

ALLEN COUNTY FIRE DISTRICT

Fire Prevention & Code Compliance

The Evolution of Fire Codes

How Tragedy Shaped the Rules That Protect Us Today

Fire marshals from the Northeast Fire District, West Central Fire District, Northwest Fire District, Southwest Fire District, and East Central Fire Territory are out in Allen County communities every day — working alongside local businesses, not against them. Their goal is simple: to apply the fire code in a fair, practical way that fits real-life situations, with the shared aim of preventing the kind of tragedies described below. In January 2027, these districts will unite under the Allen County Fire District, bringing a unified approach to fire prevention across the county. We look forward to partnering with your business to keep your employees, customers, our firefighters and community safe.

Why Fire Codes Exist

Fire codes are not born in boardrooms or legislative chambers — they are written in the aftermath of disaster. For most of human history, communities learned about fire safety the hard way: through devastating losses of life and property. Each major fire tragedy revealed a gap in safety practices, and over time, those lessons became law.

Today, fire codes govern everything from how wide a hallway must be to what materials can line a wall. They exist because someone, somewhere, died in a fire that did not have to be so deadly. Understanding that history helps us appreciate why these rules matter.

Early History: Before Formal Codes

Organized fire safety dates back further than many people realize. Ancient Rome established one of the first fire brigades under Emperor Augustus around 6 AD. Medieval European cities, repeatedly devastated by urban fires, began requiring stone construction and tile roofs in place of wood and thatch.

In early America, cities like Boston and New York experienced catastrophic fires that wiped out entire neighborhoods. These events spurred local ordinances — some of the earliest fire regulations on the continent — requiring firebreaks, brick construction in dense areas, and basic equipment like leather buckets kept at the ready.

But these efforts were scattered and inconsistent. There was no national standard, no unified body of knowledge. That would change in the late 1800s.

The Birth of the NFPA (1896)

The National Fire Protection Association was founded in 1896, largely driven by the insurance industry's frustration with inconsistent fire sprinkler installation practices. Different manufacturers and regions followed different standards, making it nearly impossible to assess risk or guarantee safety.

The NFPA's early mission was to standardize sprinkler systems, but its scope quickly expanded. Over the next century, it would become the world's leading authority on fire safety, publishing hundreds of codes and standards — including the National Fire Code and the Life Safety Code — that are adopted by jurisdictions across the United States and around the globe.

The International Code Council and Model Codes

In 1994, the International Code Council (ICC) was formed to bring consistency to building and fire safety standards across the country. The ICC developed the International Fire Code (IFC) and the International Building Code (IBC) — model codes updated every three years that states and localities adopt as their own. Indiana, like the majority of states, uses the ICC model codes as the foundation for its fire and building safety requirements, ensuring that standards reflect current research, emerging hazards, and lessons learned from past tragedies.

The Incidents That Changed Everything

The most significant advances in fire codes have come not from theory, but from tragedy. The following incidents are among the most pivotal in shaping modern fire safety requirements.

Incident	Year	Lives Lost	Primary Cause / Key Failure
Iroquois Theatre — Chicago, IL	1903	602	Locked exits, inward-swinging doors, no panic hardware
Triangle Shirtwaist Factory — New York City	1911	146	Locked stairwell doors, inadequate fire escapes
Cocoanut Grove Nightclub — Boston, MA	1942	492	Overcrowding, flammable décor, blocked and locked exits
Our Lady of Angels School — Chicago, IL	1958	95	No sprinklers, no connected fire alarm, open stairwells
MGM Grand Hotel — Las Vegas, NV	1980	85	No sprinklers; smoke spread freely via elevator shafts

Incident	Year	Lives Lost	Primary Cause / Key Failure
The Station Nightclub — West Warwick, RI	2003	100	Flammable foam ignited by pyrotechnics, inadequate exits
Ghost Ship Warehouse — Oakland, CA	2016	36	No sprinklers, no alarms, unpermitted assembly occupancy
Gabriel House Assisted Living — Fall River, MA	2025	10	Recalled sprinkler heads never replaced, NFPA 25 inspection overdue

Read below for more details on each incident.

1903 — Iroquois Theatre Fire, Chicago, Illinois

On December 30, 1903, a fire broke out during a packed holiday matinee at the Iroquois Theatre in downtown Chicago. The theater had been promoted as 'absolutely fireproof.' It was not.

A lighting malfunction ignited a stage curtain. Stagehands tried and failed to lower an asbestos fire curtain. Backstage doors were flung open, sending a massive fireball into the audience. Panicked patrons found emergency exits locked or hidden behind heavy drapes. Many doors opened inward, trapping crowds in the crush.

In less than 15 minutes, 602 people were dead — the deadliest single-building fire in American history.

CODE IMPACT	<i>The Iroquois fire directly led to requirements for panic hardware (push-bar exit devices), outward-swinging exit doors, illuminated exit signs, and clear pathways to exits. Cities across the country immediately revised their theater and assembly occupancy codes.</i>
--------------------	---

1911 — Triangle Shirtwaist Factory Fire, New York City

On March 25, 1911, a fire ignited on the upper floors of the Asch Building in Manhattan, where the Triangle Shirtwaist Company employed hundreds of young immigrant women. The fire spread rapidly through piles of fabric scraps and flimsy materials.

Workers found stairwell doors locked — a common practice by management to prevent theft and unauthorized breaks. Fire escapes were inadequate and collapsed under the weight of fleeing workers. With no way out, 146 workers died, many of them leaping from windows to the street below while horrified bystanders watched.

The fire became a national rallying cry for labor and safety reform.

CODE IMPACT	<i>The Triangle fire led to sweeping changes: mandatory fire drills, unlocked and outward-opening exit doors during working hours, limits on the number of occupants per floor, required sprinkler systems in factories, and greatly improved fire escape standards. It also accelerated the growth of labor protections and workplace safety oversight — laying the groundwork for what would eventually become OSHA.</i>
--------------------	--

1942 — Coconut Grove Nightclub Fire, Boston, Massachusetts

On the night of November 28, 1942, the Coconut Grove nightclub was packed far beyond its legal capacity — nearly 1,000 people filled a space licensed for 460. A fire ignited in a basement lounge and spread with terrifying speed through the club's highly flammable decorations: artificial palm trees, fabric walls, and a low ceiling of flimsy material.

In minutes, the entire club was engulfed. Revolving doors at the main entrance became death traps as panicked crowds pressed against them. Many exits were hidden, locked, or unknown to patrons. Of the nearly 1,000 people inside, 492 died.

CODE IMPACT

The Coconut Grove disaster fundamentally transformed nightclub and assembly occupancy codes. It brought about strict occupancy limits and their enforcement, requirements for multiple clearly marked exits, bans on flammable interior decorations, requirements for outward-swinging exit doors, and dramatically improved emergency lighting standards.

1958 — Our Lady of Angels School Fire, Chicago, Illinois

On the afternoon of December 1, 1958, a fire broke out in the basement of Our Lady of Angels Catholic school on Chicago's west side. The old building had no sprinkler system, no fire alarm connected to the fire department, and no fire doors on stairwells. Smoke and fire raced up open stairwells to the second floor classrooms.

Teachers and students on the second floor had almost no warning. Many jumped from windows. Others were overcome by smoke. By the time the fire was controlled, 92 students and 3 nuns had died.

CODE IMPACT

The Our Lady of Angels fire triggered a national overhaul of school fire safety codes: automatic fire alarm systems connected directly to fire departments, fire-resistant stairwell enclosures, sprinkler systems in schools, regular fire drills, and clear egress pathways in all educational buildings. Tens of thousands of schools were retrofitted or rebuilt in the years that followed.

1980 — MGM Grand Hotel Fire, Las Vegas, Nevada

On November 21, 1980, a fire started in a restaurant on the ground floor of the MGM Grand Hotel in Las Vegas. The casino had been built under older codes that did not require sprinklers in most areas. The fire spread rapidly through the open casino floor and into the hotel tower above via elevator shafts and stairwells, filling upper floors with deadly smoke.

Many of the 85 people who died were not near the fire at all — they were in hotel rooms on upper floors, overcome by smoke that traveled silently through the building's ventilation and vertical openings.

CODE IMPACT

The MGM Grand fire led to Nevada's mandate that all high-rise hotels install sprinkler systems — one of the first such statewide requirements — and accelerated similar mandates nationwide. It also drove improvements in smoke control systems, stairwell pressurization to keep smoke out of evacuation routes, and guest notification systems in hotels.

2003 — The Station Nightclub Fire, West Warwick, Rhode Island

On February 20, 2003, a rock band's pyrotechnic stage show ignited acoustic foam installed on the walls and ceiling of The Station nightclub. The foam, intended to reduce noise, was highly flammable and not rated for use near open flame. The fire grew from a small flame to a fully engulfed inferno in under 90 seconds.

The club had only one main entrance and inadequate emergency exits for the crowd of roughly 460 people. In the chaos, 100 people died and over 200 were injured — at that time the deadliest building fire in the United States since 2003.

CODE IMPACT

The Station fire led to stricter national standards for interior finish materials, requiring flame-spread testing and fire-rated foam in public assembly occupancies. It tightened requirements around indoor pyrotechnic displays and prompted the NFPA to lower the sprinkler threshold for nightclubs and assembly occupancies from 300 occupants down to 100. The grandfathering exemptions that allowed older buildings to avoid sprinkler upgrades were significantly curtailed.

2016 — Ghost Ship Warehouse Fire, Oakland, California

On the night of December 2, 2016, an electronic music event at an illegally converted artist warehouse known as the 'Ghost Ship' ended in catastrophe when a fire broke out on the first floor. The two-story building had been converted from an industrial warehouse into a live-work space for artists — without permits, inspections, or any fire safety systems.

There were no sprinklers, no smoke detectors, and no fire alarms. A makeshift staircase built from wooden pallets connected the floors. Exits were narrow, unmarked, and blocked by art installations. When fire swept through the cluttered building, 36 of the roughly 100 people inside died — making it the deadliest building fire in the United States since The Station in 2003.

The building had not been inspected by the fire department for decades, despite multiple complaints filed with the city in the years prior to the fire.

CODE IMPACT

The Ghost Ship fire renewed national attention on unpermitted assembly uses in warehouses and industrial buildings, an increasingly common phenomenon driven by urban housing pressures. It drove reforms in how cities track and inspect commercial and mixed-use properties, strengthened enforcement protocols for change-of-occupancy triggers, and reinforced that any building used to host the public — regardless of how informal — must meet life safety requirements. The fire stands as a stark reminder that fire inspection and code enforcement are not bureaucratic formalities: they are the last line of defense between a crowd and catastrophe.

2025 — Gabriel House Assisted Living Fire, Fall River, Massachusetts

On the night of July 13, 2025, a fire broke out in a second-floor unit at Gabriel House, a 100-unit assisted living residence in Fall River, Massachusetts — about 50 miles south of Boston. The building housed roughly 70 elderly residents, many with mobility limitations or cognitive impairments. Ten residents died, ranging in age from 61 to 86. Dozens more were injured, and approximately half of the building's residents required rescue — many pulled from windows by firefighters. It was the deadliest fire in Massachusetts in more than 40 years.

The building was equipped with a sprinkler system. But the sprinkler in the unit where the fire started failed to activate. Investigators later revealed that the system contained sprinkler heads

that had been subject to a nationwide manufacturer recall issued in 2001 — more than two decades before the fire. A required five-year internal inspection under NFPA 25 was overdue. Critically, a fire-safety contractor had alerted the building owner to these deficiencies just five days before the fire.

The building's physical layout compounded the tragedy. Converted from a former hotel, it had no hallway fire doors or smoke compartmentalization, allowing smoke and heat to spread freely throughout common areas. Window-mounted air conditioning units were sealed in with plywood fastened by screws, blocking normal means of escape and forcing rescues through narrow bathroom windows. The sole elevator had been out of service for approximately nine months in the period prior to the fire.

State records showed a decade-long pattern of regulatory concerns at the facility, including staffing deficiencies, unreported resident incidents, and incomplete emergency preparedness plans — all documented in state inspections but not resolved.

**CODE
IMPACT**

The Gabriel House fire exposed critical gaps not in the existence of fire safety systems, but in their maintenance and oversight. The sprinkler system had passed annual inspections — yet contained recalled components and missed a mandatory five-year internal inspection. This revealed an 'honor system' at the heart of fire safety compliance, in which fire departments largely rely on documentation submitted by building owners and their contractors rather than independent verification. The disaster prompted Massachusetts Governor Maura Healey to order an emergency review of all 273 assisted living residences in the state and triggered calls to apply the same sprinkler standards to assisted living facilities that already apply to nursing homes. It is a sobering reminder that installing a sprinkler system is only the beginning — ongoing inspection and maintenance under NFPA 25 are what make the system work when lives depend on it.