

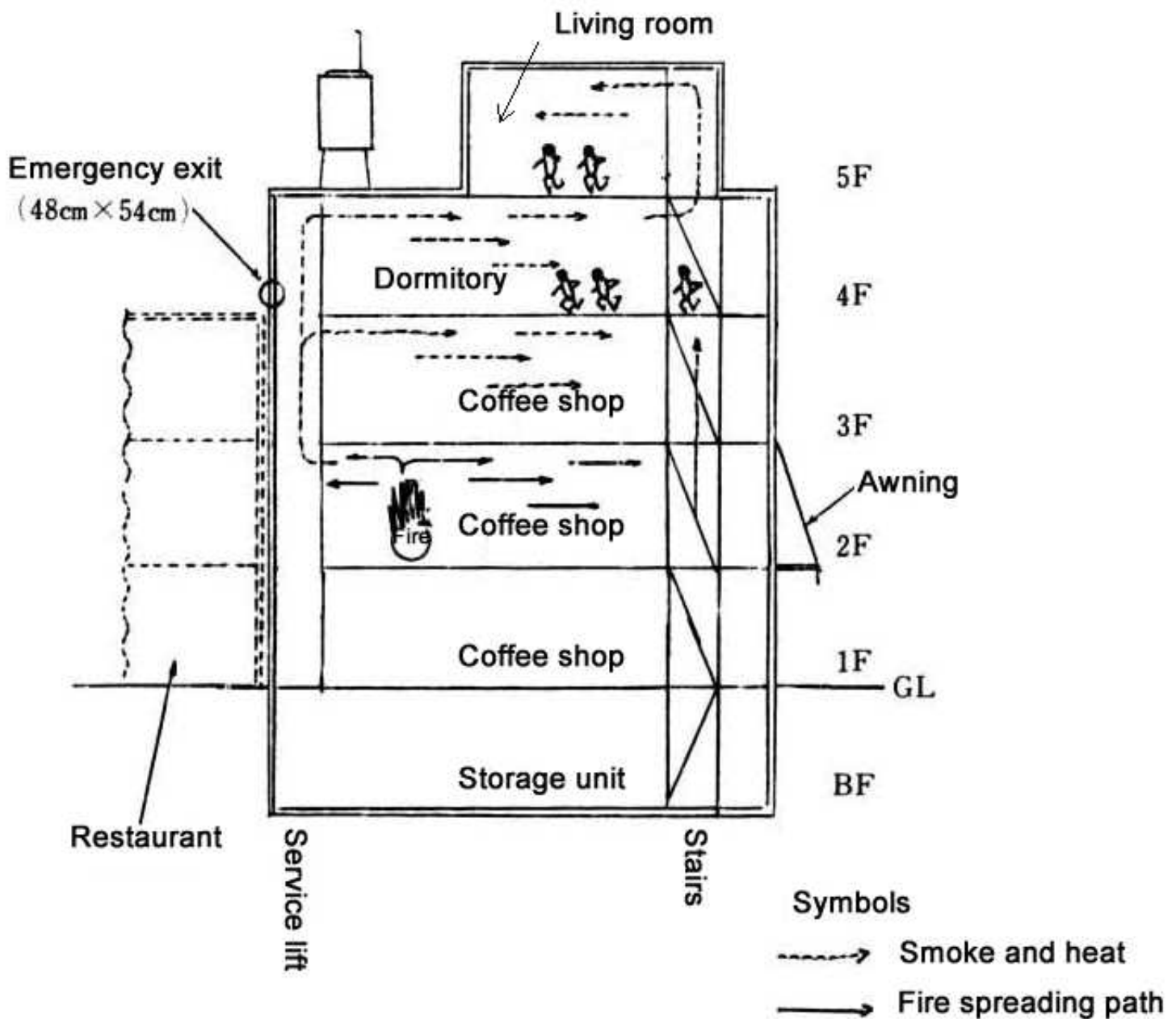
Building Name Address	Use (as per FSA Annexed Table 1)	Date and Time of Incident	Structure and Stories Area	Extent of Damage (Damaged Area/ Total Area)	No. of Casualties
Coffee Shop Denen Building	Complex (16) a	Jan 17, 1968	Partially fire resistive Fire preventive 4 stories above ground and 1 below	All, <u>Half</u> , Partial, Small 80 m ² (20%)	Fatalities 5
		Breakout at 05:30 (approx) Detected at 05:37 Notified by emergency call Extinguished by 06:35			
91 Yonemachi Ogura-ku, Kitakyushu, FUKUOKA					

I. Summary of Fire Incident									
(1) Summary	This fatal fire originated from the 2nd floor of a slender building that was comprised of coffee shops on the lower floors and an employee dormitory on the upper floors. The heavy smoke completely obscured the only stairs in the building and trapped 10 female employees who resided in the dormitory. Six employees did not know where the emergency exit was and they were disorientated from the smoke and became unconscious. Although they were all rescued by the firefighters, 5 of them were pronounced dead at hospital.								
	(2) Conditions per Floor	FL	Total area m ²	Damaged area m ²	Use (Purpose)	No. of persons	No. of fatalities	Fire escape equipment	Firefighting equipment
R		9.9		Employee dormitory	1	2 females	1 set of inside stairs (1st basement floor to rooftop)	Fire extinguishers	
4		80.0		Employee dormitory	9	3 females			
3		80.0		Coffee shop					
②		80.0	80.0	Coffee shop					
1		80.0		Coffee shop					
B1		80.0		Storage unit					
Total		409.9	80.0		10	5			
(3) Origin of Fire		(Floor, Room, Part, Combustibles, Habitable/Non-habitable Rooms, Present/Absent)				(4) Cause of Fire			Unknown
	<u>The fire emerged from the kitchen on the 2nd floor.</u> ◦ The interior of the small kitchen was finished with combustible materials for esthetics, and the kitchen was crowded with cooking appliances (gas cooking range) and a kerosine stove.								

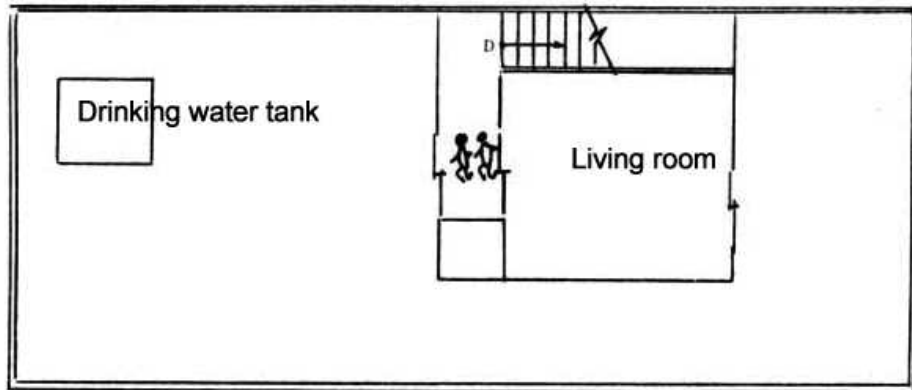
(5) Fire Propagation Path	<div style="display: flex; justify-content: space-around; align-items: center;"> <div style="border: 1px solid black; padding: 5px; text-align: center;"> (Location of Fire Source) Kitchen on the 2nd floor </div> <div style="border: 1px solid black; padding: 5px; text-align: center;"> (Propagation from Source) Spread to the combustible counter and interior materials </div> </div>									
	<p>The flame from the kitchen burned the combustible counter and interior materials, but did not spread to other floors because the firefighters were able to contain the fire on the 2nd floor.</p>									
	<p>○ Main Reasons for Propagation of the Fire No fire propagation</p> <p>○ Smoke Propagation Path Mainly through the vertical shafts (inside stairs and service lift), the heavy smoke traveled upward from the kitchen to the top floor within a minute or two.</p>									
II. Summary of the Building										
(1) Built	Construction, Completion, and Major Renovations (Completion) March 1958									
Fire Prevention Management	(2) Vertical Shafts									
	<table border="0" style="width: 100%;"> <tr> <td style="width: 50%;">Stairs <input checked="" type="checkbox"/></td> <td style="width: 50%;">Duct Spaces <input type="checkbox"/></td> </tr> <tr> <td>Elevator <input type="checkbox"/></td> <td>Pipe Shafts <input type="checkbox"/></td> </tr> <tr> <td>Escalators <input type="checkbox"/></td> <td>Other <input type="checkbox"/></td> </tr> <tr> <td></td> <td>(Service Lift) <input checked="" type="checkbox"/></td> </tr> </table>		Stairs <input checked="" type="checkbox"/>	Duct Spaces <input type="checkbox"/>	Elevator <input type="checkbox"/>	Pipe Shafts <input type="checkbox"/>	Escalators <input type="checkbox"/>	Other <input type="checkbox"/>		(Service Lift) <input checked="" type="checkbox"/>
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	(Service Lift) <input checked="" type="checkbox"/>									
<ul style="list-style-type: none"> ○ No fire compartment on the stairwell. ○ Curtain on the service lift but no door and therefore the lift was always open. 										
(3) Fire Prevention										
<ul style="list-style-type: none"> ○ The building had no fire-prevention manager appointed. ○ The building had no fire defense plan in place. ○ The building had no history of fire drill. ○ The building management failed to comply with the recommendation report that was issued by the local fire station regarding the illegal living quarters (employee dormitory, fire-preventive structure) on the roof floor. 										
(4) Fire Compartment										
N/A										
(5) Firefighting Equipment										
<ul style="list-style-type: none"> ○ Each floor had fire extinguishers only. ○ The building had no fire alarm. 										

III. Actions Taken after Fire was Detected			
(1) First Detected	<ul style="list-style-type: none"> ◦ Detected by (Milkman, passersby) ◦ How and why (Witnessed the smoke) ◦ Action taken (Loudly alerted people nearby) 		
	<p>The building was located on the street leading to a nearby train station. The milkman and a passerby, who were on their way to the train station, witnessed smoke emerging from a window, and loudly alerted people in the vicinity.</p>		
(2) Emergency Call	Emergency Call	Yes [X] () No []	Time elapsed since discovery (7) minutes
	<p>The passerby who witnessed the smoke made a 119 call from the phone of the tobacco shop nearby.</p>		
(3) Initial Firefighting Activities	Initiated	Successful [] Failed [] <ul style="list-style-type: none"> ◦ Extinguished time [] ◦ Firefighting difficulties [] ◦ Firefighting method [] 	(Reasons or Conditions) <p>Evacuating the building was the only option when the fire was first noticed; therefore, no attempt was made to contain the fire.</p>
	<u>Not initiated</u>	<ul style="list-style-type: none"> ◦ Extinguished time [X] ◦ Firefighting difficulties [] ◦ Firefighting method [] ◦ Other [] 	
(4) Summary of Firefighting Activities	(Obstacles or Difficulties in Fire Control)		
	<ul style="list-style-type: none"> ◦ The overhead cables on the street in front of the building compromised the ability of the ladder truck and the snorkel truck. 		

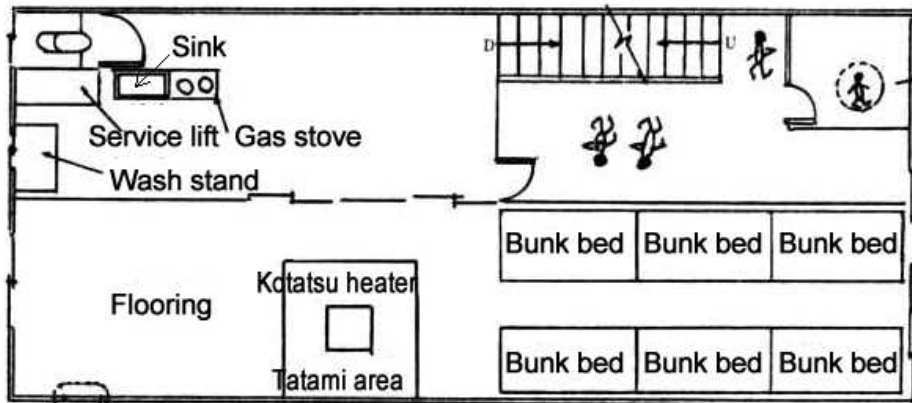
(5) Evacuation	Means of Escape (No. of Persons)	Obstacles to Evacuation
	<ul style="list-style-type: none"> ◦ Stairs [] () ◦ Elevator/Escalator [] () ◦ Escape equipment [] () ◦ Directly to ground from windows or openings [] () ◦ Rescued [X] (2) ◦ Other (to the rooftop through emergency exit) [X] (3) 	<ul style="list-style-type: none"> ◦ No windows [] ◦ Barred openings [] ◦ Locked emergency doors (Exits) [] ◦ Alarm system [] (Poorly controlled, Malfunctioned, Not installed) ◦ Power outage [] ◦ Other [X]
	<ul style="list-style-type: none"> ◦ One of the female employees, G, was sleeping in the rooftop dormitory and the smoke from the fire woke her up. She called for help from the rooftop and was rescued by firefighters. ◦ In the dormitory on the 4th floor, 9 female employees woke up because they felt suffocated and thus became aware of the fire. Via an emergency exit (48 cm x 54 cm), 3 of them evacuated to the rooftop of an adjacent building and then walked down to ground level. In a state of confusion, the remaining 6 called for help from the window of the 4th floor or some of them were running around the stairs to the rooftop or the hallway. When the firefighters rescued them they were unconscious. (5 fatalities in total.) 	
(6) Casualties	Healthy individuals 5 (Drunk persons) Individuals in need of assistance Infants Elderly Handicapped Patients/ill persons	Obstacles to Evacuation <ul style="list-style-type: none"> ◦ No windows [] ◦ Barred openings [] ◦ Locked emergency doors (Exits) [] ◦ Alarm system [] (Poorly controlled, Malfunctioned, Not installed) ◦ Power outage [] ◦ Other [X] (Unable to open door to the rooftop)
	<p>As previously described, 5 female employees who died in the hospital tried to escape in panic. They called for help from the windows of the 4th floor and ran up the stairs to the rooftop or walked around the hallway where piled-up obstacles (cases of beer) were in the way of people passing by. The firefighters found 4 of them unconscious on the 4th floor, and 2 of them in front of a broken sliding door to the rooftop. However, 4 of them were pronounced dead at hospital and 1 of them died 48 hours later.</p>	
IV. Issues and Lessons Learned		
<ol style="list-style-type: none"> 1. The evacuees lost their way out because the smoke obscured the only stairs inside the building. 2. Only a few of the occupants knew about the emergency exit on the 4th floor. Although 3 occupants were able to escape from the exit, their self-serving behavior resulted in fatalities. 3. The building management and the employees completely disregarded the fire safety of the building (no fire-prevention manager, no fire defense plan, and no fire drill). 4. The slender building was not equipped with any fire alarm. In order to detect a fire earlier and to facilitate evacuation, officials should strongly promote the installation of a detection device such as a smoke detector. 5. The building management ignored the recommendation from the fire station regarding the employee dormitory on the rooftop. The broken sliding door to the rooftop trapped the occupants and resulted in the fatalities. 		



Note: The location where each occupant was found is indicated by the human figures (6 in total) on the 4th and 5th floors. Of the 6, 3 were pronounced dead at hospital the same day, 1 was pronounced dead 48 hours later. The 2 found on the 5th floor were also pronounced dead at hospital.



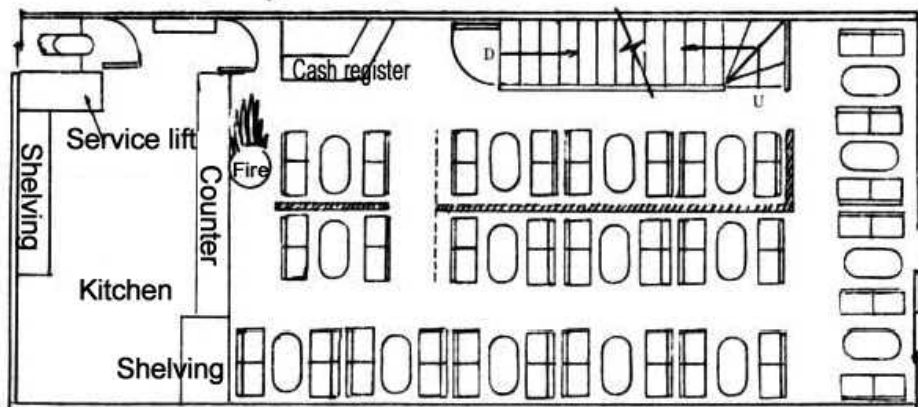
5th floor



This person died 48 hours later so is not included in the fatalities.

Emergency exit
3 females escaped to
the rooftop of an
adjacent building

4th floor



3rd floor

* 3rd floor has same layout