



**National Fire Fighter Near-Miss Reporting System:**

**April 2012 Reports**

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Report Number: 12-0000100

Synopsis: Sounding the floor prevents injury.

Event Description: We were dispatched for a working fire in a mostly vacant strip of townhouses. There had been a fire several months ago in a neighboring unit, which resulted in that unit being demolished. Upon arrival, the first unit encountered a heavy fire condition at the "C"-side of the building and initiated an attack with a 2 1/2" hand line. The fire was knocked down quickly and a crew was directed to the interior, Division 2, to check for extension. Portions of the attack near the fire area and along the "D"-side, which shares a wall with the adjoining townhouse (the fire was in the end unit) were opened up revealing no further extension. While on Division 2, the crew moved toward a bedroom on the "C"-side, sounding the floor as they advanced. Upon entering the bedroom the floor dropped three to four inches. All personnel retreated from that location, command was notified, and access to the area was blocked.

Lessons Learned: We reinforce the need to sound surfaces when exiting ladders on to roofs and when going through windows from the exterior, but it is important to sound flooring even when working from the interior. Based on the amount of fire and its location, it is important for personnel to sound floors even when their current surroundings may not indicate the need. Reinforce the idea of sounding the floor as you advance in non-vision obscured circumstances (we were in overhaul mode, no smoke and little heat existed in the area of operation). A lesser experience firefighter may not have taken the time to sound that floor and would have fallen down to the first division most certainly resulting in a lost time injury or at least some minor bumps, bruises, etc.

Report Number: 12-0000101

Synopsis: Lithium batteries explode during overhaul.

Event Description: Fire companies responded to a rural incident for a fully involved barn and shed fire threatening a garage and home. The first due engine arrived with six firefighters staffing a 1500/1000 engine. Command and accountability was established with that engine until an assistant chief arrived and assumed command. The chief arrived and placed his vehicle on the "Charlie" side and assumed the exposure protection and "Charlie" side operations. The second due engine with four firefighters staffing a 1500/1000 arrived and supplied the first due engine. Automatic aid departments arrived and a water point/shuttle was established. Several oxy/acetylene welding tanks were removed and placed on the Alpha operational area. The barn and shed area contained seven farm tractors; some were antiques in the process of restoration. Four of these tractors were on fire and the large farm tires were freely burning along with the fuel in the tractors. The fire was knocked down, crews were rotated and two automatic aid engines were returned to service. The fire investigation began simultaneously with overhaul.

The barn contained a shop and an office. The shop area contained paint and solvents along with a lift and associated mechanical tools. The Bravo side wall had burned through and egress to the office area was made from that side. Crews had extinguished the garage adjacent to the Bravo side of the barn which had ignited due to radiant heat and convection. The heat had melted the siding and ignited the

soffit and fascia and traveled into the garage. There was a 12' distance between the two buildings. It was in this area that the incident occurred. Four 1.75" lines had been stretched along with a 2.5" blitz. The A/B exposure had two lines as did the A/D side with the 2.5" positioned Alpha center. The barn was 30' by 60' with a shed overhang on three sides.

Crews were operating in full PPE and on air during overhaul. The A/B crew of three was operating in the office area on the Bravo side. One firefighter had a 6' NY style hook and two were carrying/dragging a four-drawer metal filing cabinet to access a work bench area with hot spots. The filing cabinet was placed in the area between the barn and the garage. Crews returned to extinguish the hot spots while a second crew stood by with a 1.75" line. The first crew returned to the area between the two buildings and noticed that the contents of the second drawer of the file cabinet were burning. The drawer was opened and the papers were extinguished.

At that time a firefighter opened the top drawer of the cabinet and turned to say something to the second firefighter with the line. There was an explosion and all three firefighters left the area immediately along with the backup crew. The IC was positioned on the Alpha side and witnessed the explosion and immediately called for a PAR check. All crews were accounted for. The chief was adjacent to the B/C corner and joined the two engine crews that had been operating in the area of the explosion. The chiefs had discussed hazards with the property owner and no ammunition, reloading supplies, or compressed gasses were in the operational areas.

The area was re-entered and it was found that the top of the filing cabinet had been peeled back. The top drawer was 5' from the cabinet and missing the side support and door front. The drawer had contained 12 dog tracking collars. These collars were powered by lithium batteries. The collars were piled on top of each other and stored that way. They were not plugged into a charger. Several collars and collar parts were found 20' behind the B/C corner and two collar buckles were found 10' in the other direction on the Charley side. Firefighters were checked by the Safety Officer and EMS and no injuries occurred.

Lessons Learned: Crews followed proper procedure, had a back-up line in place, and were in full PPE on air when the explosion occurred. Crews assumed that the office area contained the normal office type contents even though the office was in a barn. The owners had been questioned about hazards by the IC, Safety Officer, and Fire Chief. Numerous tractor batteries were found throughout the barn and shed. Paint and thinners along with other solvents and diesel fuel were present. Crews were operational with the understanding that exposure issues to the gases from the batteries and other associated hazards such as the burning tires presented an extreme health issue. No one had any idea about the lithium batteries. Many of us read the warning labels on batteries about proper disposal. It did not enter anyone's thought process during overhaul that the batteries may constitute an explosion hazard.

Report Number: 12-0000102

Synopsis: Nozzle reaction too much to handle.

Event Description: Companies were operating on a machinery fire in a commercial factory building utilizing a 14' roof ladder to gain access to a hopper. Pulverized metal and rubbish were burning in the hopper. A 1 3/4" hoseline was being utilized by companies to wet down the burning contents. A surge in water pressure occurred at which point the hoseline was released by the firefighters and the hoseline

began whipping around out of control. The hoseline hit the roof ladder where a firefighter was operating and nearly knocked the firefighter off the roof ladder. The two firefighters who were working on the ground level regained control of the hoseline and secured the nozzle bail.

Lessons Learned: The operators of the hoseline were new firefighters who should not have been in the IDLH environment. These firefighters had not completed required training. It's unknown why the two firefighters were permitted to enter the IDLH or by whose authority.

Furthermore an Incident Safety Officer was not established and full PPE was not being followed by firefighters operating interior. SCBA was not being worn by firefighters inside the fire room.

Report Number: 12-0000104

Synopsis: SCBA cylinder does not seat properly.

Event Description: While conducting live burn training, two of our firefighters were changing out a bottle on a high pressure SCBA equipped with a quick release D-ring style 4500psi cylinder. When the firefighter with the SCBA on his back attempted to turn the bottle on, he heard a loud hiss from the air discharge and the bottle flipped up, striking his helmet. The bottle went flying to the ground behind him and spinning on the pavement until the pressure was reduced enough for another firefighter to turn it off. After interviewing the involved parties and witnesses, it was determined that the FF installing the bottle saw the indicator lights flash indicating a secure connection. He was unable to see that the D-rings on the quick release were not engaged due to inadequate lighting, as could be the case at any fire scene. He sent the firefighter off thinking that the bottle was properly seated due to the indicator lights coming on, even though the connection at the pressure reducer was not engaged. Luckily, the firefighter that actually changed the bottle did not turn it on as he could have been in a position to be injured or worse due to the bottle striking him in the head or face.

Lessons Learned: We have contacted the manufacturer expressing our concerns regarding the fact that the indicator light was able to be activated even though the bottle nipple and D-rings were not seated properly. We found during the investigation that we were able to jostle the bottle enough to misalign it and activate the lights while still being able to pull the bottle free of the pressure reducer with far less pressure than the air from the bottle would generate. Whether the manufacturer addresses this concern or not is really out of our hands at this time unless others are experiencing these issues. We have revised our SOG's on changing out SCBA bottles. All bottles will now be changed out at Rehab. No one will be allowed to change them on the fly while in the hot zone. All bottles will be changed out with adequate lighting to visually inspect D-ring indicators. No one will rely solely on indicator lights to insure proper engagement of the bottles. Although we feel the manufacturer needs to address the safety redundancy of the indicators. We also realize it is up to us for our individual safety and we are working to avoid complacency and take the extra step to insure our PPE is properly used in all situations. Please be safe and we hope that this info will help.

Report Number: 12-0000106

Synopsis: Rain causes slippery surface on tile roof.

Event Description: We were dispatched to a residential structure fire. Weather was rainy all day. The structure was a residential two-story house with a tile roof. The Charlie side of the structure was north-facing and pitch was 6/12. The fire was in a zero clearance fire place and was putting out a lot of smoke from the top of the chimney. Upon arriving on scene my captain asked me to throw a 24 foot extension ladder to the Charlie side of the structure to prepare for ventilation operations. After throwing the ladder, my captain told me to go up. I reached the roof and took a step off. After taking a second step on the roof I realized that it was very slippery, so I sat down on the roof and waited for my captain to come up with the rubbish hook. I told my captain how slippery it was and he broke some tiles before getting off the ladder. He then handed me the rubbish hook which I used to break some tiles around me and make a path to the chimney which was about six feet away from the ladder. The intent of breaking the tiles was to improve our footing. This worked until the tar paper became wet and the roof became slippery again. My next order from the captain was to remove the cap from the fireplace. The smoke was pretty thick at this point so we masked up. My engineer had a sledge hammer and I had the rubbish hook and we had started to knock the cap off when my feet came out from under me. I started sliding down the roof until I hit the chimney. That prevented me from falling off the roof. My engineer helped me up and we finished our operations and got off the roof.

Lessons Learned: The lessons learned from this incident were to keep aware of all the aspects that added up to this near miss. First, the weather was rainy. The roof aspect was north-facing and had some moss growth. The roof make up was tile and the pitch was steep. The chain of events all lead to the cause of the near miss. There were options, such as using a roof ladder for footing, however the roof was too large and a roof ladder would not have reached where we were working. We could have used different footing techniques such as burying the pick of a pick head axe or burying one pike of the rubbish hook. On a normal dry day there would probably not have been any problems with this operation but due to all contributing factors, it led to a near miss. If you have that feeling in your gut that tells you this is dangerous, use extra caution.

Report Number: 12-0000107

Synopsis: Fire engine gets stuck on railroad tracks.

Event Description: Engine [1] responded, driver-only after receiving a call in-station to a report of smoke coming from the railroad tracks to the rear of a nursing facility in a rural part of the response area. Engine [1] arrived and found smoke coming from the tracks about 300 yards south of the road crossing. Chief [1] responded and stopped at the station to determine whether or not the engine would need to respond. When it was determined that there were other drivers at the station, Chief [1] continued to the scene. Engine [1] positioned in a stone area out of the road and tracks, then proceeded to walk down the tracks with a water can to investigate.

Engine [1] found four railroad ties on fire on the tracks and knocked the fire down with the water can. Dispatch contacted Engine [1] to determine if the tracks needed to be shut down in that area and was advised negative due to the situation being under control. During this time, personnel arriving in POV's proceeded to attempt to bring Engine [1] down the tracks to the fire location. However, Engine [1] became stuck with the driver-side dual wheels in-between the two rails. At this point, the original driver of Engine [1] looked south and saw a headlight in the distance and then north and saw Engine [1] on the tracks. He radioed to Engine [1] to get off of the tracks and to Dispatch to attempt to stop the train. Chief [1] arrived at this point to find Engine [1] stuck. The original driver of Engine [1] began to work to attempt to free Engine [1] while Chief [1] ran down the tracks in an effort to stop the train. Engine [1] was placed into four-wheel drive causing the unit to become more stuck as it sunk into the stones. The crew of Engine [1] waved to a neighboring farmer who brought a four-wheel drive tractor over and pulled Engine [1] out of its stuck position with a chain. Chief [1] was able to get the train stopped several hundred yards away from Engine [1].

Once Engine [1] was removed from the tracks, the train was allowed to pass through the area and final extinguishment of the railroad ties was completed using water bladders. Units cleared.

Lessons Learned: 1. Communication – The driver of the brush truck had no idea that additional personnel had arrived POV and were attempting to move the unit to his position. It is vital that all personnel communicate with one another on incident scenes over the radio to determine if equipment needs to be relocated and to let it be known that they have arrived on scene.

2. Situational Awareness/Decision Making – Remember that any time units are operating on a railroad right-of-way to transmit that information to Dispatch with the closest crossing number so that they may contact the appropriate railroad to stop all rail traffic. Do not enter a railroad right-of-way with a vehicle until Dispatch advises that the appropriate contacts have been made and that rail traffic has ceased. Additionally, any time that we are operating on a railroad right-of-way within 10 to 20 feet of the tracks, we should communicate to shut down rail traffic until the operation is complete.

Report Number: 12-0000109

Synopsis: Radio call from dispatch forces crew to retreat.

Event Description: Ambulance [1] was sent on a medical response. During the response, supplemental information received via dispatch, noting imminent danger to the EMS crew was relayed to ambulance [1] as they literally began to knock on the door of the home. As a direct result, the crew was able to safely and quickly leave the area before anything could occur.

I heard the radio transmission to ambulance [1] over Talk Group 1 while I was in the station. I thought that my ambulance should have been on scene of the call they were sent on. I looked up their call on the CAD and I saw there was information being entered into the text of their incident by the 911 operator indicating that a person on scene said he was going to murder the crew when they arrived. I then called the ambulance [1] attendant via cell phone. He answered and said they were safe and that they had just started to knock on the door when they turned the radio on and eventually heard the priority message.

As it turned out, the crew had momentarily forgot their portable radio then remembered to bring it before going up to the house. They did not actually turn the device on until they began knocking on the door of the home. The radio went through its normal "talk back" mode then was able to receive transmissions from dispatch. It was just prior and during this time that dispatch began to call them on Talk Group 2 and Talk Group 1 in efforts of warning them of the threat. The crew later told me that it was the tone of voice and rare terminology "Priority" that got their attention. Dispatch told them to immediately leave the area. The crew sensing from the dispatcher that something was wrong immediately retreated to their unit and drove away.

Lessons Learned: The lesson to be learned here is to make sure the radio is brought on every call and to ensure it is turned on (and set to the proper talk group/channel) before leaving the unit.

Report Number: 12-0000111

Synopsis: Smoke exposure overcomes FF.

Event Description: Our department responded on a mutual aid call for a house fire. The city that the incident was in is a volunteer department and no firefighters responded initially. I was the driver operator and on arrival our chief was in command and we attacked the basement fire. We were using positive pressure ventilation and one firefighter was directing the fan into the rear door and had to hold it in place. After about an hour on scene I walked behind my engine and observed the above mentioned firefighter on the tail board and he was lethargic and pale, but stating that he was fine. Command was unaware of this firefighter's situation. I am an EMT and believed that this firefighter needed medical attention. Other firefighters offered to take him home in a support vehicle, but I notified command and requested medical attention. This firefighter had an elevated carbon monoxide level and a low oxygen saturation. Medical treated him after being told to by command. Our chief and I later followed up by checking on him at home.

Lessons Learned: Even firefighters who are not interior and not on SCBA need to have rehab and medical monitoring. Firefighters who are not interior also need accountability. Firefighters who appear to have an issue with health must be evaluated by medical on scene.

Report Number: 12-0000112

Synopsis: Faulty seatbelt creates unsafe situation.

Event Description: Each time I am assigned as the company officer I have found that the seat belt will not work without spending time trying to get it to retract. Sometimes the seat belt needs to be removed to fix it. Others are finding this problem as well but since it is ongoing they do not take the effort to fix it. This basically puts the seat belt out of service when there is an emergency response since there is not

time to fix the problem. Since this is an older vehicle, the problem is not going to be fixed. Seat belt use is encouraged but it seems a different message is being given.

Lessons Learned: Since seat belt use is important, the equipment should be fixed. The design of the seat belt requires careful use to prevent it from becoming jammed. Most likely we are not the only department with this problem and the manufacture should be contacted to find a permanent fix.

Report Number: 12-0000113

Synopsis: Open compartment doors damage station.

Event Description: We had a structure fire at 0800 and were back at the station to clean equipment and get the truck back in to service. We cleaned the SCBAs and left the door to that compartment open so that they could dry. The chief was the last one to drive the truck and he did not take the key out of the ignition and place a note on the steering wheel like we always do. At about 1100 hours a call came in for an MVA, but as soon as the tones ended they canceled the call for our station. The two firefighters responding did not pay attention to the call and were in a hurry to get out of the station. They pulled out and the door of the truck was pulled off along with the brick and block on the front of the building. This was about \$30,000 worth of damage to the truck and the station. What makes this even worse is that the chief was not concerned about the accident at all and he was in the passenger seat of the truck.

Lessons Learned: Nothing has been done about the accident at this time. I would like to see a report of the situation completed and this be used as a training tool for the department and the rest of the county. We need an SOG stating how we need to leave the truck in this type of situation.

Report Number: 12-0000114

Synopsis: Wind shift endangers personnel at wild land fire.

Event Description: Fire Department was dispatched to a wildland fire in the [Town name deleted] area. Engine [1] was behind Engine [2] as we arrived on scene. Engine [2] continued past the fire that was between highway [name deleted] and a river.

Our directions were to anchor a wet line off of the road. Engine [1] stopped 100 feet from the fire on the eastern flank. After charging a 1 ¾" cross lay, Engineer [A] prepared a second 1 ¾ "dumpster line to be used for protecting the engine. While connecting the dumpster line the wind picked up to the point that the flames were lapping over the road about 10 feet and blowing in Engine [1]'s direction.

Even though the engine was over 100' from the fire front, Engineer [A] was pelted with large burning embers while connecting the dumpster line.

If we were to have any type of mechanical problems or more consistent winds, it could have taken an engine out of service or worse.

Lessons Learned: If attacking a fire from the downwind side, be sure you have an escape route in place; stop the engine far enough away, if you need to take a few seconds to add more hose do so. Also make

sure to advise all firefighters to roll up the windows. We did have our windows up, which may have saved the engine.

Report Number: 12-0000117

Synopsis: Floor burned away prior to entry by attack crew.

Event Description: Just after 0100 hours, my fire department was dispatched on a mutual aid call to assist a neighboring fire department on a residential structure fire with possible entrapment. When the engine that I was riding on arrived on location, we were tasked to assist with suppression operations. After donning my SCBA face piece, I assisted a fellow firefighter with pulling an attack line in through the front door. Just as we were about to enter, Command informed all personnel on scene that there was no floor just inside the front door. Upon hearing this, I and the other firefighter repositioned the attack line to the rear of the building. Upon repositioning the attack line, suppression operations continued

Lessons Learned: A major lesson that was learned upon entering a room is to make sure that you and your crew sound the floor. After the fire was extinguished and the smoke cleared, I surveyed the front room. Upon looking at this, there was no floor left. If another firefighter or I had not known this, it would have resulted in a firefighter falling in between floor supports and falling 12 feet below the floor boards.

Report Number: 12-0000118

Synopsis: Training burn results in burned foot.

Event Description: Engine [1] was at the local live burn center drilling on first attack of a residential fire. The crew had proper PPE on and was flaking out the 1 and 3/4 inch hose line. The irons man secured the front door, the nozzle man and the spotter moved in for an attack on the seat of the fire. I was on the nozzle. While attacking the fire I started to feel heat around my foot inside my boot. I thought it was just the leather on the boot getting hot. After about five to ten minutes of firefighting, the hose crew backed out of the building. When I was standing up and walking around I noticed the heat getting hotter. After a second attack, and packing up the truck, I found it unbearable to stand on my foot. I went to the side of Engine [1] and removed my boots. A few crew members saw me sitting on the rig and got the line officers to check on me. After having the boot and sock inspected at the training center, the fire chief took me to the local ER. At the hospital I was told I had second degree burns to the left outside of my foot. The company sent the boots back to the maker to be checked since they were new boots.

Lessons Learned: The boots were replaced and a full investigation later revealed that the floor was too hot for the way that the firefighter had his foot positioned.

Report Number: 12-0000119

Synopsis: Complacency gets the best of fire crew.

Event Description: We responded to a fire alarm at an abandoned hospital where there had been numerous alarms to that location in the past. Upon our arrival, we observed that no smoke or fire was showing.

We noted that there was an active fire alarm in the building, but the sprinkler system water motor gong was not sounding. We then notified and waited for a key holder to open the door, since nothing was showing; forcible entry tactics were not used.

Upon his arrival, the key holder went to the rear of the structure. I followed him to the rear where he opened the door to the old maintenance part of the building and we found a light haze of smoke showing. The key holder attempted to go into the building, but was stopped from entering.

At that time, forcible entry was made into front doors of the building and the second-in engine was staged at the sprinkler system. There was still nothing showing in the front area where entry to the building was made. As crews made their way through the building to the second set of fire doors, they encountered a smoke condition.

During their search for the source of the fire they found a flammable liquid pour pattern burned into the floor and the hallway. This flammable liquid was also soaked into several cardboard boxes in the area.

The building was found to have been broken into through a second window and as the person(s) were leaving the building, it is surmised that they lit a fire next to the door which they were exiting from. Law Enforcement was called to the scene and after the initial search for fire was made they searched the building for any perpetrators.

An investigation found that when ignited, the fire had flashed and then burned itself out before the sprinkler system activated. The accelerant found was xylene which was used for x-ray processing. This is what the maintenance supervisor told fire crews.

Fortunately for the crews entering the building, the fire was out since there is a possibility of the fire flashing when they opened the fire door and introduced air into that area.

Lessons Learned: Crews began to experience complacency due to the number of fire alarms at that facility, and their guard was down for the potential of it actually being an incident. Also during the search they found a window that had been forced open. There would have been the chance of encountering an armed individual that was in the building who wasn't supposed to have been there.

Report Number: 12-0000121

Synopsis: Smoking bystander endangers EMS providers.

Event Description: We answered a call to an unresponsive person. When we arrived we made immediate contact with the patient who was in need of oxygen. We started providing oxygen through a non-re breather. As we continued our assessment and care, one of the crew members noticed that an acquaintance of the patient had approached and was standing very near while smoking. The crew member immediately told the person they had to leave the area and could not smoke near the patient because of the oxygen.

Lessons Learned: Some of the lessons learned in this case were to complete a better scene survey and then maintain it. It is also important to maintain that survey and situational awareness. Maintaining a vigilant and constant survey of the scene would have helped in this situation by ensuring better situational awareness.

Report Number: 12-0000122

Synopsis: Good SA prevents FF from being struck.

Event Description: I would classify this event as truly a “near miss”. I was assisting a neighboring fire department with using an acquired structure building in my department’s response area. The visiting department brought their recruit class to use a house that we had converted into a Rapid Intervention Building. The near-miss involved me almost getting squished between the visiting department’s ladder truck and my department’s vehicle. The road where the training house was located was barely wide enough to allow two vehicles to pass. The ladder truck driver was moving the truck into the drive way when he decided to make a wide turn which caused the rear of the truck to swing into the oncoming traffic lane. I was getting into my vehicle when I saw the rear end of the truck coming my way. I had to jump out of the way and was nearly pinned between the two vehicles. There were just a few inches of space between the two vehicles. The ladder truck driver never saw me or even knew it was that close. I picked myself up and spoke to the officer of the visiting department, just to advise them of a near-miss.

Lessons Learned: Maintain situational awareness and watch out for yourself all the time.

Report Number: 12-0000123

Synopsis: Apparatus compartment door left open.

Event Description: While responding to a medical call (shortly after getting on the truck) the open door light came on in the cab. The backseat firefighter checked both rear doors as the driver applied the parking brake so he could get out and do a walk around. After slamming the second door, the open door light turned off (due to the driver applying the parking brake). The crew then went en route. Shortly after leaving, but not immediately, the door open light came back on and the crew received a report over the radio from a firefighter on another company at the station that one of the compartment doors was open. As the truck drove past a mirror window building, the firefighter confirmed the door was

open and the backboard was hanging out, based on the reflection. The driver stopped the truck and the firefighter replaced the equipment and closed the compartment. After returning to the station it was found that a firefighter from the other company was doing some maintenance, was looking for a tool off the truck, and forgot to close the compartment.

Lessons Learned: Be sure that all personnel are accountable for checking all doors as they are getting on the apparatus.

If the door open light goes on, have somebody get out and do a full walk around the truck to make sure everything is in order.

Report Number: 12-0000124

Synopsis: Ambulance nearly collides with fire truck.

Event Description: While responding to a medical call with lights and sirens activated on the engine, we experienced a near miss with the responding ambulance from another agency. Our city has [signal preemption devices-brand deleted] on the street lights, where a light on the engine triggers the stop light to turn green and all other directions to turn red. To designate which direction of travel has the light locked up, a solid light is lit up on the light pole while all other directions have a flashing light to designate that there is an emergency vehicle coming from another direction.

In this near miss, we had the intersection locked up with a green signal light and the solid white light illuminated. Approximately 200 feet before the intersection, the responding ambulance came into the intersection.

Lessons Learned: Having the light locked up is not a sure thing. Be sure to yield at every intersection. Make sure other agencies have the correct training to know what the lights mean. Have good situational awareness.

Report Number: 12-0000125

Synopsis: FAO slips and falls on apparatus floor.

Event Description: The engine company, along with the rescue (a transporting ambulance) was dispatched on an alarm for a medical call. The driver of the engine woke up, got dressed, and came downstairs. While walking across the apparatus floor, he slipped on an oily patch and his feet slid out from under him, resulting in the firefighter landing hard on his back. The firefighter responded to the call, driving the engine, but once on scene was unable to assist the companies with the medical call. He was able to drive back to quarters, but, once there, notified the company officer that his was experiencing significant pain and requested a transport via ambulance to the hospital.

Lessons Learned: As a result of this injury, we learned that we need to ensure that the apparatus floor is free from any slip hazards by cleaning the apparatus floor on a more regular basis and applying speedy dry when needed.

Report Number: 12-0000126

Synopsis: Unsecured EMS scene dangerous to fire personnel.

Event Description: Law enforcement dispatch indicated that the scene of domestic violence was secure, but on arrival at the scene, fire rescue units were advised the scene was not secure and that there was a person barricaded inside the structure, possibly armed. Units retreated at the point they were told the scene was not secure. The person inside was extricated from the scene without incident, and no injuries occurred as a result of the communication failure.

Lessons Learned: In this case the law enforcement dispatcher made an error in judgment, being told that a patient from the scene could be checked out, but misinterpreted that as the scene being secure. She then relayed this incorrect information to fire rescue dispatchers. The lesson learned is for the field personnel to evaluate every emergency from the perspective of scene safety, which they did in this case, and not to take scene security for granted. Training in the law enforcement communication center on what it means for a scene to be called secure will be undertaken to reduce the risk of the problem recurring.