Report of the Week

We just did what we were told
7/9/09

Report Number: 09-482
Report Date: 05/11/2009 0808

Synopsis
Hoseline accidentally pulled away from crew.

Demographics
Department type: Combination, Mostly paid
Job or rank: Driver / Engineer
Department shift: 24 hours on - 48 hours off
Age: 25 - 33
Years of fire service experience: 4 - 6
Region: FEMA Region IV
Service Area: Suburban

Event Information
Event type: Fire emergency event: structure fire, vehicle fire, wildland fire, etc.
Event date and time: 05/08/2009 1500
Hours into the shift:
Event participation: Involved in the event
Weather at time of event: Clear and Dry
Do you think this will happen again?

What were the contributing factors?
Communication
What do you believe is the loss potential?
Property damage
Life threatening injury

Event Description
Brackets [] denote reviewer de-identification.

Companies from [department names removed] responded to a house fire. Upon arrival, the first arriving company reported fire showing from sides A & D of a residential single-story, wood-frame structure. Personnel deployed an attack line and made entry into the structure to begin offensive operations. Additional units began arriving on the scene. This included, the battalion chief who assumed command. A second attack line was deployed and a primary search began. Firefighters on the first attack line advised command that they were getting a good "knock down" on the fire but needed some more slack on the hoseline so they could advance further. Command advised the R.I.T. (who was standing-by on side A) to "pull the hoseline." R.I.T. personnel thought command meant for them to pull the hoseline away from the structure and began pulling the hoseline. Interior crews had the hoseline pulled from them and attempted to chase it down. The nozzle was pulled 50' from its original position before the interior crew could regain control of it. The fire was completely extinguished and the rest of the incident went on without complications.

Lessons Learned
Fortunately, interior crews had already succeeded in knocking down the main portion of fire before the nozzle was pulled from them and no injuries were sustained. If they would have been in a heavy fire situation, the outcome may have been different.

This event was a communication error! Interior crews asked for the line to be pulled, command ordered the line pulled, and the R.I.T. pulled the line. Therefore, all personnel did exactly what they were asked to do. The issue was terminology. When command told the R.I.T. to pull the line, he did not specify in which direction he wanted the line pulled. The R.I.T. did not know which direction to pull the line so they assumed he meant away from the structure.

Assumptions can be dangerous! Command's order should have been precise and specified which way the line needed to be pulled and the R.I.T. should have asked which direction if they were unclear. Also, a predetermined terminology should be in place. Since "pull hose" is subjective and doesn't specify which direction, it can cause confusion. "Advance the hoseline" would have been a clearer request in this situation. "Retract the line" could be used for requesting the line to be pulled out of the house. Personnel should be familiar with the terminology used on the fire ground to prevent communication errors that could cause injuries.

Discussion Questions
The Communications Model states that the sender and receiver have to understand each other for good communication to take place. If either side of the model miscommunicates (sends an unclear message or misinterprets the message), confusion occurs. There are attempts to correct the confusion during this period, but typically the sender resends the same message and the receiver repeats the same action. Both know something is wrong, but the natural human response is to make the situation fit the model each has formulated as the “right” way in their own minds. The sooner one party crosschecks their side of the communication (Sender: Am I clear? Receiver: I think this is what you said?) the sooner confusion changes to compliance. Once you have reviewed the entire account of 09-482 and the related reports, consider the following:

1. Are there routine sender/receiver errors in your communication with subordinates, peers and superiors?
2. If the answer to #1 is yes, are the major cause’s sender errors, poor medium (i.e., ambient noise, poor equipment, etc.) or receiver errors?
3. What was your supervisor’s reaction to the last miscommunication incident you and he/she were involved in (i.e., reassessment of communication model, supervisor admitting role in miscommunication, or blaming receiver for not understanding message)?
4. Does your team practice the process of repeating messages back to promote understanding and reduce miscommunication?
5. Good communication is often said to be clear, concise and complete. What would you offer as a suggestion to fulfill that definition for the incident that occurred in 09-482?

Related Reports
05-336 06-114 07-693 08-095

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.