Report of the Week

Do you hear a PASS device?
07/29/2010

Report Number: 10-0000277
Report Date: 02/12/2010 10:57

Synopsis
Personnel fail to respond to PASS activation during fire.

Demographics
Department type: Paid Municipal
Job or rank: Assistant Chief
Department shift: 24 hours on - 48 hours off
Age: 43 - 51
Years of fire service experience: 21 - 23
Region: FEMA Region VII
Service Area: Urban

Event Information
Event type: Fire emergency event: structure fire, vehicle fire, wildland fire, etc.
Event date and time: 02/09/2010 02:37
Hours into the shift:
Event participation: Involved in the event
Weather at time of event: Clear with Frozen Surfaces
Do you think this will happen again?

What were the contributing factors?
- Accountability
- Communication
- Individual Action
- Situational Awareness
- Command

What do you believe is the loss potential?
- Lost time injury
- Life threatening injury
- Minor injury

Event Description
Fire department units responded to a reported residential fire [just after midnight]. Size up indicated heavy smoke showing with confirmation of the residents being out of the structure. The residents also reported that the fire appeared to be in the basement laundry area, around the dryer. Entry was made into the structure simultaneously with some ventilation underway. Further ventilation operations were ordered following reports from inside.

The basement stairway was located next to the main floor kitchen, with the seat of the fire located directly below the kitchen in the basement. The incident progressed as expected through the first twenty-minute PAR. Water supply was established, utilities were ordered for disconnect, RIT team was established, and ventilation was well underway.

Do you hear a PASS Device?

About thirty minutes into the incident, a request was made from interior crews to have someone bring another 1 ¾" line in through the garage to access the basement. The RIT team was assigned to perform this task and then stopped, as the garage was too packed full of stuff to even make their way inside. That crew was then outside the structure, but had not reassembled for RIT assignment (IC's call).

The IC was making another 360 to check on a utility worker when dispatch notified IC of the forty-minute operational mark. During this PAR, command heard a PASS device activate and yelled in the direction of the activation, thinking that someone might have been standing still and it activate. The PPV fan was still operating so the noise level was elevated. Soon after hearing the PASS device, dispatch also reported the radio emergency alarm activation of a radio. IC was on Side "A" looking in the open front door of the structure and could see the faint blinking of the PASS strobe in the direction of the sounding PASS device.

Immediately, one of the personnel originally assigned to RIT was told face- to-face to get that person out of the building. At the time, IC was extremely unhappy, thinking that somebody had just let their PASS device activate and didn't bother to stop it. The RIT member followed the hose line in a short distance, approximately thirty feet, toward the strobe and dragged the downed firefighter out. Upon exiting the structure, he was helped to his feet, immediately assessed for injury, and then relocated to the ambulance for further evaluation. Subsequently, he was transported to the hospital, as a precaution, for further testing.

In interviewing the [downed firefighter], he stated that he was with his crew member in the basement on fire attack, along with another two-person crew. His low-air alarm had activated and he continued to work, thinking he had plenty of time. After a time, he told his partner that he was going to run outside and get another bottle. He then left his partner and headed out of the laundry area in the basement, following the hoseline around the corner and up the stairs. Part way up the stairs, he completely ran out of air. In a condition of "high motivation," he started to hurry. Staying low and following the hoseline, he became disoriented and ended up reversing his direction. He then fell back down the stairs, knocking his face piece off.

The conditions were still untenable. He repositioned his face piece so his Nomex hood would give him some filtering action. He then activated his PASS device and activated the emergency button on his radio. He stated that he was unable to speak due to the heavy smoke conditions.

As a side note, his partner thought he heard a PASS device activate, but he stopped hearing it (the captain went back up the stairs to attempt exit) so he assumed that it was an accidental activation. As the captain cleared the top of the stairs, he had to keep his face close to the floor. It was at this point that the RIT person located him and pulled him to the exit.

Lessons Learned

One important lesson learned that must be addressed is that the SCBA Lost and Disoriented Firefighter Training conducted by this department worked in its most

basic form. When the situation became less than ideal, the captain controlled his emotions, remained calm, activated his PASS device and his radio emergency button, took steps to get the best quality air he could find, and was actively involved in rescuing himself. Remembering those important training points is very commendable. However, although the outcome of this "near miss" incident was positive, this particular incident itself was completely preventable. Several opportunities for improvement have been identified in response to this incident:

1) Strict adherence to the "Two-In Two-Out" rule should be enforced.

2) Strict adherence to the department's air-management protocol (when the low air alarm activates, you call for relief and then immediately exit with your assigned partner or crew) should be required. Additionally this should be reinforced with a department SOP/SOG regarding SCBA Operational Procedures and Air Management.

3) A "ZERO TOLERANCE" departmental policy regarding PASS device activations should be implemented and enforced. When a device activates, it gets immediate attention. Anything less than this creates a potential environment of dangerous complacency when hearing them activate.

4) Incident Command should diligently track at any moment where their personnel are and maintain a good communication link with anyone on the fire ground.

5) Once a RIT team is assigned, they should not be reassigned unless activated or relieved by a replacement, until the incident de-escalates.

6) Regular training should be conducted on the Lost and Disoriented Firefighter Procedures, along with SCBA Air Management training.

7) Training should be regularly given to reinforce the importance of the SOP/SOG's that are in place to keep personnel safe on the fire ground.

Discussion Questions

This week’s ROTW presents a situation that is encountered frequently on the fireground. The sound of an activated PASS device does not elicit an immediate emergency response by personnel on the scene. The devices activate so frequently (“false alarms”) they have become an often ignored signal except for a chorus of “reset that noisy $&%*!.” We fail to take into account that the device is functioning exactly as designed. The SCBA is immobile for a specified period of time; the PASS device sounds a warning. If the wearer doesn’t react to the warning, the device goes into full alarm. The device is not programmed to sense danger, just lack of motion. We, on the other hand, don’t always sense danger, and too often stand immobile on the scene, causing incorrect responses to the properly operating technology.

Once you have read all of **10-277** and the related reports review the following questions with your group or members:

1. How often do PASS devices activate on your incident scenes?

2. What type of response does an activated PASS device generate on your incident scenes?

3. Are your PASS devices calibrated periodically to ensure they are still set to manufacturer's specifications?

4. Who conducts your PASS device activation response training and how often is the training conducted?

5. How many different suggestions can you generate to avoid or reduce the number of "false" activations of PASS devices?

Related Reports – Topical Relation: PASS Activation Response.

06-302 **07-994** **07-1146** **08-077** **08-362**

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.