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## Report of the Week

**Snared, but not trapped.**

**01/06/2011**

**Report Number:** 10-0001286

Report Date: 12/27/2010 09:00

### Synopsis

FFs become entangled in HVAC wiring.

### Demographics

Department type: Volunteer

Job or rank: Fire Chief

Department shift: Respond from home

Age: 34 - 42

Years of fire service experience: 24 - 26

Region: FEMA Region III

Service Area: Rural

### Event Information

Event type: Fire emergency event: structure fire, vehicle fire, wildland fire, etc.

Event date and time: 12/13/2010 14:12

Hours into the shift:

Event participation: Witnessed event but not directly involved in the event

Weather at time of event: Clear and Dry

Do you think this will happen again?

What were the contributing factors?

- Situational Awareness
- Unknown
- Task Allocation
- Other

What do you believe is the loss potential?

- Life threatening injury

### Event Description

Brackets [] denote reviewer de-identification.

While at a working structure fire, engine [number deleted] was working in the basement extinguishing all remaining fire and hot spots. The engine company officer and nozzle man became entangled in HVAC duct wiring. The nozzle man and the company officer worked on cutting themselves out with a cutting tool that all firefighters are required to carry in their gear. The company officer notified command that they were in the basement, were not in distress, and were tangled up in wiring. Command sent half of the RIT team to assist.

The engine company that was working on the first floor to ensure the stairwell was protected at all times. The engine company officer attempted to contact command, but was unreadable. Command requested for the message to be

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repeated a second time and no answer was received. Because of this, command declared a mayday and a full RIT was sent after the engine company. As soon as county communications transferred all additional companies to an additional channel, the safety officer notified command that the firefighters were disentangled and were exiting the basement with PAR. The mayday was canceled and normal operations were continued.

The mayday was declared due to not being able to communicate. The engine company has had multiple trainings in self extrication and this training proved to be beneficial. They worked as a team and kept calm and were able to cut themselves out. The engine company self extricated before the RIT company reached them. In addition, it was very positive that the engine company officer did not hesitate to notify command what was happening instead of waiting until they were in distress.

### **Lessons Learned**

Never hesitate to report your situation and continue to keep command aware of what is taking place. Command should never hesitate to call a mayday and activate RIT companies. The sooner a problem is recognized and egos are kept out of the picture, the better the chance of survival. While this turned out to be a minor event, it was still positive in the fact that the engine company officer and command did not hesitate to elevate and activate RIT to ensure everyone went home.

### **Report of the Week**

This first ROTW of 2011, [10-1286](#), takes us into a basement fire where a familiar hazard is encountered. The advent of flexible duct work has added an additional entanglement hazard to the list of materials that break down during fire exposure and ensnare firefighters. Cool heads, the right tools and prompt notification to command helped end this near miss on a high note.

*Brackets [] denote reviewer de-identification.*

*"...engine [number deleted] was working in the basement extinguishing all remaining fire and hot spots. The engine company officer and nozzle man became entangled in HVAC duct wiring. The nozzle man and the company officer worked on cutting themselves out with a cutting tool that all firefighters are required to carry in their gear. The company officer notified command that they were in the basement, were not in distress, and were tangled up in wiring. Command sent half of the RIT team to assist..."*

*...The engine company has had multiple trainings in self-extrication and this training proved to be beneficial. They worked as a team and kept calm and were able to cut themselves out. The engine company self-extricated before the RIT Company reached them. In addition, it was very positive that the engine company officer did not hesitate to notify command what was happening instead of waiting until they were in distress."*

Practice like you play and success rules the day. Report [10-1286](#) stresses a significant point that wise members in our service should live by: repetitive drills involving tactile skills, so performance pay off when stressful situations occur. The two firefighters, who became entangled remained calm, recalled their

training, were prepared for the situation and successfully worked their way out of the hazard. Their actions *and* the decision to capture the incident in a near-miss report provide all of us with a reminder to keep focused on readiness and share lessons. Once you have read the entire account of [10-1286](#), and the related reports, consider the following:

1. Where would you get the tools to self-extricate from a wire entanglement hazard?
2. Is air consumption a factor in the disentanglement timeline?
3. What is "Step One" in the disentanglement process?
4. Does this incident meet the "mayday" threshold under your department's SOPs? Why, or why not?
5. What are the critical steps you take to "remain calm" in stressful situations?

### **Related Reports – Topical Relation: Entanglement**

[05-548](#)

[05-276](#)

[07-1166](#)

[08-296](#)

[10-696](#)

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Note: The questions posed by the reviewers are designed to generate discussion and thought in the name of promoting firefighter safety. They are not intended to pass judgment on the actions and performance of individuals in the reports.