the cause of the fire. On January 16 he stated, without giving details, that his insurance investigators had arrived at a different conclusion. Because of all these investigations, it was not until February 14, 1964, that work was commenced on completely clearing the debris at the Home.

## Organizations Involved

### The Police

More so than the other crisis organizations involved, the various police units appeared to have followed standard operating procedures in mobilizing a large number of men. In fact, there is some evidence that at a minimum, around 300 police officers and auxiliaries were eventually mobilized and actually in the field. Such a number, however, was disproportionate to the needs of the situation, and apparently led to some duplication of effort.

The first police unit reached the disaster scene by 5:10 a.m. This was a patrol car of the New London Police Department which had been alerted by the village fire department. This patrol immediately radioed the Huron County Sheriff's office in Norwalk, requesting the dispatch of all available fire and police equipment and personnel. The Sheriff's Department, in turn, notified the State Highway Patrol, a procedure usually, but not always, followed in any case where traffic might have to be rerouted. (This contact had to be made by phone, there being no direct radio link between the two groups).

The Sheriff's dispatcher notified various sub-units and related organizations by telephone and radio. Within an hour all deputies and many members of the Sheriff's auxiliary (volunteers who are called upon in emergencies or unusal cases requiring a large force) were on the scene. This eventually involved a total mobilization of six regular and nine part-time deputies plus 84 auxiliaries. They worked at patrolling the roads, helping take the bodies from the ruins and around the two morgues.

The regular Highway Patrol, notified at 5:18 a.m. had two men on the scene by 5:30 a.m. Within two hours, another seven to ten cars had arrived, some from Massilon, 60 miles away. These were supplemented at that time and also later by members of the Highway Patrol auxiliary, off duty highway patrolmen, and turnpike personnel, the latter two categories being exclusively volunteers in this particular disaster. At least 80 auxiliaries were mobilized. The regular State troopers partially controlled traffic in the very immediate emergency period, and then seemed to have directed most of their disaster activity to helping the coroner in identifying the bodies. (e.g. the Highway Patrol brought an identification team and a van with necessary supplies for such purposes, from Columbus--this being one of five such units in the State).

As far as can be ascertained, the Highway Patrol auxiliary performed the same tasks as the Sheriff's auxiliary, i.e., traffic control, body recovery, and morgue duties. There were overlaps in other police activities too. Both the Highway Patrol and the Sheriff's Department apparently had

had tried initially to notify a hospital in Norwalk of the disaster. Both police groups left a car at the disaster site for communication to Norwalk (in the instance of the State Troopers this was a routine procedure in such a situation). Men from both groups also apparently were left on overnight guard duty at the fire site.

There seemed to be no central point of control. According to some personnel at the disaster site, the Sheriff's office had overall control. The Highway Patrol, however, said it automatically came under the orders of the Coroner, the chief law enforcement officer of the county. Yet the 11 man Norwalk Post of the Patrol was supplemented by troopers from outside the county, who were sent upon orders from a higher Patrol headquarters at Bucyrus, 35 miles away.

Actually most of the actions of the Highway Patrol appeared to follow temporary but nonetheless usual patterns of this organization for emergencies. For example, on Saturday, while most of the men from the Norwalk Post and those brought in from outside were dealing with the disaster situation, three of the troopers were kept on reserve to cover any other eventuality that could arise. This is a standard operating procedure in such kinds of situations. The Sheriff's office, on the other hand, seemed to shift its activity and its personnel depending on particular situations as they arose. In retrospect, respondents from this organization noted that they had tended to hurry their decisions and improvise their actions.

The Fire Departments

While nearly 100 firemen from six departments were eventually mobilized, the last unit did not get to the scene until an hour after the outbreak of the fire. Notification of various fire organizations proceeded in no formal way; in fact, without discernable plan or pattern. There was only informal and somewhat erratic communication and coordination between the various departments, and between themselves as a group and other organizations. Lines of authority at the highest levels were never clear.

The first organization of any kind to reach the Nursing Home was the New London Fire Department. Its chief immediately judged the situation as one that would require additional equipment, especially water tankers. However, the New London Department, not being a totally volunteer organization in that it had four paid and 20 volunteer members, had no mutual aid agreement with any of the volunteer departments. (Its only agreement was with Wellington, over 20 miles away by road). He, therefore, advised the Sheriff's office patrol car at the scene to radio request to Norwalk for all available units and tankers. The request was apparently a very general one and did not specify any details. Although the department had direct radio contact with the New London Police, no calls were made to them at that time.

The Sheriff's dispatcher alerted most of the fire departments in the surrounding area, although it is unclear what criteria were used for choosing the department which was notified. The calls were staggered through time, the last department being alerted three-quarters of an hour after the outbreak of the fire, and about half an hour after the Sheriff's office itself knew of the fire. Apparently, as will be indicated later, different requests for equipment and personnel were made to different departments.

The New London Department, although first on the scene, had some difficulties in getting fully mobilized. Their pumper responded to the first call, but the tank truck was out of order due to faulty brakes. A spare tanker was available, but could not be immediately put into action since it was locked up. A New London policeman eventually had to remove the lock from the door on the garage where it was housed. It got to the fire scene somewhat late.

The North Fairfield Department, since the fire was outside of its jurisdiction and it had no mutual aid agreement with New London, did not respond to the first request for aid at 5:20 a.m. Five minutes later, the Sheriff's office called again, explained the situation, and said ambulances were needed. The chief decided not to call out the department but personally drove the ambulance to the scene. There he was told it was not needed, and sent it back by two of his volunteers who had come to the scene in their own private vehicles. They eventually returned with the department tank truck probably after 5:45 a.m.

The Greenwich Department, 8.1 miles from the Nursing Home appears to have been alerted at 5:21 a.m. It, along with New London, had a contract with Fitchville for fire protection. This department sent ten men, later added six more, and three pieces of equipment.

Some time after 5:30 a.m. personnel and equipment from the Plymouth and Ashland Fire Departments arrived on the scene. The Wakeman Department, arrived last. The Willard Department, reported by some of the mass media as being on the scene, was represented solely by its fire chief who said he came only "as a matter of record." This organization, closer than some other fire companies to the location of the fire, sent no equipment.

There seemed to have been some confusion on who, if anyone, was in charge of the fire fighting activity. Some police said the North Fairfield Fire Chief was in charge. Others, however, singled out the New London Chief. A few volunteer firemen reported each department worked on its own. But still others said they were under the control of the State Fire Marshal. It would appear that perhaps the various chiefs informally got together at the scene and more or less agreed on what to do. For instance, the New London and the Greenwich Departments divided the physical coverage of the fire between them, one concentrating on the front, the other the rear of the burning building. Much later, the North Fairfield, Greenwich, and New London chiefs did consult and devise a plan for the recovery of

bodies so that activities of each department would be coordinated. Whatever the actual case was, it is clear that different people and organizations had differing perceptions on the coordination and control of the fire fighting activities. (Paralled to different conceptions on the part of various police units on who had overall charge of the disaster operations).

It does seem the case that those departments with mutual aid agreements did cooperate in their activities. Thus, the North Fairfield Fire Department used its tank truck to transport water from a pond in Fitchville for use by the 16 man Greenwich unit; the Plymouth Department hauled water from New London for the New London Department. However, there was no overall control even though an early consensus had been reached that the fire could not be controlled and should be allowed to burn itself out. An additional factor operative in this decision undoubtedly was the lack of enough water tankers at the scene. There is no explantion why more were not summoned.

On the surface there was a harmonious but informal relationship between the fire companies and other organizations at the disaster scene. However, there were some subtle overtones of criticism in the remarks of other organizational personnel. These seemed to focus on the apparent decision to cool the fire down rather than putting it out, and on a supposed failure when knocking down walls to take enough care not to disturb the burned bodies. The lack of anyone in overall charge of the fire fighting who could be consulted regarding decisions that other organizations had to make was also commented upon.

There was open questioning of how the Nursing Home could have passed any fire inspection in view of the rapidity with which it burned. However, most persons seemed to be willing to await the findings of the official investigation. The State Fire Marshal did, with the help of a trailer lent by the Highway Patrol, set up an office at the scene Saturday afternoon and then launched the lengthy investigation alluded to earlier which culminated in the mentioned technical report.

The Salvation Army

The Salvation Army unlike the other organizations directly involved, mobilized most of its members without any resort to requests or orders. Its personnel simply came to the disaster upon hearing of it. Initially, the Captain in the Salvation Army in Norwalk was informed by the Sheriff's office sometime between 5:30 and 6:00 a.m. (This kind of notification was typical in emergencies, but did not stem from any formal agreement or understanding). Anticipating his group could be of service, the Captain went immediately to the scene. His wife brought the unit canteen out at 6:30 a.m. Other local volunteers arrived at the fire site on their own;

still others came after being phoned by the Captain on what had happened.

More distant units, on their own initiative, sent in personnel and equipment. Thus, groups arrived from Sandusky and Mansfield, the latter with a canteen truck. Eventually a colonel from Cleveland, bringing supplies with him, took overall charge of the Salvation Army activities.

In this respect, the Salvation Army confined itself almost exclusively to feeding the personnel of different agencies at the fire scene, and to a lesser extent at the morgue in the school. Even the food they distributed was initially brought to them by local restaurants. The only non-feeding activity appears to have been the temporary assistance rendered by a few Salvation Army members in bringing some bodies to the morgue in the school auditorium.

The Red Cross

The Red Cross, unlike the Salvation Army, was never informed by local officials of the disaster. Instead, an area field representative, being in Maumee, Ohio, (60 miles or so from Norwalk) heard of the fire on a 6:15 a.m. radio broadcast from Minneapolis, Minnesota. He called the Red Cross in Norwalk giving the local chapter its first alert. As a consequence of this indirect notification, while the local Red Cross followed usual procedures, its initial mobilization trailed considerably behind the actual sequence of events.

Thus, the Norwalk chapter verified with the police the kind of disaster that had occurred, checked with the hospital on the need for blood, notified two nearby chapters (with greater resources) in Toledo and Richland that their help might be requested, alerted its first aid and canteen units, etc. all after 6:30 a.m. -- more than an hour and a half after the fire had broken out and after almost all the emergency operations on the scene had been carried out.

As it happens, the Norwalk Red Cross chapter disaster director was actually at the fire scene by 5:30 a.m., but not in that organizational capacity. Being also a funeral director he was called earlier and responded to the request for ambulances transmitted by the sheriff's office. Apparently, however, no attempt was made to alert the local chapter.

The chapter executive and volunteer field consultant from Sandusky eventually went to the disaster scene sometime after 8 a.m. It was discovered that the Salvation Army had already established a canteen on the spot. The Red Cross, therefore, decided not to set up one of its own, but offered volunteers to man the existing canteen. Not much else was done at the disaster scene because by that time there was little apart from

waiting for the fire to burn itself out so the bodies could be recovered that could have been done.

Instead, the Red Cross directed almost all its activities on Saturday toward the events occurring at the morgue in the school and the survivors brought to the hospital. At the morgue, the Red Cross after assessing the needs in the situation, provided nursing and first aid personnel, set up the reception room, helped with the laying out of the bodies in the auditorium, etc. At the hospital the Red Cross checked on possible needs of the evacuated survivors, gave them clothing and comfort kits, and on Saturday afternoon provided automobiles, drivers and first aid people to assist in moving the survivors to other rest homes in the area. In addition, responsibility was assumed for assembling a list of survivors, where they were sent and in general, for the handling of inquiries as to victims and survivors. (After Saturday, assistance was also given to kin in making burial arrangements).

As it turned out, once the Red Cross had fully mobilized, there was more than an abundance of everything. Thus, while preparations were made to handle calls from all over the country, there were actually very few requests for information or names. Clothing for the victims, obtained through a radio appeal by a church auxiliary in Norwalk, was available in larger supply than could be used. Volunteers were plentiful; in the first 36 hours the Norwalk chapter had used over 65 volunteers in varying capacities, and had received direct offers of aid from Red Cross chapters in four surrounding counties. A mobile unit from Mansfield with a first aid team arrived at the fire scene around 10:30 a.m., but in the absence of any need was not utilized. It was likewise reported that there was not any great need, although they were used, for the Red Cross specialists that came in from the Eastern Area Office.

The relationship of the Red Cross with other organizations was rather informal and tended to be developed as situations arose. This was general but particularly noticeable in regard to the Salvation Army. For example, the Red Cross vehicle which was set up near the morgue in the school used food supplied by the Salvation Army and was manned by personnel from both organizations. Similarly, when the Salvation Army moved its canteen near the school on Sunday morning, the Red Cross sent its own vehicle to the fire site but members of both agencies continued to work together. . Part of the informality of relations undoubtedly stemmed from such pre-disaster factors as that an important local member on the board of the Red Cross was also on the board of the Salvation Army. (He himself ended up peeling potatoes in the school kitchen when his groups were distributing food).

The sheriff's office saw the Red Cross and Salvation Army as "reporting" to the chief deputy on the scene. There is little to indicate personnel from

these organizations perceived the situation in this way. If anything, Red Cross personnel were far more attentive to medical and related organizations than they were to law enforcement agencies.

Medical and Related Organizations

There were some erratic patterns in the alerting of medical and related organizations. As already indicated, the hospital supposedly notified by two different police organizations, seemingly was not aware of the disaster when the first survivors arrived. On the other hand, the sheriff's dispatcher called to many different localities in Huron County and three neighboring ones -- Ashland, Richland and Lorain, for ambulances. The result was that at one time, "at least 40 ambulances" including two from Mansfield, over 30 miles away, were on the fire scene. As far as can be ascertained, however, only one or two were used to transport survivors (in the later afternoon, some of the ambulances were used to transfer bodies to the temporary morgue).

The Huron County Coroner, legally in charge where there are any fatalities, was notified early by the Highway Patrol. The patrol car on the scene radioed the Norwalk Post station, which called the Coroner on the phone. He, in turn, notified one of his five assistants, thinking that would be all that would be necessary. The Coroner himself went to the fire scene and eventually supervised the search for and initial tagging of the bodies. His assistant was dispatched to take charge of the temporary morgue at the school. The Coroner later joined him. Apart from the initial notification of the Coroner these activities followed no prior plans, but were of an ad hoc nature.

The DRC team was able to ascertain little of what occurred at the hospital, other than that already indicated. It is known that the survivors were brought to a central room for treatment and that physicians got to the hospital soon after it became aware of the disaster. Later in the morning, indirect communication was established between the hospital and the disaster site to determine if there would be any other medical needs. In one sense of course, for reasons described earlier, there was really little need for hospital facilities and equipment. Along the medical line, the hospital underwent little stress. Such problems as these were, had to do with the initial overload of survivors admitted, with consequent need to send elsewhere already residents patients.

Civil Defense

In this non-urban area, Civil Defense was not extensively organized. Thus, only two CD units participated in the disaster operations. As it turned out, they were not very visible to personnel in other organizations.

In fact, there seemed to be a greater haziness and the greatest misperception of CD operations than of any other organizational activity.

Men from the Plymouth CD unit primarily assisted in the recovery of bodies, and also set up a portable light plant to provide electric power at the scene. They also, purely voluntarily, helped haul water for their town fire department. The Willard unit, the other CD organization at the disaster scene, may likewise have provided lighting equipment.

While newspaper accounts alluded to these units, rescue and relief personnel on the scene had difficulty recalling their presence or activities. One high official in another organization when asked about CD operations said, "If you find out what they did, tell me so I'll know." Other persons reported that CD had cooperated with the sheriff's office in putting up a rope around the fire site and keeping mass media representatives from entering. Still others thought CD had helped in directing traffic. None mentioned any of the actual activities of the Plymouth and Willard units.

There apparently also was some nominal CD plan in Norwalk for the handling of disasters, but the coroner after stating his unit followed the plan, was unable to specify what this involved when asked for details. Likewise, an allusion was made by one respondent to a CD involvement in a communication network involving the Highway Patrol and the Sheriff's office, but respondents in these organizations were unaware of its operations. What seemed to have been referred to here was a citizen band radio emergency group which helped in the coordination of communication between the Highway Patrol and its auxiliary, and in which apparently CD was only nominally involved.

Because the field trip was for training purposes, and because the field team obtained relatively limited data, the above constitutes all that the DRC will report about this disaster.