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## Report of the Week

### Board On The Side Of Safety.

02/03/2011

**Report Number:** 10-0001279

Report Date: 12/15/2010 13:18

#### Synopsis

Training helps prevent tragedy during collision.

#### Demographics

Department type: Paid Municipal

Job or rank: Driver / Engineer

Department shift: 48 hours on - 96 hours off

Age: 25 - 33

Years of fire service experience: 7 - 10

Region: FEMA Region VIII

Service Area: Suburban

#### Event Information

Event type: Non-fire emergency event: auto extrication, technical rescue, emergency medical call, service calls, etc

Event date and time: 12/11/2010 20:30

Hours into the shift:

Event participation: Involved in the event

Weather at time of event: Cloudy and Snow

Do you think this will happen again?

What were the contributing factors?

- Human Error

- 

What do you believe is the loss potential?

- Life threatening injury
- Property damage
- Lost time injury

#### Event Description

The engine company was operating at a motor vehicle accident on the local interstate. After the scene had been cleaned up, the crew returned to the engine to depart the incident. As the crew was boarding the apparatus, the engineer announced that a vehicle strike was imminent. Shortly thereafter, a vehicle impacted the rear crew cab door and front driver side tire of the engine. Immediately all crew members were checked for injuries and none were reported.

The critical decision made on this call was that of the firefighter sitting behind the engineer. Had the firefighter decided to enter the pump on the traffic side of the scene, the timing would have been such that the firefighter would have been struck by the vehicle. The actions of this firefighter were within the organizations

training practice, and this practice greatly improved the outcome of this near miss.

At the time of the vehicle impact the only member that was seat belted was the engineer. All other members had just re-entered the apparatus and were finding their seats and seatbelts. One member was actually walking across the rear crew cab toward his seat to sit down.

Road conditions during the incident were extremely icy and snowy, a condition our department encounters often.

### **Lessons Learned**

As an organization, we have dealt with apparatus being struck on the interstate in the past. We have established an operational procedure to enter the apparatus from the non-traffic side if possible (primarily for the crew as either the engineer or officer will have to enter on the traffic side).

Should the strike have occurred while the crew was out of the engine, the positioning of the apparatus had shielded the work area.

### **Report of the Week**

This winter has deposited ice and snow on areas of the country not accustomed to such weather. Even areas that do receive their share have not been spared record accumulations over the past two years. The Washington Metro Area, for instance, experienced one such event last week that left motorists stranded and others taking up to 12 hours to get home.

What these conditions mean to us is clearly illustrated in ROTW [10-1279](#). A crew is picking up after an incident the report notes is a familiar situation for them, the motor vehicle accident on an icy, snowy interstate. One would think the danger had passed.

*"The engine company was operating at a motor vehicle accident on the local interstate. After the scene had been cleaned up, the crew returned to the engine to depart the incident. As the crew was boarding the apparatus, the engineer announced that a vehicle strike was imminent. Shortly thereafter, a vehicle impacted the rear crew cab door and front driver side tire of the engine. Immediately all crew members were checked for injuries and none were reported.*

*The critical decision made on this call was that of the firefighter sitting behind the engineer. Had the firefighter decided to enter the pump on the traffic side of the scene, the timing would have been such that the firefighter would have been struck by the vehicle. The actions of this firefighter were within the organization's training practice, and this practice greatly improved the outcome of this near miss."*

Established operational practices adhered to make the difference in this incident. In our haste to clear the scene, whether to get off the road faster or just get out of the lousy weather, we sometimes deviate from safety practices. Once you have read the entire account of [10-1279](#) and the related reports, consider the following:

1. Does your department SOP for roadway incidents call for members to board apparatus on the non-traffic side?
2. What is your definition of the "end of the incident" when it comes to highway incidents?
3. The secondary collision into blocking apparatus seems inevitable given the road conditions. Are there any other steps that can be taken to avoid the collision or has your department exercised all the due diligence it can when it comes to highway incidents?
4. What additional steps come to mind for boarding apparatus as units are clearing the scene of a highway incident with slippery road conditions?
5. The engineer's call that a vehicle strike was imminent is an example of what type of situational awareness; high or low? Is the callout important to the outcome of this incident?

Related Reports – Topical Relation: Roadway Safety

[05-277](#)

[06-051](#)

[07-898](#)

[08-098](#)

[09-622](#)

[11-035](#)

Involved in a near miss where best practices averted injury? Submit your report to <http://www.firefighternearmiss.com> today so everyone goes home tomorrow.

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.