SUMMARY IN ENGLISH

On the night of Tuesday, August 27, 2013 a fire started in the main building at Textes HVB-hem in Norrtälje. In the building there were seven caretakers. The residents had been medicated for the night and there was no staff present in the building. The building was located in a residential area in central Norrtälje and consisted of three levels with a attic and a basement and was built in 1918.

The facility that would become Textes HVB homes AB was founded in 1972 on the property as a family owned care facility for people with mental disabilities. The residents had a variety of degrees of reduced functionality in terms of learning, memory, visuospatial ability, linguistic ability, attention, and executive ability. Impairments that may cause difficulty in purposeful activity and affect the mobilization of action and inaction.

The fire started on the balcony used as a smoking area on the north side of the property and spread into the building due to combustible interior surfaces and developed to a flashover rapidly after the fire started. On the balcony there were neither smoke nor heat detectors. Because of that the fire was not discovered at an early stage. First when there was enough smoke inside the building the detectors were activated and the evacuation alarm started to sound and warn the residents.

At the time when the alarm from the case facility came to the emergency response center the fire brigade from Norrtälje was busy with another rescue operation with no possibilities for another engagement for a second emergency from that fire station. That lead to the response time for rescue service and firefighting at Textes HVB-hem was delayed.

Due to the rapid fire development the two escape routes became unfit to use as an escape route in the early stages of the fire, very quickly after the detectors were activated and the residents become aware of the fire. Four people managed to evacuate the building. Three people died in the fire.

The investigation has shown that building permit was missing for the activities in the building and that the fire safety protection in the building, both structural and organizational has had several shortcomings. The lack of building permit and the shortcomings in the fire safety protection has not been noticed in the authorization and supervision process.

The accident was caused due to the fact that the fire protection in the building allowed the fire to grow in size without being detected and spread into the building before it was detected, which led to the existing evacuation routes were blocked by the fire and gave no opportunities to evacuate the building safely.

A contributing factor was the lack of handling of the authorization process and supervision of the facility by governmental agencies, which admitted that it was conducted in a building and with a staffing that from a fire safety protection perspective did not take into account the residents' abilities and needs.

RECOMMENDATIONS

The Health and Social Care Inspectorate is recommended to:

- Develop procedures to ensure that the facilities are deemed safe, also from a fire safety perspective, when authorizing and supervising HVB home. *(RO 2015: 01 R1).*

The National Board of Health and Welfare is recommended to:

- Investigate and consider the need for clarification through regulations or general advice to secure that authorization is not granted and facilities starts to operate before the fire safety protection has been deemed adequate for the particular target group concerned, and clarify the scope of supervision under the Social Services Act (RO 2015:01 R2).

The Swedish Civil Contingencies Agency is recommended to:

- Out of a fire service operation and working environment point of view clarify the conditions, necessary planning and training for emergency response procedures where the fire brigade use portable ladders as the only possibility for life rescue in a fire and the distressed lacks the ability to climb down the ladder (RO 2015:01 R3).

- Follow up on the efforts made to implement the approach outlined in the MSB's supervisory guidance ”Kommunal tillsyn enligt lagen om skydd mot olyckor” has been effective in the supervising municipal organizations and thus contributed to a stronger fire prevention in nursing and care homes (RO 2015:01 R4).

The County Administrative Board in Stockholm is recommended to:

- Take the necessary measures to ensure the reliability in the cases where municipal emergency services use multiple alarm / control centers for alerting the same rescue units (RO 2015: 01 R5).

- Investigate and determine whether the rescue service in Norrtälje has implemented procedures and practice and are working with them, inter alia, tactical movements in such a way as reported in the impact assessment conducted at the decommission of the part-time fire department in Norrtälje (RO 2015: 01 R6).