National Fire Fighter Near-Miss Reporting System
Reports Related to Rules of Engagement: Firefighter Location and Status Reports

07-890

Event Description
We were dispatched to assist at a structure fire with a mutual aid department. Our department was sent for RIT & tender operations. The RIT team arrived and staged at the A/D corner of the structure.

Our RIT did a 360* of the building, set ladders checked conditions, number and locations of crews working and stood ready. About 20 minutes into the response, crews lost water for a short time and were forced to retreat. After water supply was re-established the crews made a second aggressive attack.

After about 10 minutes into the 2nd attack, the conditions rapidly deteriorated. After a quick consult (less than 20 seconds) with command the evacuation order was given and air horns sounded. Crews were attempting to retreat when there was a flash over. The RIT was activated due to lack of accountability of 2 crew members.

The RIT made their way into the 1st floor, did a quick search, found 1 FF wandering in the first floor hallway dazed and confused. He was assisted to the front door and handed to waiting FF's from the RIT support. The crew then made their way to the second floor landing which was the other FF's last known location. Following the hose line, there were no other FF's located. The RIT was cut off by fire that was coming now from a first floor room across a ceiling and then across the stairway.

The fire was hit from a hose line manned by additional RIT members and allowed other RIT members to egress to the front door. At this point it was determined that all FF's were accounted for and out of the structure.

Lessons Learned
The function of a command staff was needed. The IC attempted to do too much and the span of control was too great. Other department chiefs assisted with getting this under control.

There was a need for a committed accountability officer. The accountability officer was not keeping accurate records of crew locations or job tasks. There was only an attendance system initially, until a new accountability officer was assigned. If the accountability would have been in place, we would have known there was only 1 FF missing. Make sure that all firefighters are trained with the knowledge of an accountability system.

Have all FF's understand the RIT function and what the need of every FF is if the RIT is deployed.

There is no real way to change the fast changing fire conditions except to never do an interior attack with the risk of potential injuries of FFs.

08-104

Event Description
Our fire department was dispatched for a possible structure fire in a 1 story commercial brick building after a passerby reported fire visible inside the structure with light smoke showing. The building was occupied by both a restaurant and a drycleaner. The first fire personnel on scene was a deputy chief who arrived within 2 minutes of the initial alarm, assumed command, performed a size-up, and communicated a working fire from the drycleaner occupied part of the building.

As a deputy chief and the department's safety officer, I arrived on scene, advised command I was the incident safety officer for the incident, and performed a 360 of the structure to identify any possible hazards. Upon my return to the alpha (A) side of the building, the truck company had forced entry to the structure with the engine company entering with a 1 1/2" line. There was a moderate smoke condition at the time. The fire was located and confined to a commercial dryer. The building was ventilated with PPV and checked for extension.

This was the first fire that the department has had in quite some time. As I was checking I realized that our accountability procedures were not in place and that I had no reliable information on the number of firefighters in the structure. Not one accountability tag had been placed at the door. We have a two tag system where one tag remains on the rigs and one is left with an accountability officer at the door. Had the incident escalated into a major fire, the IC would have had limited information on the number of personnel inside of the structure.

Also, as the building was being ventilated and checked for fire extension there was still a light smoke condition inside of the structure. I observed 50% of the firefighters had removed their SCBA masks and walking around inside of the building. I notified the OIC of the interior to have all firefighters go back on air which they did. The building was then metered and elevated CO was detected. I believe that the excitement of the fire quickly caused the firefighters to ignore or forget the department's mandated SOPS on accountability procedures and our current policy on the use of SCBA during salvage and overhaul procedures need to be evaluated.

Lessons Learned
The lesson I learned was to make sure as the incident safety officer that if I was not able to tend to the tasks that I was responsible for that I should delegate those tasks to other personnel. While a 360 of the building is important, my biggest responsibility was for the accountability of the personnel entering the structure.

08-121

Event Description
We responded to a reported structure fire in a residential structure. The first arriving engine reported heavy smoke in an approximately 6,000 square foot, two story house. I

arrived shortly after the first engine and as other apparatus arrived they were assigned tasks. There was an IC in place, accountability in place, and fireground communications on a dedicated TAC channel. There was a primary and secondary water supply established and two aerial trucks positioned for a defensive attack if needed. About ten minutes into the fire, the IC asked for a progress report. Interior crews reported some progress. They were operating two 1 3/4" handlines on the second floor at the top of the stairwell. About 15 minutes into the fire, a significant structural collapse occurred. An emergency evacuation order was declared on the TAC and Dispatch channel, secondary emergency evacuation signal (apparatus horns sounded) was given, and radio confirmation was received. Crews were removed and an accountability check was OK. The structural collapse was a large section of masonry chimney that extended past the roof line, but was supported by a 2x4 frame underneath the roof. The chimney was for aesthetics only, not a function chimney. The large piece fell into the garage were it smashed a late model Cadillac down to the concrete slab like it was a beverage can. If the chimney had fallen in the other direction, it would have collapsed directly where the crews were operating. It is unlikely any of them would have survived the impact.

Lessons Learned

Try to identify these structures in their construction phase. Our department is considering a visible marker to indicate structures with these features. It is difficult to identify real chimneys from these "fake" ones post construction. We are also working with plans review and the fire marshal's office to receive notification of these structures. This will be entered into our dispatch program.

The owner of the home rebuilt the home after the fire. I had a chance to speak to him after the fire and we discussed the potential for significant loss. The new home does not have the chimneys.

10-157

Event Description

We were dispatched to structure fire forty-five minutes before shift change. We had personnel from both shifts on the scene. When we arrived on the scene, we found a restaurant on fire and we did a 360. I was the nozzle man on the initial attack. While completing our 360, I noticed several HVAC units on the roof and noted their relation to our entry point. When we entered the building, the visibility was only about three feet. We entered the kitchen and started attacking the fire. A gas line was apparently feeding the fire and we were not making much progress. There was heavy fire underneath the HVAC units, so I advised the crew to move back. We heard the air horn on the engine sound off three times, so we immediately left the building. As we left the building, there was a complete roof collapse in the area our crew had been working. Because of situational awareness, accountability, and safety, we were all able to go home.

Lessons Learned

Always do a 360 and be aware of your surroundings at all times. Keep your crew together so you can exit together and have accountability. There was only a small flame

visible over the back door when we made entry. What you see on the outside before making entry can quickly change.