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October 23, 1989

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155 Route 46 West
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Re: Hillhaven Fire
October 5, 1989

Dear Counsel:

As you will recall, immediately upon learning of the San Juan Dupont Plaza Hotel fire on December 31, 1986, we initiated an investigation in behalf of certain PVC clients in order to protect their interests in the event they became involved in the resulting litigation. Subsequently, this investigation proved extremely valuable and led to the present joint defense position enjoyed by the PVC industry and related companies in that litigation.

When we learned of the unfortunate fire at the Hillhaven Nursing Home in Norfork, Virginia, on October 5, 1989, which resulted in at least 12 deaths and more than 100 injuries, we thought it appropriate to initiate a preliminary investigation to determine whether or not our clients face a potential exposure from any litigation resulting from that occurrence. On October 12, 1989, Vic Maddox and Mike Mercer from this office stopped in Norfolk, Virginia, while returning following the trial recess in the San Juan Dupont Plaza Hotel Fire Litigation pending in San Juan, Puerto Rico. I enclose a confidential memorandum reporting on the results of that investigation.

Unfortunately, it appears that a number of vinyl products were involved in the initial stages of that fire. Further, all of the deaths and injuries reportedly resulted from smoke inhalation. As a result, it now appears probable that one or more manufacturers of vinyl upholstered furniture covering, wallpaper and bedding materials will become involved in the ensuing litigation.

As soon as we receive the results of our additional inquiries into the areas of pathology and toxicity, we will be in a position to discuss this case with you in more detail. At that time, we can discuss any preventive measures which may be available to us to deflect or avoid entirely the resulting litigation, as well as how best to position ourselves at this time to defend any lawsuits which may arise. We will keep you closely advised. Best regards,

Sincerely,

Carl Arthur Henlein

Enclosure

PRELIMINARY REPORT REGARDING THE ORIGIN, DEVELOPMENT AND AFTERMATH OF THE FIRE AT THE HILLHAVEN CONVALESCENT AND REHABILITATION CENTER

NORFOLK, VIRGINIA

OCTOBER 5, 1989

PRIVILEGED AND CONFIDENTIAL

Prepared For and on Behalf of
The Clients of the Law Firm of

BROWN, TODD & HEYBURN

Louisville, Kentucky

CONFIDENTIALITY OF THIS REPORT

This preliminary report regarding the fire that occurred on October 5, 1989 at the Hillhaven Convalescent and Rehabilitation Center in Norfolk, Virginia (the "Hillhaven fire") has been prepared by Brown, Todd & Heyburn attorneys on behalf of certain clients of the firm in anticipation of potential litigation involving the Hillhaven fire and those clients. By its nature, this report contains the mental impressions and legal opinions of legal counsel and communications between counsel and clients of the firm on whose behalf the investigation was conducted. Consequently, this preliminary report contains confidential attorney/client communications and attorney work-product information. Brown, Todd & Heyburn shall assert the protections of the attorney/client privilege and the attorney work-product doctrine regarding all matters contained in this report. Nothing in this report is intended to be disclosed to third parties, and both the clients and the firm understand that this preliminary report shall at all times be confidential.

SUMMARY AND BACKGROUND

The fire at the Hillhaven facility appears to have initially involved at least polyurethane foam, vinyl upholstery, vinyl wall coverings and vinyl mattress covers. There may have been other related products consumed in the fire. It is certain, however, that polyurethane foam was

one of the initial, and perhaps primary, fuel sources, followed shortly thereafter by vinyl/vinyl covered room furnishings, wall coverings and perhaps window dressings. Flashover occurred within minutes after ignition, and 12 deaths and 100 injuries were apparently the result of smoke inhalation.

PENDING LITIGATION

Brown, Todd & Heyburn arrived in Norfolk, Virginia, on October 12, 1989. Their review of courthouse records revealed that a lawsuit had been filed against the facility's owner/operator, Hillhaven Corporation, doing business as Hillhaven Rehabilitation and Convalescent Center, on October 11, 1989. That suit, styled as Edna D. Carroll v. The Hillhaven Corporation, No. L 89-2645 in the Circuit Court of the City of Norfolk, Virginia, seeks damages of $3,000,000. On October 12, 1989, a second lawsuit was filed in the same court, styled as Jacquelyn H. Eure v. The Hillhaven Corporation, No. 89-2649. That lawsuit seeks damages of $2,010,000. The Carroll suit includes a claim for punitive damages, while the Eure suit seeks only compensatory damages. Counsel for the plaintiffs in both cases, Steven Wainger for Carroll and Robert Sondej for Eure, appear to be local attorneys in the Norfolk and Portsmouth, Virginia area.

As of October 12, 1989, Brown, Todd & Heyburn had not discovered evidence of attorneys from Fetterly & Gordon or

any of the other well-known plaintiff/subrogation attorneys having been in the Norfolk area, though that possibility remains.

CIRCUMSTANCES OF INVESTIGATION

The scene of the fire had been completely cleaned, and repairs were in progress within two days of the fire. Consequently, and because the lawsuits had already been filed, it was not possible to examine the scene of the fire on October 12. Brown, Todd & Heyburn did, however, interview the chief fire investigator for the Office of Fire Investigations of the City of Norfolk, and obtained substantial information concerning the cause and spread of the fire, its fuel load, and the extent of the official investigation thus far. Other information was obtained from the National Institute for Standards and Technology ("NIST"), the successor to the National Bureau of Standards, which investigated the fire along with the National Fire Protection Association ("NFPA"). These matters are explained in the following sections of this preliminary report.

The information provided in this preliminary report has been taken from numerous sources, both public and private. Included in these sources are observations by legal counsel while in Norfolk, research and information obtained from media reports, discussions with fire investigators and experts, and other available sources. Necessarily, the

information provided is preliminary only, and may prove to be subject to revision.

THE HILLHAVEN FIRE

On the evening of October 5, 1989, at approximately 10:15 p.m., Major Leary, a resident of the Hillhaven facility, accidentally ignited a fire on his bed with a lighted match. Apparently within a matter of minutes, the fire developed into a full room fire, which resulted in flashover. Mr. Leary, and at least eleven other residents of the Hillhaven facility, died as result of smoke inhalation, according to the chief of the Norfolk Fire Department, Thomas Gardner. Forest "Lin" Parham, the fire investigator responsible for the investigation for the Norfolk Fire Department, confirmed for us that there were apparently no thermal injuries. The injuries were all due to smoke inhalation. In addition to the 12 deaths confirmed as of October 12, 1989, at least 98 other persons were hospitalized, many of them in critical condition. Almost all of the victims and injured residents were elderly persons, many of whom were using respirators, walkers, wheelchairs or other ambulatory and respiratory aids before the fire.

There appears to be little doubt about the origin of the fire. It was ignited by a single match thrown accidentally onto bed linens, which covered a foam "egg carton" support cushion on top of a foam mattress.

The room of origin, Room 226, was completely gutted by the fire. In addition, the immediately surrounding hallways were also damaged by the flames. Heavy black smoke filled the entire second floor of the facility.

Room 226 had been checked by a staff nurse shortly after 10:00 p.m. on the evening of October 5. Mr. Leary had been observed sitting in a chair at the end of his bed while his roommate was asleep. At approximately 10:15 p.m., the same nurse, farther down the hall, smelled smoke and began a room to room search of the second floor hallway. When she reached Room 226, she observed Mr. Leary, standing and attempting to escape the flames, which had already climbed the walls and had reached the ceiling. When the nurse assisted Leary (who died as a result of the fire) and his roommate (who survived) into the hallway, she left the door open, which allowed the fire and smoke to spread into and down the hall.

The initial call to the fire department was received at approximately 10:18 p.m., and fire fighters arrived at 10:22 p.m. The flames were extinguished, according to press accounts confirmed by the fire investigator, at approximately 10:40 p.m. Nevertheless, fire fighters continued to clear heavy black smoke from the second floor and other floors of the facility for the next 90 minutes.

THE HILLHAVEN FACILITY

The Hillhaven facility did not have automatic sprinklers, but it was not required to have them pursuant to local codes and regulations. According to Fire Chief Thomas Gardner, the facility met all building codes when it was constructed in 1969. At that time, the Southern Standard Building Code of 1957 was in effect, and did not require sprinklers. Current Virginia state law requires sprinklers for facilities exceeding one-story, but the Hillhaven facility was exempted from compliance with that code.

The Hillhaven facility had been inspected by local authorities on a regular basis, and no significant code violations had been reported. The inspection of December 21, 1988 had revealed only seven minor deficiencies, regarding such things as exit lights, and certain kitchen repairs. Only one citation appeared to involve fire safety, a missing fire extinguisher on a welding cart.

The facility itself incorporated fire walls and fire resistant doors, smoke detectors and fire alarms, and apparently employed well-trained personnel. The facility had regularly conducted fire drills, and the residents, those who were ambulatory, were aware of these fire safety procedures.

There was apparently a malfunctioning fire alarm, but it is not at this point clear how, if at all, the alarm may have been involved in the fire. The alarm was installed by Simplex Time Recorder Co. in 1969 and was monitored by MGI

Security Systems, Inc. Additional investigation will be necessary to determine the extent of the involvement of the fire alarm system and its role, if any, in the deaths and injuries.

The Hillhaven facility is owned by Hillhaven Corporation of Tocoma, Washington. That corporation, through subsidiaries, operates 360 long-term care facilities nationwide, including the Hillhaven facility. We have no information at this point concerning the extent of available insurance coverage or the identity of insurance carriers.

THE FIRE INVESTIGATION

The fire was investigated on behalf of the City of Norfolk by Mr. Forest L. Parham. Parham is an affable individual in his late forties who was knowledgeable of fire investigations and helpful in our inquiries. He confirmed for us that the fire resulted in flashover and that, so far as he is aware, there were no thermal injuries involved. From his prospective, the fire was "not a severe fire" in the sense that the flames were under control in a short period of time. As he and Chief Gardner point out, however, the serious problems were caused by what he described as "the unusually black sooty smoke" that was produced.

According to Parham, the NFPA had conducted its investigation at least preliminarily in the first five days following the fire. Tom Klem, known to us for his involvement in the San Juan Dupont Plaza and MGM Hotel fire

investigations, had been on the scene, as was Martin Conant of the Building Officials and Code Administration International. Harold Nelson was involved on behalf of NIST.

Parham allowed us to view a sample of what appeared to be conventional polyurethane foam that had been used in the "egg carton" application common in nursing home facilities to prevent bed sores in patients. This material, which was approximately four inches high with a base of approximately two inches of foam, was identified by the NFPA as the initial fuel for the fire. From this egg carton foam material, the fire apparently spread to the vinyl mattress covers and polyurethane foam mattresses underneath, and from there involved the remaining materials in the room.

According to information obtained from NIST, the mattress used in the Hillhaven facility, and involved in the fire, was a mattress with inner spring systems covered by an outer layer of polyurethane foam. On top of the polyurethane foam mattress was a green vinyl mattress ticking, and this vinyl ticking was evidentially one of the early fuel sources involved in the flashover. Both the vinyl ticking and the polyurethane foam egg carton product used to relieve bed sores, were apparently covered with a cotton ticking.

Also in the room of origin and involved in the fire were two highback chairs, each of which was covered with what appeared to be vinyl upholstery. The vinyl material

covered polyurethane foam, although we have no information concerning the type of foam used. These observations were made from the furnishings in each of the other rooms, which were standardized.

The dressers in the rooms were wooden as were the doors leading to the bathroom and hallway. The hallway door was a two-hour rated fire door. The walls in Room 226, as in the other rooms, were apparently covered with a vinyl wall covering, and the drapes on the windows were either a vinyl or plastic material. We are attempting to obtain additional information concerning the nature of these products.

There were fluorescent light fixtures in the rooms and in the hallway. These fixtures appeared to have plastic diffusers though we are not certain about the precise nature of the product. They were totally consumed. Often, PMMA is used for this purpose, though our investigation to this point suggests that these diffusers were a different material. All of the information available to us at this point suggests that the fire was primarily a polyurethane foam and polyvinylchloride fire with some contribution from other plastic materials and natural fibers.

INITIAL ACTIVITIES

Our initial investigation has been limited because of the necessity that we mask our purpose and the absence of information concerning the identity of the manufacturers of products involved. Of course, Hillhaven will have detailed

records of the standardized products it employed in the nursing home.

Initially, we have contacted Mr. John Hoffman with whom we have worked successfully in the past. He is providing us additional information, which we will provide in a supplemental report. We also expect to be in contact with Dr. Frank Cleveland, a pathologist in the Cincinnati, Ohio area. Dr. Cleveland provided the pathology work on the Beverly Hills matter in the late 1970s, and has worked with us successfully in subsequent fire cases, including the MGM and San Juan Dupont Plaza fires. In the future, we will obtain a full list of the investigators and other experts retained by any of the plaintiffs counsel in this case. We will continue to monitor developments in the local and federal courts in the Norfolk area to keep apprised of the lawsuits that may be filed. In addition, when our sources provide pathology and toxicological data concerning the cause, nature and extent of smoke exposures, we will report to you.

CONCLUSION

The analysis we have been able to provide in this preliminary report is necessarily incomplete and will be supplemented as more information becomes available. Further investigation should provide a much clearer assessment of the potential involvement of the polyurethane foam industry, the vinyl industry and other product

manufacturers in any litigation resulting from the Hillhaven fire.

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