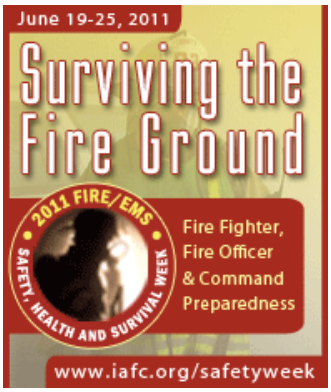

National Fire Fighter Near-Miss Reporting System

In Support of the 2011 Fire/EMS Safety, Health and Survival Week

Reports Related to Self Survival Skills

SCBA Familiarization, Emergency Procedures, Disentanglement, Upper Floor Escape Techniques

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10-1286

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 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.

10-1072

Event Description
It was a very hot evening and several neighboring departments were dispatched to a structure fire involving a single family dwelling. Due to the heat of the day and the intensity of the fire, mutual aid was requested from our department. We sent an engine

and a quint to the scene. I was on the quint and our unit was the first from our department to arrive on the scene. Upon arrival, our crew went to Side “A” of the structure to meet with the IC. We were advised by the IC that the fire originated in the basement due to an accidental flash fire from acetone material used to treat the floor (approximately 3 gallons). We were advised that the basement was difficult to access for attack and that they believed the staircase was burned away or compromised. My deputy chief, [name omitted] and I suggested using a cellar nozzle in the front foyer of the structure to try and get a knockdown on the fire. The IC agreed with our tactic and we proceeded to get our equipment together for the attack.

Upon approaching the front door, there were three firefighters inside the structure in the foyer area. I stepped inside and told them to back out due to our operation. They removed their equipment and our crew prepared for entry. Our crew consisted of five personnel; my deputy chief who has over 30 years experience, myself with 26 years of experience, firefighter [name omitted] with approximately two and one half years of experience, firefighter [name omitted] with approximately six years of experience, and recruit [name omitted] with right at one year of experience. Due to the nature of the operation and the need to act quickly, the deputy chief and I decided that one of us would lead the attack in to get the job done quickly. My deputy chief stated, "You take the lead....I've got your back!"

I made sure my crew was ready to enter, sounded the floor for stability, and then crossed over the threshold entering the structure. When I was approximately five feet inside the structure, I felt the floor start to give way. I turned toward the front door to try and bail out and at the same time yelled at others to get out, when the floor system collapsed. This was no ordinary collapse. More than two thirds of the first floor collapsed simultaneously. The living room, dining room, kitchen, bathroom and foyer all fell at once.

When the collapse happened, I was the only one that fell into the basement, right into the heart of the fire. All I could see around me were flames. I could not see the hole that I had fallen through. I could not see my fellow firefighters above me. All I could see was fire. I began to try and find something to use to climb back up with. Since I did not know what type of collapse had occurred, I just started clawing away at anything as I was trying to climb. During this time, my legs were burning. Fire was burning up between my boots and my bunker pants. The pain was intense. My deputy chief was trying to put a line on me for protection, but the fire was extremely intense. He was lying on the porch with fire shooting out over his head. He stated he could occasionally see the top of my helmet and the reflective stripes on my coat sleeves. By a bit of luck, a roof ladder was laying in the front yard that had just been taken off the roof after completing a ventilation operation. My deputy chief directed the crew to get the ladder into the hole for my escape.

By this time, I was burned pretty well on my legs and struggling with exhaustion and the intense heat. I was screaming both from pain and due to fear. I could hear screaming coming from above, but was unable to make out the majority of it. I finally heard the word "ladder" and then felt something across my back. Once they got the ladder in to the basement, I had to get around to it. I still could not see anything but fire, so this was all

by feel. As I started up the ladder, I got two rungs up, reached for the third rung, and lost my grip and fell back into the basement landing on my back. I was so exhausted that I started making my peace with God that this was where I was going to die. My wife and my three boys [names omitted] were at the foreground of my thoughts and I was thinking about never getting to see them again. Somehow, by the grace of God, I found the strength to get up again and start climbing the ladder once more. I got to the fourth rung and felt hands grabbing hold of me helping to pull me out.

Upon exiting the fire, I was told by my deputy chief that they had to extinguish me in the front yard. EMS personnel could not touch me as my equipment was too hot, so fire gloves had to be used to remove it. I was hosed down to assist with the cooling process, placed on a stretcher, and transported to the hospital [name and location omitted] where I was admitted and treated for second and third degree burns to both of my legs and minor burns to my left hand and wrist.

A lot of things fell into place just right that night. There was no time to call for a RIT team. I never had the chance or the forethought to call MAYDAY. I knew I was burning alive and had to do whatever I could to get out. My level of training gave me enough forethought to not leave the area so that my crew knew where to find me. It also enabled me to react quickly and try options that had been discussed and practiced in training many times. I was panicked, but did not panic to the extent of removing my SCBA, though I was inhaling so hard my mask was touching my nose. My deputy chief kept his composure and facilitated immediate actions by the rest of our crew to enable my rescue. The ladder that had just been removed from the roof was in the right location for use. My crew did not give up on me and I did not give up on them. I owe them my life.

Since this incident, I have had to undergo skin graft surgery with the possibility of having to have a second surgery in the near future. I am off work from both of my jobs with an undetermined date of return. This incident has played hard on my mental status as well as physically. Nothing can really prepare you for the emotional roller coaster that you ride after a situation like this. I have spoken with my crew several times since that day and we all experience many of the same emotions, but also many different ones. They will hopefully never know what it was like down in that inferno, but they do know how it feels to watch it happen to one of your own.

Lessons Learned

TRAIN! TRAIN! TRAIN! Train like you have never trained before. We followed everything by the book, no hot dogging, no free-lancing, nothing like that, and things still went wrong. We have gone over the scenario again and again in our heads and agreed that there is nothing we should have or would have done differently. Accidents happen, but you have to train hard and take the job seriously, whether you are a paid or volunteer firefighter, if you want to survive. Most of us go through our career in the fire service without injury, but it can happen at any time and at any fire. BE PREPARED!

Take your training seriously. The more you train, the better prepared you will be. Nothing can really completely prepare you for this type of event, but the more you practice what to do, the more likely you are to react in the proper way.

RIT teams are an essential part of the fireground operation; however, they are not the only resource. Had I had to wait on the RIT team for rescue, I would not be typing this today. Rely on your own skills and training to try and get out. Don't give up and just wait. Work together as a crew and keep track of all your personnel. Make sure everyone understands the operation, knows their responsibilities, and has the proper equipment to get the job done.

Remember Critical Incident Stress Debriefing, not only immediately following the incident, but for weeks or months after an incident of this magnitude. Every time you talk, more emotions will surface. Don't try and play the "Macho Firefighter" and make everyone think that things like this don't bother you. It will eat you up inside. I have had a very hard time with many issues and talking with my fellow firefighters and especially my crew has helped not only me, but them as well.

Keep your protective equipment in top notch condition and in date. My equipment saved my life that day.

More consideration should have been given to the duration and intensity of the fire prior to our entry. Even though it appeared stable, obviously it was not. No warning signs were present.

Know the crew you will be entering a fire with. Understand their level of training and confidence. Remember, you may have to get them out of a bad situation, but they may also have to get you out of a bad situation. You must work cohesively as a unit, be able to read each other, and know what is expected of each other. This is hard in many combination and/or volunteer departments, but that again goes back to training.

08-287

Event Description

This was a two-story balloon-frame single-family residence. Upon arrival, the first engine reported heavy fire on the first floor with auto exposure to the eaves on the "D" side. [Unit number deleted] was the 3rd engine on scene and ordered to search for extension in the second floor. Upon [unit number deleted] entering the building, the main body of fire was extinguished on the first floor. [Unit number deleted] advanced a dry line to the second floor in case fire was found. Upon entering the 2nd floor, a TIC revealed no excessive heat or active fire from the top of the stairs. [Unit number deleted] crew made their way to the front area of the 2nd floor and began opening the knee walls along side "D." Fire was found on the inside of the knee walls at the eave line extending midway down the "D" side from the "A/D" corner. Vertical ventilation was completed by

the tower and [unit number deleted] crew took out the "A" side window. Smoke conditions improved greatly allowing [unit number deleted] crew to walk around the area moving furniture/debris and extinguishing the last remains of fire in the knee walls. The crew was still on SCBA but had no heat and good visibility. The 2nd floor was divided into three rooms with the front room being 8x10 in size. The wall dividing the front room from the middle room had a closet. During the extinguishment and overhaul phase on the 2nd floor, flames began coming from the top of the closet wall. Another crew member stated there were flames coming from the middle room extending into the hall towards the engine crew. The hoseline was directed to the flames in the closet and then to the hallway. Immediately following this action, conditions rapidly deteriorated. Thick black smoke and a rapidly increasing high heat conditions occurred resulting in the immediate order to evacuate through the Division "A" window. This window led to a porch roof and an escape ladder that had been provided by the RIT team prior to the bailout, was in place at the porch. All four members of the engine crew (two of whom were probationary) safely exited onto the porch roof. The hose was pulled from the interior to the exterior and the nozzle directed into the building through the window. Once the fire was knocked down, the [unit number deleted] crew reentered the building from the porch roof and completed extinguishment.

The crew involved was utilizing a TIC throughout the incident and had evaluated the conditions in the middle room prior to passing it by. This examination revealed no significant heat conditions or active fire. The contributing factors were a balloon frame home and a dry wall ceiling covering the underside of the original cedar shake shingles. Brackets [ ] in this report denote identifying information removed by the reviewer.

Lessons Learned

The major lesson learned is to always maintain situational awareness while working in and around a fire building. Our crew had been working on the 2nd floor for approximately 15 minutes with increasingly good conditions. The known fire in the knee walls was easily being extinguished and the truck work (vertical vent) had been completed. The rapid change in fire conditions, we believe, was caused by fire extending in the walls from the 1st floor into the dividing wall on the 2nd floor. This fire then extended above the dry walled ceiling, igniting the cedar shakes. At some point, the dry wall failed, resulting in the rapid change in conditions. The changing conditions were first noted from the exterior crews as the black smoke came from the vent hole and the window on the "D" side. Command attempted to make radio contact with the [unit number deleted] captain but during that attempt the captain had already ordered the evacuation. Other lessons reinforced are:

- Bring a line when checking for extension or working above.
- Use the TIC.
- Know your escape routes.
- Explain to your crews what their actions should be when ordered to evacuate.
- Need for RIT to be constantly aware of the entire scene until everyone is out.
- Don't underestimate the potential dangers even when conditions are improving.

Brackets [ ] in this report denote identifying information removed by the reviewer.

07-946

Event Description
I was told about a failure of a breathing apparatus at a recent fire. The individual reported that while in the middle of fire attack and under heavy fire conditions, he took a breath and the system failed. He then removed his mask and took in "hot and smokey air". He proceeded to “bail out” of the area. He was hindered by many other firefighters in the narrow hallway. He felt that his life was in danger and he was very close to going down. The individual also stated that he had not opened the tank valve more than a "turn or two", as this was his "normal practice with no previous problems".

Be advised this isn't the first time that this type of event has occurred. This is the second time I know for sure and have heard of at least one other.
After the first event, my department had the SCBA manufacturer come out and investigate the SCBA failure. Their investigation concluded that because of the high pressure (4500psi) air system, the valve system had frozen because of a restricted opening. They advised that this type of problem would not happen again if the SCBA bottle valve was opened completely. The department did not have the SCBA from the previous incident evaluated by an outside source.
The individual involved has not advised our staff of the incident. I will speak with the individual to do so and if not I will advise that we have a training issue or a problem with our SCBA's

Lessons Learned
[Reviewer provided: Failure to fully open the cylinder valve completely is a recipe for disaster. The National Fire Fighter Near-Miss Reporting System has received several near miss reports dealing with "SCBA failure due to restricted airflow" and the high pressure valve has only been opened "one or two turns as a regular practice." After discussion with several manufacturers, all have advised that this is a dangerous and ill advised practice.

Fully open the cylinder valve any time SCBA is used.]

06-572

Event Description
During "routine" single family frame structure fire (with known victims), the pumper took 4 attempts to engage causing a delay in water to the hose for approximately 5-6 minutes. During this delay the interior suffered a flashover (4 minutes after arrival) forcing all interior crew members back down stairs. (The attack line was manned by one FF and one officer. The remaining FF from the engine was attached to the ladder crew for rescue due to four known victims.) One member of the ladder crew was unable to make it back to stairs and was forced to self rescue from second floor window to ground.

He was operating in room next to fire room approximately 10'-15' from stairs. He had just vented the only window in the room and was starting to search when the flashover occurred. He went back to the window and waited for us to start knocking the fire down. He decided to bail when conditions weren't getting any better. He suffered 10% 2nd degree burns to his back, right arm, and face (hood was pulled from around his mask exposing a ring of skin). A radio report claiming a partial collapse of second floor ceiling with members still in area initiated a PAR and attempt to re-enter area to find missing member. A radio report from IC verified missing members self rescue. A second line was now in place, (first line had burnt through due to being hung up on railing upstairs), and entry was attempted again. This was delayed due to first line (burnt through) still flowing and causing a reduction in pressure. Radio communications where intermittent and the P.O. wasn't getting the message to shut down the first line. This was accomplished by sending a runner. Once proper pressure was established extinguishment was accomplished and the 4 victims were found (none survived).

Initial crews on scene: 1 Ladder company w/ one Officer and 3 FF's (3 entered structure while operator placed ground ladders to porch); 1 Engine company w/ one Officer and 3 FF's (3 entered with Officer and FF on line and remaining member w/ Ladder company to initiate rescue; and 1 ALS unit w 2 FF Medics (we are a fire based EMS system).

Conditions on arrival: Smoke showing from 2 windows (fire room and victims location) and no fire visible. Occupants on sidewalk claiming victims on second floor. Moderate to high heat encountered at top of stairs. Smoke down to approx. 8"-10" from floor.

Operator error ruled out and no problem could be found with pumper. Initial thoughts were the twist the chassis experienced turning corner at fire scene (recent storm drain work had left approx. 18" drop from pavement. Unable to replicate. Shop changed alternator, batteries and cables thinking a low voltage issue was responsible.

Problem experienced: Delay in water; flashover; burnt hose line; intermittent radio communications; low pressure due to open line.

It is my firm belief that the injured FF's training, experience, and level headedness prevented this from becoming a LODD.

Lessons Learned

The importance of self rescue training can't be overstated. The RIT companies had just arrived on scene and were unable to respond without some delay. Two-in-two-out wasn't an option here due to KNOWN multiple victims.

Be the eyes and ears of the IC when you are inside. The call of a partial collapse (it didn't register that we had just had a flash-over initially) and resulting PAR call reduced the discovery time of a missing member.

If there's any delay in getting water to the line let all companies know. This will let interior crews back out of the hazard area and will alert incoming companies that a shift in positioning may be warranted. Our SOP's have the 2nd arriving engine stop at the nearest hydrant and await further instructions. If they know coming in that the on scene engine is having difficulties they can respond directly to the scene and take over pump operations with a minimum of delay.

This was a "routine" fire on arrival but resulted in a cascade of problems that, I believe, were a direct result of the delay in water. If we had gotten water on the first attempt this situation would probably still have resulted in the civilian casualties but not the injuries suffered by a member of my station.

06-521

Event Description
An Engine Company was preparing to operate at an interior structural fire. One member of the unit removed the regulator from the facepiece to conserve air while waiting for water. Once the hoseline was charged, he reconnected the regulator but was unable to obtain an airflow from the SCBA. The member activated the regulator purge valve in order to receive an airflow and then continued to operate.

Lessons Learned
The SCBA facepiece should be donned prior to entering the IDLH area. The inhalation of smoke or toxins can decrease the members lung function capacity inhibiting the members ability to exhert enough force to release the regulator manual shutoff switch to start airflow.

The cylinder valve must be fully opened. Activation of the vibra alert is not an indication that the valve is fully open. The valve handle must be turned counter clockwise until it reaches the open stop position. If the cylinder is not fully opened, it will restrict airflow, possibly causing an extremely dangerous condition similar to mask shutdown.

Whenever a member is confronted with a situation where they have to operate using the purge valve, the member must notify the Officer and immediately leave the contaminated area, accompanied by another member.

Exposure to 1.3% of carbon monoxide will cause unconciousness in two or three breaths and will cause death in a few minutes. Exposure to small concentrations for only a few seconds inhibit's ones ability to think clearly, rapidly causes disorientation, and gives a feeling of euphoria compounding the risk hazard.

06-186

Event Description

On Sunday, March 5, 2006 at 0959, (Name deleted) Fire Department Station X(Number deleted) and (Name deleted) Fire Department Station XX (Number deleted) were dispatched to a reported structure fire at (Address deleted). At the time of the dispatch, units were advised that everyone was reported to be out of the building but there were animals inside. Shortly after dispatch, a fire police officer who lives in the area reported a working fire. Deputy Chief (Name and call number deleted) requested the (Name deleted) Fire Department Station XXX (Number deleted) be dispatched for their Rapid Intervention Team. Engine X (Number deleted) went responding with a crew of 4, followed by Truck X (Number deleted), who also responded with a crew of 4. At 1008 hours Truck X arrived on the scene and was advised by Deputy Chief (Name deleted) that he now had a report of a possible occupant unaccounted for on the second floor of the building.

Knowing that Engine X was not far behind, Chief X (Name deleted), OIC of the truck crew, advised that they would start a search for the missing occupant. Chief X, along with Lt J (Name deleted) and Lt. K (Name deleted) entered the building through the open overhead garage door.

Upon arrival of the truck there was fire showing in the garage with smoke showing from the rear C/D corner.

The truck crew was able to enter the garage and actually masked up just inside the garage. Inside they observed fire in the rear corner of the garage, which was extending up to the ceiling level and across the ceiling towards an entry door to the kitchen. It appeared at the time of entry that there was also something burning on top of a shelf unit, or possibly a refrigerator, in the opposite corner of the garage. Lt. K was able to extinguish the bulk of the fire with a PW (pressurized water extinguisher). Upon entering the door, the crew found the kitchen. Conditions were very tenable, medium smoke only. The crew was able to stand and rapidly cover the kitchen. Once entering the dining room, towards the B side, the crew split up. Lt. J headed for several rooms towards the B side, Lt. K continued towards the A side into a living room area along with Chief X. Chief X noticed that the fire in the garage was now starting to lap into the kitchen from the garage. After trying to get Lt. J's attention to close the kitchen door, Chief X realized that the lieutenant was already committed to the opposite side of the first floor. Attempting to "buy time," Chief X found a second entrance into the kitchen. Chief X was able to lean into and over a bar area and close the kitchen door after moving some large furniture.

Lt. K advised at this time that he found the stairs to the second floor. The crew of 4 met at the stairs and started up together to conduct a search for the reported missing occupant. While ascending the stairs Chief X heard the glass to the kitchen door fail, and yelled to the crew, "Make it fast we don't have much time!"

Once on the second floor the truck crew found medium to heavy smoke. The second floor looked to be connected by a narrow hallway, which appeared to run the length of the home. The crew split with Lt. K going left, Lt. J and Chief X headed right to the longer and deeper area of the second floor. Chief X and Lt. J encountered what appeared to be a master bedroom, Lt. J split off and started a search of this room while Chief X, equipped with the TIC at this time, could see an additional room on the opposite side of the bedroom. Chief X continued straight and to entrance of that room. Once in the doorway, it was very clear that the room was currently under construction. There was no furniture or carpet. The only thing in the room was a stepladder and several 5-gallon pails. However, equipped with the TIC Chief X could see fire starting to come up through the rear walls (D) side of the home. This room was directly over the garage. At that point Chief X advised command that there was fire coming up through the walls above the garage area and that they needed a 2nd hose line to the second floor ASAP.

After clearing that room Chief X turned to return to the room were Lt. J was searching, at that time Chief X remembers having to wipe off the screen on the TIC to assist in being able to see it. After meeting back up with Lt. J, Chief X questioned the lieutenant if he had found anyone. Lt. J advised that he was pretty sure the room was clear; a quick swipe on the room was done with the TIC, again having to wipe the screen first to be able to see. Being sure that the room was clear, Chief X and Lt. J continued back out of the room and back down the hallway to assist Lt. K. Immediately after exiting the room Chief X and Lt. J met Lt. K in the hallway. Chief X asked Lt. K if he found anything. Lt. K advised that he checked the best that he could everything appeared clear. Wanting to make a quick check with the TIC, Chief X advised to head back to the room to the left of the stairs that Lt. K had searched and make a quick second check. With Lt. J in front now, Chief X handed off the TIC to Lt. J as the crew headed back down the hallway. Partway down the hallway the crew passed the stairs that they had come up, conditions had changed; there was now heavy smoke and heat coming up the stairs. Opposite the stairs was a bathroom. Chief X stopped, entered and checked the bathroom briefly. Finding nothing continued with the crew. Once inside the last bedroom Chief X broke off to the right to search, Lt. K broke off to the left and again searched while Lt. J sweep the room with the TIC. Once sure there was no one in the room, Chief X called command and advised that the primary search was completed, no one was found and they would be heading out. However, they were now experiencing high heat conditions on the second floor and that they needed to put a rush on the line to the second floor.

As the crew turned to leave the room and head back down the hallway to the stairs they experienced extreme heat. Chief X's description of the conditions was that it felt like someone had opened up doors to a blast furnace. Conditions continued to deteriorate rapidly. Chief X advised the crew that they needed to find the stairs "now," that the place was going to light up. Several attempts were made to locate the stairs even with the TIC. Conditions had now banked down to the floor. Even with the TIC the crew could not find the stairs. Concerned that the second floor was about to "light up" Chief X yelled for someone to just blind poke and find a window and take it out, Lt. K almost immediately hit a window. This provided little if any relief. On one last attempt to find the stairs, Lt. J had turned the TIC towards the direction of the hallway, at that time the screen to the

TIC went RED. Knowing now that they were in trouble, Chief X yelled to close the door to assist in again "buying time". It was quickly found that there was no door on the entranceway. Chief X again radioed command with urgency that they were cut off by fire on the second floor and that they needed a ladder to the rear second floor window ASAP.

Finding a window directly in front of Chief X, "which the crew thought was in the rear of the building", again they radioed that they needed a ladder to the rear, and that they were cut off by fire. Concerned about possibly drawing more fire towards them, the crew did not immediately take out the widow in front of Chief X. However, with the heat intensifying greatly, Chief X told Lt. J, "take this window". Once the bottom windowpane was broken out, Chief X made one quick glance out the window to determine the height of the drop. It was decided that the crew was going to exit via this window using a second floor window "hang and drop". Chief X yelled for Lt. J to take the remaining sash out to clear the entire opening. This was done right away. Looking outside again, Chief X could see a ladder coming towards the window. Immediately Chief X started to hang out the window beating his hand on the outside wall while yelling "Right here! Right here! Right here!" Later it was found that Chief X was striking the wall so hard that he actually broke the vinyl siding as well as the Celetex board behind it.

The ladder crew happened to be the RIT crew from Station XXX, who did see and hear Chief X. They started to raise the ladder, a 2-section 35' ladder, to the second floor window where the crew was trapped. Seeing the ladder coming up and being closest to the window, Chief X started to climb up into the window sill to get on the ladder. However, once in the window the Chief X was driven back inside and to the floor by the extreme heat coming from behind. At that point Chief X started yelling "Kick it out! Kick it out! Bail! Bail!" Luckily the crews raising the ladder had attended, and were familiar with the firefighter survival training program. They were able to quickly reposition the ladder for the trapped crew to bail out. The tip of the ladder probably wasn't even in contact with the window sill and Chief X dove onto the ladder head first with Lt. J directly behind followed by Lt. K. All three came down the ladder all the way head first. Lt. J later stated that he had hoped the Chief did not hesitate on the ladder because he was probably coming over the windowsill at the same time as the chief's feet cleared the windows sill. Chief X also stated later that as an instructor he had taught the survival class several times to an unknown amount of people. The proper evaluation is to flip on the ladder but "all I wanted was down and away from the building. I decided to come all the way down head first, with no hesitation." Luckily the RIT team recognized quickly that the crew was doing all right coming down all the way headfirst and did not intervene. They let the crew come all the way down.

While the RIT team was assisting the truck crew in exiting the building a MAYDAY was transmitted from the first floor (A) side of the building. Additional members of the RIT Company immediately responded to this MAYDAY call. The engine crew from Engine X, which entered the A side of the building, was attempting to hold the fire back away from the stairs knowing that the truck crew was still upstairs transmitting this MAYDAY. Two

firefighters on this attack line exited the building via first floor front windows after the fire from the kitchen overran them, over their heads, driving them out.

The RIT Chief stated that he could feel the heat coming off of the crew even through structure gloves as they passed him coming down the ladder. Additionally, an EMS supervisor that had come to assist the RIT team attempted to assist in removing the PPE off of the Truck Crew. However, they could not due to all but burning his hands when he touched the equipment. All three members of the truck crew did make it out of the building with some minor 1st and 2nd degree burns and some damaged equipment.

It would be learned later that causal factors of the rapid-fire spread were due to weather. The day of the fire was a very windy day with the wind coming from the (C/D) corner of the building blowing towards the (A/B) corner. This factor, coupled with the building construction, large void spaces, and knee wall area on the second floor allowed hidden fire to be pushed directly towards the truck crew on the second floor. It also assisted in driving the fire over the engine crew's heads when they were in the front living room. All of the change in conditions and actions taken happened in the first 6 minutes of the call. Truck X arrived at 1008 hrs. The Chief from the RIT Company stated that he listened to the first transmission of Chief X stating that they were cut off by fire as they entered the block. The RIT Chief knew the urgency and went to work with his crew immediately upon arrival to find and deploy a ladder for the truck crew. They successfully did. The RIT Company arrived on scene at 1014 hrs.

Lessons Learned

The truck crew realizes now that they never declared and announced an official MAYDAY. They knew that if they could get a ladder that would solve the problem.

Each time the truck crew yelled for a ladder to the rear, the operations officer said another ladder was sent to the rear. Every window was laddered. Operations could not understand were the truck crew was and why they were not exiting the building.

Somehow the truck crew got turned around and what they thought was the rear of the building actually turned out to be the B side.

The Truck Crew never set off a PASS device to assist the RIT team in possibly locating the crew.

A new, unprinted radio procedure of announcing your crew size upon response, assisted greatly in determining exactly how many people were on the truck crew that was trapped and the engine crew that transmitted the MAYDAY.

The operations officer stated that he remembered both apparatus signing on the air with 4. Once the truck crew reported that they were cut off, at a quick glance down the street the operations officer saw the engineer and knew there were three people missing.

When the engine crew transmitted their MAYDAY, he again saw the chauffeur and one crewmember so he knew he had two people missing from the engine crew.

The truck crew entered through an open overhead garage door and never thought about propping it open by some means. This door could have easily closed once they entered the garage area.

Although the crew had radio contact as well as yelling contact to each other, they did split up unnecessarily on the second floor.

05-681

Event Description

I gave a guy early relief at 0700 hours. The box came in at 0715; structural fire, report of people trapped. The early hour gave weight to the report, as false alarms don't usually come in at that time. Pull up to find a row frame nfp (non-fireproof) structure with both adjoining houses previously removed, now standing isolated, fully involved, people on the street screaming about people up there trapped. I am the ovm (outside vent man) in a TL (tower ladder). Drop the roof man on the roof and see the fire blowing thru the skylight opening. Drop down with the bucket to the bedroom window as the engine is knocking down the fire that is rolling out of the front porch. I clean the window and as I am putting my mask on, I hear noise inside the apt. I start yelling into the apartment with no response. I enter the apt. and I CAN SEE ACROSS THE ROOM AT THE FIRE IN THE HALLWAY. I came to realize I was in a studio apt. and the noise I had been hearing was other firemen getting on the roof above me from the rear mount that just pulled up. I start searching the apt. sure that there must be someone in there. I get to a crib by the front door and stick my hands in between the bars to feel the bedding that is in the crib. I keep moving, as the fire is right outside the OPEN door next to the crib. I move to the bed and find a body; I pull it close to find it is a pit-bull. I go under the bed and find another body again I pull it close to find it is another pit-bull, both dead. I then say to myself "I have to check that crib better if these two dogs couldn't make it out then someone has to be in here." I go back to the crib stand up and lean into it to check the bedding better. The crib was clear and debris started dropping down on my back. I could feel the heat had burned my ears and the side of my face as my hood was around my neck but not up. The burns didn't feel bad but I had to cool them down so I started to the window. As I was moving, the place started to light up. I stuck my head out the window to cool down my ears and my helmet came off from the sash. The window I had cleared for my bucket was on the other side of the room. With that, I realize the apt. is lighting up and I bail out onto the fire escape. With no helmet, I pull up my hood over my head and start to the fire escape railing to get the chauffeur to bring over the bucket. I just want off and I picture myself sailing away from the whole mess in my bucket. I hear him yelling into the intercom to get down, get down!!!! He sees what is going on behind me as the black smoke that has been pushing out is starting to light up. With that, the whole thing lights up around me and burns my gear from the inside of my coat

collar down to the back of my pant legs with my name completely burnt off of my coat. I control myself and move methodically down the fire escape steps. I look to my right and see the nozzle man with the second line opening it up on me. As if it was in slow motion, I see the water coming at me, taking the heat from me, and then going above me to push the fire back into the window. I got down and into the ambulance where a little girl with soot all over her face asked me if I had seen her doggies. I realized that she was the one I was looking for and I said no honey I didn't see them. End result My gear was condemned due to excessive heat exposure, helmet lost to the fire, 2nd degree burns to my ears, 1st degree to one side of my face, and a first hand knowledge of when a room is about to light up.

Lessons Learned

The lesson I learned and why I feel this story is important for others to read is this: I had read all about how the first thing you should do when you come in a window is to close the door to the room you are about to search. I read it and I knew it. What happened to me that day was that as things progressed I let myself get distracted by the fact that I thought for sure there had to be someone in that apt. and I had to make my search fast if I was going to get them out. I let that thought distract me from doing what my training had told me I should be doing. Had I closed the door to the apt., which I could see was open because I could see the fire out in the hall, I would have not gotten burned checking the crib and the place may have never flashed over on me. It was a very near miss and had my helmet not come off I would have never pulled my hood up and I would have suffered a much more serious burn to my ears and face as was evident from the discoloration of my gear along the inside of my coat collar. Reading the procedures is good but you must follow that up with training and ultimately you have to focus on the task at hand to avoid distractions that might cause you to skip steps that your training has told you to take.

05-666

Event Description

On February 9th 2003, I was involved in a flashover that took seconds to erupt. While driving the ladder truck to a reported structure fire, a confirmed working fire w/possible entrapment report came from the first arriving chief. I radioed command to see if we were going to stick the building. The chief requested forcible entry first since the 9-1-1 call originated from within the structure.

I donned my PPE and met the assistant chief at the Exposure A" entry door, already opened by the police department. This was the given address only to be the Exposure "D" Side. Together with the rest of the truck crew, 2 firefighters, we searched the first floor. Found heavy fire in a bedroom, B-C Corner, with extension to a center room "C" Side where the second floor stairwell was located. No victims were found on the first

floor. Soon after, I brought the firefighter with the nozzle, a charged line, to the center room with the stairwell.

Since he was alone, the ladder crew backed the line up and the assistant chief and I proceeded to the second floor, myself going first. The confirmed entrapment was on the second floor. When I got to the top of the stairs with my left hand on the wall, I inadvertently walked into the pitch of the roof that occupied most of the hallway. It knocked my helmet, mask & hood off. I calmly removed my gloves, replaced my PPE and before I could reach my gloves, I had placed between my feet, is when my partner reported the fire rolling over our heads. Within seconds it flashed, consuming us in fire from ceiling to floor. We backed away, but with all the rooms being locked we had no place to escape. I then told my partner I was going to try the windows that were at the top of the stairwell on the "D" Side. At first I tried using my elbow to break the window and then my helmet. It didn't break! Found out later on they were made of plexi-glass.

I then retreated back to where my partner was and told him we were going to die here. With one last effort, I told my partner I was jumping out the window. I remember thinking that the weight of my airpack and strength of my helmet, I could break the glass. I don't remember hitting the window, only seeing the outside of the structure and dangling from the window sill. I could hear people, spectators, screaming and the voice of a firefighter below me telling me to, “Let go. I'll catch you". After hearing him the second time I let go! He caught me and together with two police officers, they dragged me away from the structure. The whole time I kept telling him my partner was right behind me. Finally, about 30 seconds later my partner found his way to the open window, but wouldn't jump. Within seconds, a portable ladder was raised to him, where he descended head first. We were both transported to the trauma center, evaluated and later airlifted to the burn center. My partner spent eight days there and I spent a month. Two weeks were spent in the Burn ICU, and two weeks in the Step-Down Unit. It is almost 3 years later and I'm still having surgery to my hands.

Lessons Learned

A lot can and will go wrong at fire scene. Foremost I think accountability and situational awareness on the part of the incident commander is most important. Do you risk your personnel when the survivability of the tenant is questionable? Second, make sure the personnel riding the equipment are experienced and confident in the tasks they are about to take part in. In this event, the chief had no idea I was trapped along with the firefighter from his station. The nozzleman had left the line in heap at the foot of the engine, which afterwards wound up kinking the hoseline. Also, if you are the driver/operator of the engine, be sure to check the hand lines before charging them. I also wish to mention that through this whole event, my partner and I never lost contact with one another except after I broke through the window. Practicing self-rescue methods and keeping a calm head contributes to your safety. Knowing where your means of egress are and remembering how you've gotten to where you are is very important. Having a RIT in place may not always me able the reach you. Having tools and a TIC (thermal imaging camera) are very important, but may not be useful.

05-276

Event Description

My crew was extinguishing a fire in a second story apartment unit that had originated in a downstairs unit. It began when a resident attempted to burn a Christmas tree in his apartment fireplace. The fire had been knocked down and we were overhauling when a small section of the ceiling overhead fell on top of me. This small amount of drywall had become saturated, but normally would not have been much of a problem. What was unusual was that the ceiling contained a grid of wiring for heating. This is very uncommon in this part of the country and I had never encountered it before. The wires became entangled with my breathing apparatus. It took me a minute or two to untangle myself. Luckily, the fire was already extinguished. Under different circumstances, I could have easily been trapped and injured, or burned. I was fortunate, but quickly realized the importance of carrying a knife or cutters in my turnouts to free myself if I ever encountered a similar situation.

Lessons Learned

Knowledge of building construction features is important. Similar situations can occur in buildings with suspended T-bar ceilings and overhead phone and cable lines. The best way to prepare for this is with adequate training and situational awareness. Our RIC training now requires the firefighter to untangle himself from wires while crawling through a tight space in full tunouts and breathing apparatus with minimal visibility. By encountering this situation in training, he will be less likely to panic and more likely to think and apply lessons learned to free himself.

Review Questions

1. SCBA should be checked for operability _____.

a. Hourly
b. Weekly
c. Monthly
d. Daily

2. List two important operations that one should do as soon as they become tangled.

a. _____
b. _____

3. You should always attempt to notify command before performing an upper-floor escape technique

a. True b. False

4. Regular checks of your SCBA performed before your shift include:

a. Checking air volume, straps, belts, hoses
b. Checking air volume, hoses, and pressure testing
c. Checking volume of air, straps, belts, hoses, batteries, cylinder integrity, and mask

5. SCBA cylinder valves do not need to be turned all the way on before begin operations.

a. True b. False