Fuji, Shizuoka Prefecture: Fussho-in

PHOTO

1. Characteristics of the fire

The Fussho-in is a private-sector social service facility for the incarceration/rehabilitation of the mentally unstable, alcoholics, spouse abusers, and others. The building is notable for its repeated additions without permits and its noncompliance with both the building code and the fire code. Its inhabitants were in considerable danger when the fire broke out. Fire officials had taken a very strict view of infractions in with this facility, which was already under administrative indictment at the time.

2. Overview of the fire outbreak

(1) Date and time of outbreak

Approximately 05:26, Thursday, February 11, 1987

(2) Detection

05:35, Thursday, February 11, 1987 (emergency call to fire department)

(3) Under control

06:15, Thursday, February 11, 1987

3. Overview of fire origin

(1) Location

2455-10 Yokozawa, Ohbuchi-aza, Fuji, Shizuoka Prefecture, Japan

(2) Building of fire origin

Fussho-in

(3) Structure of building of fire origin, etc.

(1) Date of construction

1967 (originally constructed as a wooden 2-story house)

(2) Additions/renovations

Approximately 5 additions have been made since construction.

(3) Building utilization

Social service facility (Category 6, 95 (ro))

(4) Building structure

Light steel frame (wooden structure), 3-story

(5) Area

Building area: 152.06 m^2

Floor area: 3,135.06 m^2

(6) Occupants at the time of outbreak

a. Employees: 5

b. Residents: 60 (36 men, 24 women)

(7) Area and utilization by floor

Floor	**Area**	**Utilization**
Penthouse	40.94 m^2	
3	537.10 m^2	Hall
2	1,304.96 m^2	Rooms, Hall
1	1252.06 m^2	Rooms, Workshops
Total	3,135.06 m^2	

(4) Firefighting equipment, etc.

(1) Firefighting equipment

Fire extinguishers, water buckets

(2) Alarm devices

Automatic fire alarm (partial installation)

(3) Evacuation facilities

Exit lights

(4) Other facilities necessary for firefighting

None

(5) Fire prevention system

(1) Fire prevention officer

Fire prevention officer appointed April 25, 1985 but was no longer employed at the facility. Thus, there was no fire prevention officer as of the time of the outbreak.

(2) Fire prevention plan

None presented.

(3) Fire drills

None carried out.

4. Weather conditions

(1) Weather

Clear

(2) Wind direction, speed

Northerly, speed 4.9m/s

(3) Temperature, humidity

Temperature: 6.1ºC, humidity: 47.9%

(4) Weather warnings, bulletins, etc.

Dry air advisory, snow avalanche advisory

5. Cause of fire

(1) Ignition source

Cigarette (inferred)

(2) Route

Unclear

(3) Ignited substance

Futon, clothing (inferred)

6. Fire damage

(1) People

(1) Fatalities

3 males

(2) Injuries

1 (minor)

(2) Property

(1) Building where the fire emerged

a. Extent of fire loss

Partial loss

b. Area of fire loss

289.02 m^2

c. Monetary loss

14,802,000 yen

(2) Other buildings

None

7. Fire route (progression)

(1) Overview of outbreak location

There were 4 small rooms (called “prayer rooms”) on the north side of the 1st floor. The fire broke out in the most westerly of them. Each of the rooms had only 1 door, kept locked from the outside. Each room also had a window, although it ws covered with iron grating and thus prevented the occupant from going outside.

(2) Situation up to the outbreak

Apparently the first person to discover the fire was an individual with schizophrenia. Resident A, upon being awakened by (1) that individual making a fuss in the courtyard and (2) the sound of breaking glass, noticed that there was a fire at the westernmost prayer room on the first floor.

(3) Notification of fire department

A female high school student living next door saw smoke and flames coming from the 1st floor and placed an emergency call to the far department from a nearby public telephone.

(4) Initial firefighting attempts

Resident A tried to fight the fire with an extinguisher but could not get it to work. He next went and got 2 or 3 buckets, and tried scooping up water from a pond within the courtyard. This proved ineffective, however, as the flames were strong.

(5) Fire spread

Because the entrance to the fire-source prayer room was locked, the person inside could not get out and promptly inform others of the fire. The fire thus spread within that room, then to adjacent other prayer rooms, and onto a bathing room, etc. It eventually reached living quarters on the 2nd floor.

(6) Evacuation

Of the 13 residents in the living quarters (room) above the prayer rooms, 12 escaped by making use of an outside stairway. Two people within the two prayer rooms on the east side were rescued by firefighters.

(7) Activities of internal firefighting unit

None.

(8) Fatalities

Two people in 2 prayer rooms—the room furthest to the west, which was the source of the fire, and the room immediately to the east of it—died, presumably of burns, because they were unable to escape (the doors were locked from the outside and the windows were covered with iron gratings). Furthermore, of the 13 people in the living quarters (room) on the 2nd floor immediately above the prayer rooms, 1 failed to escaped in time and died of burns in the room.

8. Activities of firefighting units

(1)Dispatched units, etc.

(1) Dispatched vehicles: 9 (on station), 6 (emergency assignment)

(2) Dispatched personnel: 40 (on station), 60 (emergency assignment)

(2) Firefighting and rescue activities

(1) Firefighting activities

The first firefighters to arrive on the scene observed flames and smoke blowing out of the west-side windows on the 1st and 2nd floors of the north wing. One party secured

firewater. The next surrounded area of the fire to keep it from spreading.

(2) Rescue activities

Rescue team members cut through the iron gratings over the 1st-floor prayer rooms with a power cutter and entered inside, where they rescued a man rolling on the floor. Hearing that 2 or 3 people were missing, the rescue team members donned respirators and, while under a protective water spray, entered the building. They found 3 burned bodies, 1 in the prayer room that was the source of the fire, 1 in the prayer room immediately to the east of it, and 1 in the 2nd-floor living quarters (room).

и9. Problems, lessons

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(1) The facility was expanded many times without permit and was particular deficient in terms of its hardware (physical) aspects. The fire department and other municipal entities had been advising corrective action.

Listed below are major infractions.

a. No fire protection officer had been appointed

b. No fire plan had been prepared

c. No interior fire hydrants had been installed

The owner had continued to ignore repeated directives; and, even before the fire, municipal officials had filed an administrative indictment with the prefectural police for violations of the fire code and the building code.

(2) The facility has been a source of problems. Most notably, a fire also broke out there in May

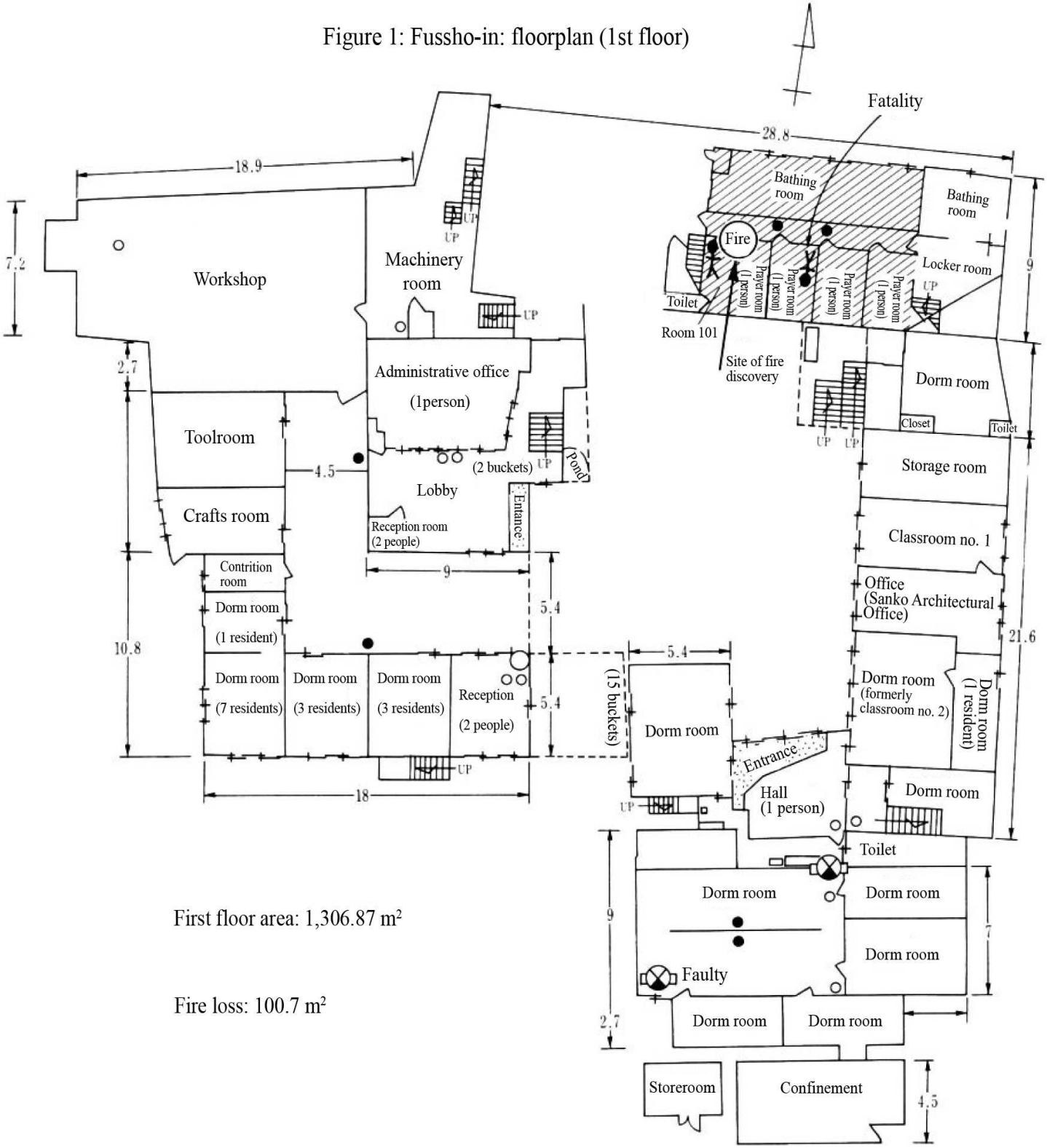
1984, in which 19 residents, locked within their rooms, were injured by smoke inhalation.

(3) Despite the fact that the facility presented a high risk to human life in the event of a fire, its rooms were kept locked and its windows covered with iron gratings. Because of that, residents were not able to escape from their rooms, and firefighters had difficulty entering the rooms.

10. Documents

10. Materials

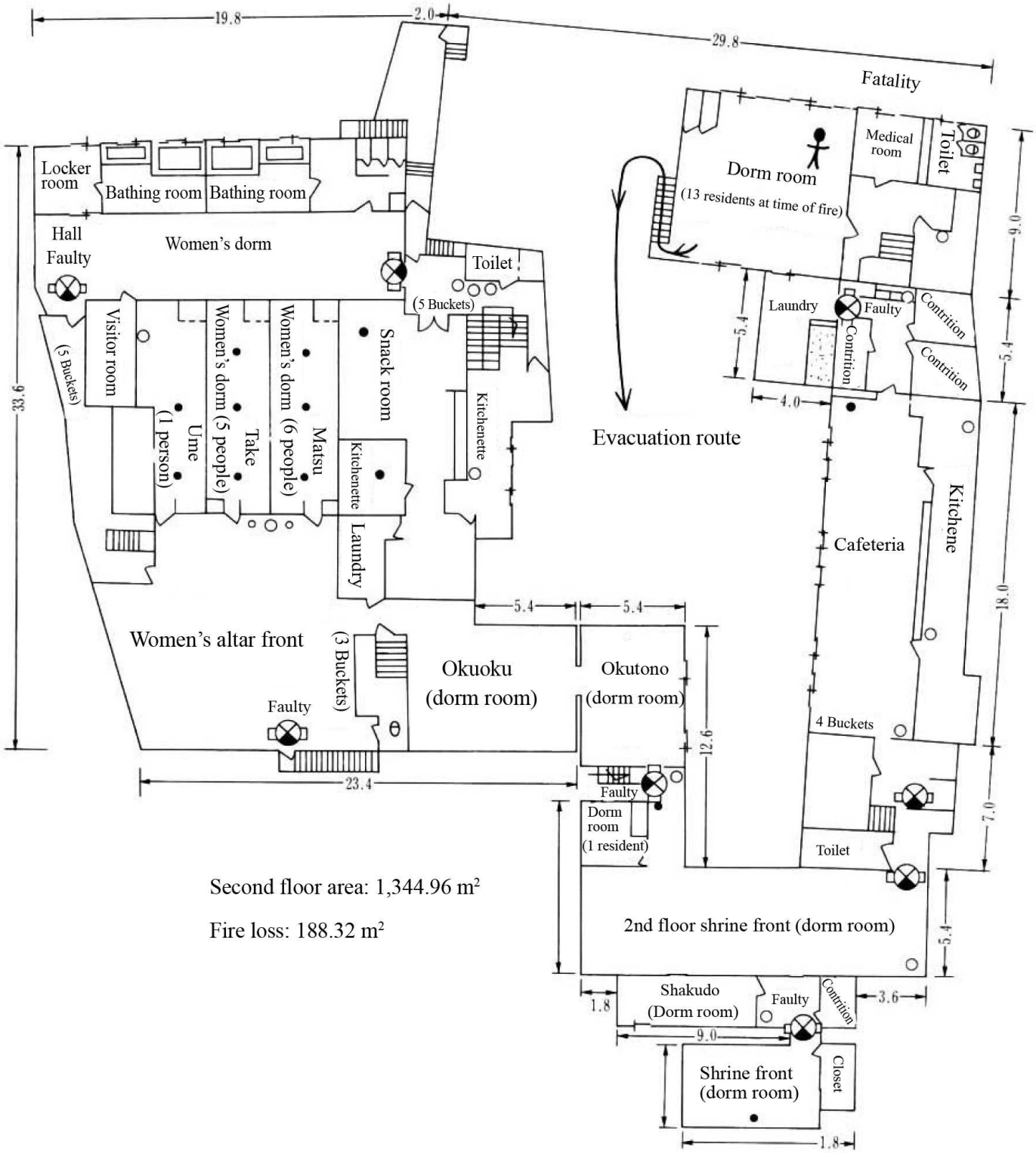
Figure 1: Fussho-in: floorplan (1st floor)



First floor area: 1,306.87 m²

Fire loss: 100.7 m²

Figure 2: Fussho-in: floorplan (2nd floor)



Second floor area: 1,344.96 m²

Fire loss: 188.32 m²

Figure 3: Fussho-in: floorplan (3rd floor)