National Fire Fighter Near-Miss Reporting System:

Reports Related to Fire Ground Accountability

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www.firefighternearmiss.com

Report Number: 10-0000489

Synopsis: FF left alone by partner during active fire fight.

Event Description We were dispatched to a structure fire in a rural part of our district. Upon arrival we found a 2-story residential eighty-year old house with heavy smoke coming from the rear of the structure. The officer assumed command, the engineer stayed with the engine and another firefighter and I pulled 1 ¾ inch line. The line went to the rear entrance, now with flames showing. We proceed to attack the fire. We were approximately twenty feet into the house and 5-7 minutes in when we heard a mutual aid engine also going interior to the second floor. Another minute or so went by when my partner said he thought I could handle the rest of the fire. He was going upstairs because his friends were the mutual aid and he wanted to say hi and mess with them. He proceeded even after I disagreed with him. I was then by myself when the wall opened up with even more fire. Luckily I was able to suppress the flames. Finally, a 3rd mutual aid engine arrived and entered my area to help and they were surprised that I was alone.

Lessons Learned:
2 in means 2 in.
Stay together.
Don't assume when you see no more flames that the fire is out.
Teamwork.
Trust.

Report Number: 10-0000545

Synopsis: Crew members separate, one falls through floor.

Event Description We got a call for a possible house fire from the neighbor next door to the actual house on fire. We arrived with only three firefighters on the lead engine. The officer in charge of the engine, as well as the ladder truck and second due engine, were on the other side of town tied up with non-fire department related business. Initial attack was started by the first-due engine company. When the ladder truck arrived, the two men on the ladder made entry thru the front door. One of the ladder company men decided to freelance on his search and went right when he entered the house. He was by himself and when he entered the first room on his right, the entire floor was burned through. He fell through the floor along with all the furniture and rug. Luckily he landed on a crew from out of town operating in the basement. They pulled him out. If he had fallen through to the basement a few minutes earlier, the volume of fire in the basement would have burned him to death.

Lessons Learned: What I learned from this is that on my department there was, and still is, a lack of communication, lack of structure, and lack of proper staffing with regards to officers on every piece. Also, I think that at this incident, the lack of the ladder company staying together as a company was a contributing factor. Freelancing was also a huge contributing factor but if we maintain company integrity, maybe this will not happen.

Report Number: 10-0000632

Synopsis: Ceiling falls on FF in mobile home fire.

Event Description We were dispatched for a structure fire in a volunteer/ part time fire department's area. Upon arrival, we found what appeared to be a single-wide trailer home on fire. Our staffing was two on an ambulance, two on an engine, and one on the tender. Mutual aid came from two other fire departments from the neighboring county. Both were volunteer, one with career staffing. Coming off the ambulance to do fire duties, I became a one man entry/suppression team. Advancing hose into the structure I found it was a converted single-wide into double-wide with less than standard building construction. My partner left to retrieve more hose, leaving me inside, when the ceiling fell in. The ceiling was a drop ceiling with injurious conditions in the room. There was warm smoke, two feet off the floor, and actual fire, which scared the hell out of me at that time. The drop ceiling consisted of only light aluminum and panels. We proceeded to extinguish fire.

Lessons Learned: Staffing= volunteer department with pay detail.
Situational Awareness= able to see.
Decision Making= entry without back up.

Report Number: 10-0000977

Synopsis: Mayday call not heard by IC.

Event Description A chief officer assumed command without a report from the initial IC. After assuming command, the chief officer proceeded to take photos of the fire and did not command. Within a few minutes, a mayday was transmitted for a lieutenant that had fallen backwards down an attic staircase. The lieutenant became wedged between the walls and staircase, effectively blocking egress for two firefighters who were running out of air in the attic. Five maydays were transmitted before acknowledgement by the IC. Fortunately, only minor injuries were sustained by the fallen lieutenant and there were no injuries to the two firefighters.

Lessons Learned: IC must command in a proper manner. He must do the job of command and must remain attentive to radio communications, especially maydays, so that RIT/RIC teams can be activated immediately.

Report Number: 10-0000987

Synopsis: Freelancing causes issues for FF.

Event Description Upon arrival at a commercial warehouse fire, one overhead door was open and one door was closed and vibrating. Visible fire was in the back corner of the warehouse and there was a report of a person behind the closed overhead door. I entered the open door into the warehouse to go around the material between the doors (approximately 30"). The fire quickly moved along the back wall shorting the electricity to the open door, causing it to close. Two other firefighters placed poles to try to stop the door from closing on me. That did not hold. I noticed the reduced sunlight and ran to the door, diving under it. On the sidewalk outside, I turned to see the door open and completely involved in fire. No victim was behind the door.

Lessons Learned: Do not freelance and do not start operations without proper training.

Report Number: 11-0000015

Synopsis: Structural collapse threatens crew.

Event Description Personnel were operating on the scene of a structure fire in a two-story, balloon wood frame, multi-family dwelling. The near-miss occurred about one hour after units were dispatched.
The fire had started in the bathroom of a first floor apartment. The fire had spread to the front door by department arrival. There was a three to five minute delay in charging the initial attack line due to pump operator error (lack of experience). The fire ignited the vinyl siding and contents of the front porch, exposing the attached porch roof to fire.
Two members were standing on the porch roof to open the exterior wall between the first and second floor for overhaul. The porch roof collapsed, falling 10-12 feet. Both firefighters were injured and transported to a nearby trauma center. One firefighter has returned to duty, the other will not return to duty for at least two months.
The personnel failed to evaluate the stability of the porch roof before using it as a work platform. Built of 2x4's with a composite shingle topside and vinyl covering bottom side, the roof was attached to the house with nails to a 2x4 stringer (poor construction). No one assessed the impact of the fire to the building stability until the collapse of the porch roof. The direct flame contact resulted in heavy charring of the 2x4's across the underside of the porch roof. There was no accountability of incident workers in place. Incident Command had weak control of units functioning at the scene. There were some reports of freelancing by individuals due to a lack of command presence and responder discipline. There was no safety officer assigned to the incident.

Lessons Learned: Incident command must maintain clear command and control of incident operations. Accountability of all incident personnel must be maintained at all times with a PAR conducted every 15-20 minutes of incident operations. A tactical command board with an aide (field incident technician) will help with this.
A safety officer (competent and experienced for the hazards present) must be assigned to monitor incident operations and halt if necessary.

Responders must stay disciplined in completing assigned tasks. They must not wander or do things at an incident as they see fit. (A strong command presence and in-place accountability system will help to prevent this.)
Company officers must constantly evaluate the building for the fire's impact to its "gravity resistance system." Remember: A building is only as sure as its connections. Load supporting members may appear safe, but faulty connections (nails into 2x4 stringer) will still result in collapse.
The Incident Commander must have a clear vision of how to manage an incident involving a MAYDAY and give clear orders following its resolution. Management of the incident must go on for the safety of those still working on the scene.

Incident personnel must be given the opportunity for an informal CISD debriefing (also known as defusing) or psychological first aid information before being allowed to leave duty. None was provided in this case.

Report Number: 11-0000056

Synopsis: Buddy system breakdown puts FFs at risk.

Event Description We were operating at a single family, two bedroom mobile home with fire in the back bedroom. My partner and I made entry through the front door via an attached lean-to. I was in the lead with the nozzle. We were unable to make access to the hallway. I mentioned to my partner to back out and he grabbed the hose line and was gone before I could turn around. I was briefly lost and felt my way to the door and stepped out into the lean-to, finding the hose line still inside and no partner. As I turned to go back in, my partner was crawling out. I had actually walked over him.

Lessons Learned: Crew integrity must be maintained along with communication between crew members. A safety officer needs to be in place and be able to account for personnel.

Report Number: 11-0000120

Synopsis: Crew integrity lost during fire attack.

Event Description: While operating as my department's Incident Safety Officer, I responded to a residential home fire with a report of victims trapped and burned. Companies reported heavy fire showing and initiated an aggressive interior attack. Upon my arrival, they were pulled out by command and started defensive operations. During this initial interior attack phase a firefighter made entry with a [rotary saw] into the structure and was "assisting" in pulling hose on the first floor of the dwelling. He reported that he was in zero visibility, encountered high heat as he stood up and was then aware that there was heavy fire in the room as well. When he stood up he realized he was being burned and was in trouble. He decided to make an exit out of the structure. This firefighter reported that he lost his partner when he exited and assumed that the other firefighter (who stayed in the foyer) had gotten out. His

partner, who was in the foyer, reported that he saw him disappear into the smoke and that was the last time he saw his partner until he heard the first evacuation order.

Both firefighters found each other in the front yard and reported PAR to command when polled but did not report that the one firefighter was injured. Once it was discovered that he was injured at the rehab area, his PPE was inspected per SOP. This inspection found that his SCBA face piece was crazed and beginning to crack. This was reported to the firefighter later and he was not aware of the extent of heat he had encountered and the critical near failure his SCBA face piece. Had his face piece completely failed, he would likely have become trapped due to the high heat he was encountering and rapid progression of heavy fire conditions.

Secondary issues that affect this near miss include the following:

This crew was from a "support unit" and should not have been in that location at that time. It was unclear to command their position and their task.

This unit clearly deviated from the SOP for their unit and did not perform in their assignment. This caused a ripple effect throughout the incident and resulted in the need to backfill their critical task.

The fact that their company captain was not aware of the actions of this support unit, as he thought they were engaged in another task defined by department SOP. When the captain was questioned about the crew and their actions after the fire, the captain advised that he was not aware they entered the structure.

This crew lost integrity at a critical time in the fire and became separated. Neither knew the status of the other at the time that the first evacuation was ordered.

Neither member of the crew had more than five years of service time, leading to a poor decision to abandon their primary assignment and engage in fire attack. The firefighter who was burned admitted that, once he was inside this significant fire, he felt that he had overextended and put himself and his partner at significant risk. We are fortunate, once again, that we are not conducting a LODD investigation today instead of a near miss investigation. Stay safe! Stay Aware!

Lessons Learned: The firefighters involved in this incident were interviewed and it was impressed upon them that their failure to follow established SOPs had put them and their would-be rescuers at a significant risk for a home that was a total loss where all victims were in fact out of the structure. Further investigation revealed that the status of the victims was not well established by the first arriving companies or if there were any other victims still inside.

There were no other victims inside the structure after the arrival of the fire department.

Insure that all department members are well versed in their responsibilities as established by SOP. Never enter a structure without notifying command of your entry and mission, especially when you are deviating from your SOP assignment for some reason. In the event that you are lost or declare a mayday it may be more difficult to locate you or your crew.

If you sustain a burn or any other injury at an emergency scene the "game" is over for you for that day! Report your injury right away and seek treatment.

Detailed or overtime company officers must make their expectations clear to all members of the company at the daily line up.

Conduct after-action investigations and conduct an on scene post-incident evaluation so that companies can get direct, quality, constructive feedback while the incident is still fresh in everyone's mind.

Report Number: 11-0000209

Synopsis: Burned balcony falls under firefighter.

Event Description: Several companies were working at the scene of a rather large apartment fire. I was assigned to Rescue [1] and we were riding five that day. Once we got on the scene of the fire, we were assigned to the floor above the fire to check for extension. We took the stairs to the seventh floor and proceeded to go door to door into each apartment looking for occupants/victims. We searched about five apartments and then reached the apartment directly above the fire.

As I walked in, the smoke was black and banked to the ground with high heat. I told my partner that I was going right, he should go left, and that we would meet in the middle somewhere. I searched what I believe to be the living room and then I fell three stories to the ground [suffering severe but non-life threatening injuries]. What had happened was the fire had auto exposed from the floor below and basically burnt the balcony off. The heat was so intense that I never felt a change in conditions.

Lessons Learned: There were several lessons that day.
First, I should have been crawling and sounding the floor the entire time.
I never should have separated from my partner.
As a crew, we should have done a 360. We would have seen the location of the fire and maybe would have made a mental note.

Report Number: 11-0000236

Synopsis: Crew becomes disoriented during search.

Event Description My partner and I were conducting a search of a bar that was on fire when our near-miss occurred. The bar that we were searching was an old renovated hotel with an approximate 25,000 square foot floor plan per level. We were searching the fire floor (third floor) which was about 25% involved. We ended up in a "safe room" which was where the bar owner lived part time. There was one way in and one way out, with no windows. We exited that room and became disoriented. Our SCBA low

pressure alarms started to ring and we were running out of air. The fire was not under control and the amount of smoke and heat were tremendous. We were unable to find an exit and had to find a window to find fresh air. We ended up on the fourth floor through an access stair case and found a window. We radioed command and they laddered the building to get us.

Lessons Learned: This call caused us to implement a MAYDAY protocol. Only the officer and the senior firefighter had radios back then. We were lucky. We got in a bind and no one knew.

Report Number: 11-0000326

Synopsis: Mayday called when FF falls into basement at church fire.

Event Description While operating at a working structure, a firefighter fell through the floor into the basement and declared a Mayday. The structure was a large old church with an addition. Initial crews found smoke hanging in the area and were unable to determine exactly where it was coming from. Crews later noted more pressurized smoke coming from the gable vents, but this did not result in a change of tactics.
Crews were making an offensive attack on what they thought was a small fire, but actually the fire was much larger and had progressed into the structural members of the fire building. Crews were not making progress but were still performing interior operations after 19 minutes on-scene when the Mayday occurred. Command had not established a RIT prior to the Mayday and had all crews on scene assigned to interior operations. Not all crews were inside at the time of the Mayday, some were doing other, self-directed tasks. Fortunately the basement was not fully involved, but conditions were limited visibility and low heat.
The crew of the firefighter involved in the Mayday asked for help to meet them at the point of entry, but efforts were not coordinated and no crew responded to assist. The crew entered the basement and located the firefighter without assistance. The firefighter was not injured and was able to follow crew members out of the structure.

Lessons Learned: Any amount of smoke visible from the exterior of a large structure is significant.
The lack of implementation of strong ICS led to lack of coordinated efforts and self-directed actions, and a lack of RIT in place at time of Mayday (SOG's exist but not followed).
There was a lack of communication to Command of interior conditions.
Investigation found lack of training in ICS at the Company Officer and Chief level.

Report Number: 11-0000330

Synopsis: Ceiling collapses on FF during overhaul.

Event Description We were on our second air bottle and had just left rehab and relieved another company operating inside the structure. We proceeded to a bedroom where the fire damage was significant in search of hot spots. One crew member ascended a scuttle hole ladder in an adjacent bedroom to better assess the attic space, while the rest of us began accessing the ceiling with pike poles. I momentarily walked to the hall doorway to acquire a PAR when I heard a tremendous noise behind me. Turning, I saw a large pile of debris consisting of heavy roof material in the center of the room where we were operating. One firefighter was against an interior wall with no sign of the second. The firefighter against the wall cried out that the ceiling had fallen on a team member. A MAYDAY call was immediately transmitted and Command initiated RIT procedures. We instantly began to dig through the rubble in search of the downed firefighter. The firefighter on the ladder informed me he could not acquire a visual on the downed firefighter, stating the possibility of him falling into the basement. I radioed this to Command & continued our search. Surrounding fire ground operations continued as we located the trapped Firefighter underneath heavy debris. He was “on air” and conscious but unable to free himself throughout the ordeal. Extrication ensued and he was taken to an awaiting ALS unit where, after assessment, he was found to have only minor injuries. Department procedure then dictated he be taken to an appropriate medical facility for observation. He was treated and released later that day.

Lessons Learned: Addressing the collapse; any time a company is operating on the interior, regardless of phase, structural integrity is always a consideration. Advanced burn depths, the presence of gusset plates, and other factors should sound internal alarms, not only for the company officer, but for all team members operating on the interior. In my opinion, training as a team and keeping our team together on the fire ground was paramount in the quick and successful extrication of the trapped firefighter. Having procedures in place, and training extensively for MAYDAY type situations and RIT scenarios gave us confidence in our actions when the need arose to save one of our own.

Report Number: 11-0000414

Synopsis: Crew integrity compromised during search and attack.

Event Description Early this morning firefighters responded to assist a neighboring department at a fire involving a multiple dwelling. Visibility was poor. An officer led a crew of three to the fourth floor where they located a victim who had become lost and disoriented in the thick smoke. The officer and Firefighter [A] led the victim to the stairwell, while Firefighter [B] continued to search for another victim, who was said to be in one of the apartments on that floor. The victim that was being led out fell unconscious and pinned the officer in to the stairwell. Firefighter [A] worked to free the officer (no mayday was called and command was not notified of a found victim), and they were able to drag the victim down to an exit. Having located a second victim, Firefighter [B] notified command and requested help to remove the second victim to safety. Hearing the call for help, the officer and Firefighter [A] returned to the fourth floor, along with another officer. The second officer had been part of the initial

attack crew and was out of air. Together, the four firefighters carried the unconscious victim from the fourth floor to awaiting medics at the rear entrance of the building. Three out of the four firefighters involved in the rescue were hospitalized for smoke inhalation and heat exhaustion. No accountability system was in place and command was not aware of the crew splitting while conducting a search.

Lessons Learned: Strong incident command, freelancing, and the lack of accountability played a big part in the second officer entering an IDLH area without an ample air supply to do the work that had to be done. Lack of experience and lack of situational awareness played a role in the first officer splitting the crew and leaving one firefighter alone to conduct a search. Neglecting to call a mayday when becoming trapped by a victim or notifying command of the situation was also an issue.

Become aware of a mayday and when to call a mayday. A strong accountability system in place can make a difference. Review the department SOPs for radio communication. Discipline among company officers and attitude reflects leadership.