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Report of the Week

Will you catch me if I fall?
3/21/08

Report Number: 07-939
Report Date: 06/04/2007 1118

Demographics

Department type: Volunteer
Job or rank: Captain
Department shift: Respond from home
Age: 25 - 33
Years of fire service experience: 14 - 16
Region: FEMA Region II

Event Information

Event type: Non-fire emergency event: auto extrication, technical rescue, emergency medical call, service calls, etc.
Event date and time: 05/25/2007 1403
Hours into the shift:
Event participation: Witnessed event but not directly involved in the event
Do you think this will happen again?

What do you believe caused the event?

- Decision Making
- Individual Action

What do you believe is the loss potential?

- Life threatening injury

Event Description

My unit was dispatched to a reported motor vehicle collision (head-on) with confirmed injuries. This writer was the driver of the first due engine. Engine company was on a detail prior to the call so the engine responded prior to the heavy rescue. After arriving at the scene, the engine split crews to check on both vehicles that were involved. The engine operator placed cones at intersection and placed vehicle in pump gear after chocking the tires. The Deputy Chief on scene directed the engine driver to assist crew #1 with vehicle hazards and stabilization. After approximately 5 minutes on the scene, the heavy rescue arrived. While approaching the scene the Rescue Operator began slowing the vehicle to position just north of the intersection/scene. The Deputy Chief directed the rescue to pull further north in an attempt to reduce the amount of diesel exhaust the crews would be exposed too. As the vehicle was slowing I noticed the rear door of the cab on the officers' side of the heavy rescue was open while the vehicle was still in motion. After hearing the instruction to continue north of the intersection, the operator of the heavy rescue continued forward and the firefighter in the rear section of the cab did not close the door. As the vehicle "almost" came to a complete stop the door opened and the firefighter stepped onto the first rung. The firefighter had made the second rung by the time the vehicle stopped and applied its parking brake.

Lessons Learned
Individual decisions can put members at risk no matter what experience level or training background a firefighter may possess. It is necessary to enforce all SOG's/SOP's regarding seatbelt usage by crew members responding to emergency alarms (and returning) Re-familiarizing operators to the meaning of visual warning lights indicating that a door is ajar/open. Individual firefighters and their officer should be reminded of department/national standards regarding the safe passage to and from alarms. This includes but is not limited to; remaining seated until arrival at destination, all doors remaining shut until vehicle is properly positioned and parked and the utilization of safety devices (seatbelts) when riding in fire department apparatus.

Discussion Questions
Revising the search to “fall apparatus” returned 19 reports, 6 of which dealt with firefighters falling from or nearly falling from apparatus. The 6 reports are listed at the end of this week’s ROTW as links to assist you in developing your own analysis of the common factors that contribute to falls from apparatus. Once you have reviewed **07-939** and the others, consider the following:

1. Is this incident avoidable or inevitable?
2. If you answered “avoidable,” is the solution technology based or human performance based?
3. If you answered “inevitable,” should anything be done? Explain your answer to your colleagues.
4. What technology is available to prevent the occurrence in 07-939?
5. Can the issue be *solved* with technology?

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.