



National Fire Fighter Near-Miss Reporting System:

February 2012 Reports

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Report Number: 12-0000026

Synopsis: Bridge weight rating exceeded by apparatus.

Event Description: While driving to a call in the early morning hours, a bridge to a residence was encountered. The parking brake was set. The officer and driver discussed checking the load rating for the bridge. It was determined the bridge "looked ok" due to its sheer size, width, and construction type. The bridge was a metal frame, 30 feet high and over 300 feet long. The apparatus drove across. After the call was completed a representative from the home we were at stated the bridge was only rated for twenty thousand pounds. The engine weighs forty four thousand pounds. The representative for the home stated that the home has a special pad installed along the side for the engine to drive to this location without using the bridge.

The crew did not ride on the engine back across the bridge per the driver's request. The load rating tag was found on the bridge and the weight limit was verified at twenty thousand pounds. It is believed that sleep deprivation due to time of call was a leading factor in this case of multiple poor decisions. The driver knew better and even stopped and asked to verify the load rating prior to driving across. The fact that any discussion occurred over this question was a lapse in judgment and discussion making by all parties involved. The outcome of this event would have been catastrophic. An entire engine company could have been seriously hurt or killed from this one mistake. The amount of financial impact to the district would also be a long term secondary effect to the traumatic loss of firefighters and equipment. This engine company is demanding that, from this event, an SOG/SOP or TASK book sign off box (requiring all drivers to determine the load rating prior to crossing, regardless of call type, unless pre written in the map book, of any non-City, County or State approved bridge) is created to ensure this event never occurs again.

Lessons Learned: This report, although created long ago, is now being presented. The training this writer has since received on leadership and personal accountability has provided motivation to make them public.

All members involved in this incident learned to defer to expertise and not allow weather, poor judgment, or sleep deprivation to affect decision making.

Drivers are required to verify all private bridge ratings prior to crossing regardless of call type.

Report Number: 12-0000027

Synopsis: Good communication keeps everyone safer.

Event Description: I was the officer of the first arriving engine company to a report of a fire. We were preceded to the scene by a chief who was standing in the neighbor's yard and reported smoke showing and made it a working fire. He didn't approach us or verbally pass on any information.

We had a single family, single story, wood-frame residence with a basement that had smoke coming from the chimney and multiple windows on the first floor. There were no signs of occupants or cars in the driveway. I had my crew stretch a pre-connected line while I did a 360 of the building. I found that there was a privacy fence on either side of the house and I was only able to visualize three sides. Since there was heavy smoke coming from the chimney, I specifically looked at the basement windows for signs of a basement fire. The windows were not dark, cracked, or broken. The homeowner had painted them white or put a covering directly on them.

I met my crew at the porch where we masked up while the ladder crew forced the door. I noticed that the smoke was dark brown and didn't lift when the door was opened. There was zero visibility. I was following my nozzle team into the first room (living room) when I heard someone say, "There's a hole in the floor!" I could hear both members of my crew talking so I knew no one had fallen in. I reported the hole over the radio and told my crew to back out to find another access, hopefully to the basement. The ladder crew searched the one room they could get to without going through the room with the hole. I went around the building and called for a second line to the rear. While it was being stretched I went in the rear door and found the basement steps. I also went through the kitchen and looked toward the front of the building where I could see a crew operating the first hoseline into a hole with a lot of heat coming out of it. I had an outside ladder guy break the fence down and we helped stretch the second line to the rear door. We advanced to the basement and put out the remaining fire.

The fire had started in, on, or near the top of the furnace which was less than a foot from the basement ceiling. It went through the floor and extended into the living room furniture, walls, and ran along the floor joists. I was amazed that the fire had started in the basement and the only sign I saw of a basement fire was smoke coming from the chimney. I think because of where it started there was little fire, smoke, or damage in the basement other than running across the ceiling. I asked the nozzle guy how he found the hole without falling into it. He said he felt that the floor was shaky and weak so he advanced cautiously. He found the hole with his hand and immediately reported it to the crew.

After the fire I heard the ladder crew say "Good thing I didn't push you guys along. Sometimes when people are moving too slow I make them hurry up." We all want to get in there and do our jobs, but we need to stop and think. Why would the crew be moving so slow? Maybe they know something I don't.

Lessons Learned: Situational awareness is a huge factor. Seeing a sign of a basement fire I specifically looked for more. The only other one that was noted was that the smoke didn't lift much from the floor when the door was opened. The nozzle firefighter took the time to survey his environment. Since he couldn't see anything he focused on the senses he did have and that was feeling the floor bounce when we moved.

The fact that as soon as the hole was found it was aired on the radio probably prevented a member or crew from going around the nozzle team and going into the hole. When we notice a problem we need to make sure everyone on the fireground who could be affected by it is aware of it.

Report Number: 12-0000029

Synopsis: On board computer distracts fire chief.

Event Description: I was responding as the first due chief to a reported structure fire at a single family dwelling. In my chief car, I have a computer that gives me all the relevant information I need en route to the call. While I was driving I was trying to scroll through the notes and almost drove off the highway. Luckily I didn't and the call was a smoke scare anyway.

Lessons Learned: Our department used to have aides that drove the chiefs to calls, so the chief could look at the data and make a plan. Now, we have to do all of it on our own. It makes us hypocrites because we have laws against texting and driving, but we let police and firemen have computers.

Report Number: 12-0000030

Synopsis: Safety briefing message not adhered to.

Event Description: We were conducting trench/collapse training at our academy. We had just finished ground school and had a thorough safety briefing. As we approached the trench, a member walked right to the edge and the edge gave way and he fell into the trench. We were able to put a ladder down and he walked out on his own.

Lessons Learned: You need to maintain situational awareness at all times. We just went over the do's and don'ts and still someone messed up. Pay attention to detail. It might save your life.

Report Number: 12-0000031

Synopsis: Wrist injury results from sharpening blade.

Event Description: I work at a local petroleum distribution plant as part of the fire brigade. I am also a career firefighter as well. We were doing routine maintenance of our tools when a fellow employee had his near-miss. We were sharpening axes and having a conversation. My fellow worker lost his focus and slid his wrist right over a freshly-sharpened blade. He gauged the wrist pretty bad and was bleeding profusely. Luckily we had a medical kit right there and applied pressure and called for ALS.

Lessons Learned: Keep focused. Never let your guard down.

Report Number: 12-0000032

Synopsis: Controlled burn quickly goes out of control.

Event Description: We were doing a controlled burn along a local river bed. The undergrowth and trees had over-run the banks and we were ordered by the local municipality to burn it off. Our officer had never run one before, but was determined to show us how smart he was. He ignored all of the tactics we offered and lit the thing off, using copious amounts of fuel oil to ignite the river banks. The thing lit off like a roman candle because the duff was so dry and thick. The fire ran away from us and ended up burning down several outbuildings that stored heavy equipment.

Lessons Learned: If you don't know how to do something, ask. There are consequences for every action we take as firefighters.

Report Number: 12-0000033

Synopsis: Attic stairs trap FF in flashover.

Event Description: We were called for a working structure fire with threatened exposures. We arrived on scene and reported two well involved structures, with high winds. The first due engine was placed in front of one of the structures while the second due engine was placed in front of the second structure. I arrived right behind our second due engine in a "run-around" vehicle. I donned my full PPE and walked up to the second-in engine. My job was to operate that engine, so I took over the apparatus operations. Our Chief came over to me and told me to "pack out and go inside" with the crew of the second in engine. I then donned my SCBA, rechecked the setup of the apparatus, and then met up with the crew as they were making entry into the structure.

We fought an extensive amount of fire inside the structure, and then determined that we needed to get into the attic. We found the attic access on the other end of the house. We pulled the attic access stairway down, which at the base of the ladder was extremely close to a wall, and I climbed up the ladder into the attic with the nozzle while the other two members of the crew stood by on the floor level. I was in the attic from my waist up standing on the attic stairs. I did not want to go further into the attic since visibility was, in my view, worse than 0%. Suddenly, the heat intensified and the attic flashed over. I tried to climb down the stairs but couldn't go down. At the same time, one of the crew members was trying to pull me down, but I wasn't going anywhere. I realized that I was hung up on one of the spring hinges of the attic access door. I kicked loose from my crew member, took another step up on the ladder and twisted my body to free myself from the hinge as I attempted to get out of the attic. I succeeded in getting out of the attic and then exited the structure with my crew.

We went to our rehab and reported to our IC what had happened. The IC had an EMS crew that was on scene to evaluate me since I was in the position that I was in. They found very minor first degree burn on the back of my neck. My flash hood was taken out of service due to damage it had sustained during the flashover. I also ended up going to the hospital for evaluation from a doctor as that is what our protocol calls for.

I believe that if I had not been wearing my PPE properly, especially my flash hood, that my injuries would have been far worse than they were, even life threatening. I also think that incident reinforced the importance of PPE, even in our training within our department and with surrounding departments that were on the scene for mutual aid.

Lessons Learned: The lessons that I learned was that the proper use of PPE can make the difference between life and death. I was taught from the very beginning of my career, 17 years ago, to always wear your PPE properly and to wear all of it. The more you train with it, the more it becomes second nature to you to put it on. I try to implement that daily to the crews I work with, train with, and associate with. Not all of us train with full PPE because it's "only training." But when it all comes down to it, we all want to go home and live to fight another day. So in order to do that, wear your PPE, train with your PPE, and do it properly!

Report Number: 12-0000034

Synopsis: Sheared pin on ladder identified by FF.

Event Description: On [date deleted], my crew and I were assisting in the training of four new recruits to our department. We were covering ground ladders and aerial ladders. The recruits had finished climbing one of our 100' straight aerial ladders and were going to simply ride up in our 100' platform aerial to full extension. We had two new recruits and a recently promoted apparatus operator (AO) in the bucket. They all were secured with ladder belts. The new AO had done a little rotation of the ladder and extended it only about 40'. At that time I had told them to extend the ladder out fully. Almost simultaneously my firefighter (who is currently on the AO's promotional list) happened to catch something that seemed out of place. He was looking at the right side of the ladder. A pin had worked its way out of a joint and was about 1/4" in from the exterior surface of the ladder. The firefighter asked the AO assigned to the truck if that was normal. After a quick inspection and comparison to the other joint there was an obvious failure and upon closer inspection the 1 inch bolt that helped keep the pin in place was sheared off. The good news was that the crew in the bucket had only gone about another 10' out from their original position when this hazard was found. An immediate halt was put to operations. At that point the bucket was about 40' off the ground and extended about 50'. The ladder was returned to neutral position and bedded. While putting the ladder back to its bedded position, the pin had moved further out of position by about another 1/2". The ladder was placed out of service and is awaiting repair.

Some additional information - We work a three on three off type shift. We were on our 2nd/or middle day. Our first day on, our AO's perform a thorough inspection of their assigned apparatus. The aerial ladder had been visually inspected the day before. This inspection includes extending out the ladder and checking every aspect of the ladder and its assemblies.

Lessons Learned: There were a couple lessons learned or reinforced during this incident. The actual finding of the imminent failure by a firefighter who was not directly involved in the drill, but just happened to look at that component at that time was pure luck or good fortune. However, this event

drives home a couple of points: Be diligent and thorough in all equipment checks. Although this failure was not visible during the operational check the day prior to the event per the memory of the AO, even he is open to the fact that when you frequently inspect the same equipment there is a possibility of missing small evidence of something wrong because you are trying to key in on more obvious potential hazards. Everyone and anyone can and should point out safety concerns. Just because "it is not your responsibility" if you see a safety issue, speak up.

Report Number: 12-0000035

Synopsis: Spongy floor consumes FF.

Event Description: Engine [1] was dispatched to a reported structure fire. The fire was at a single family dwelling (approximately 900 square feet) with fire in the basement. We were first due and laid a water supply to the front of the house. I pulled the pre-connect and started toward the door. My officer and I advanced toward the seat of the fire and knocked it. We then heard conflicting reports that the fire had auto exposed to the main floor. We saw no visible fire in the basement.

Just then, Truck [1] gave a report of a spongy floor on the main floor while they were conducting their search. The chief backed everyone out and we reassessed the scene. After further review, crews went back in. Engine [2] was the first back in and as the officer made his way to the seat of the fire, he fell through to his waist. The fire had moved from the basement to the floor joists. The officer was pulled out and once again the call was made to go defensive.

We got overwhelmed by this fire! This was a small basement fire that turned in to a labyrinth of problems! Our department is good and we don't struggle normally in fires like this. Upon further review, the house had been renovated multiple times with no fire stops installed. This caused the fire to run and hide and ultimately put us at risk.

Lessons Learned: Never underestimate a "routine fire." This should have been done and gone quickly but kicked our butts instead. Thankfully nobody was hurt.

Report Number: 12-0000036

Synopsis: Crews endangered by lack of communication.

Event Description: My department was called for mutual aid in a nearby district. While we were working on the scene, another mutual aid department was operating an elevated master stream from their tower ladder no more than 15 feet to our left. The tower was about six feet from power lines and the stream was being directed between the primary and secondary power lines. The firefighters that were operating the stream would direct it as needed to fight the fire, occasionally hitting the power lines.

My crew and I knew it was a matter of time before one or all of the lines would break. Crews were operating in the "D" side exposure no more than five feet from the fire building next to a utility pole was

five feet from the "D" exposure as well. The tower did break a secondary line as firefighters were on the porch. Luckily, when the line broke the charged end landed into the fire building where no one was operating, instead of the exposure or the street where my team was standing in water from all the master streams in operation.

Shortly after that, the crew that was operating the tower had become overcome by smoke due to wind shift and the fact that they were not wearing SCBA's. They backed out, shifted the tower without redirecting the stream or shutting it down, and hit the porch on the "D" side exposure building. The crew that was operating there had to dive into the exposure and one firefighter had to retreat by jumping off of the five foot porch. The stream knocked the door from it's hinges. Luckily no one was hurt. My crew and I tried to let the tower crew what was going on by yelling and signaling. There was no way to radio them due to the fact they are a distant department and we do not carry their frequency on our radios.

I am not sure if they realized what was going on around them and they should have been wearing SCBA's. This could have been avoided. Luckily no one was injured, just a slight scare.

Lessons Learned: The lesson learned is to always be aware of your surroundings. Obtain a way to communicate with other departments if possible. The tower that was operating was from a volunteer department and I'm not sure what their level of training is. I would hope they went back to their department and critiqued themselves in order to improve.

Report Number: 12-0000037

Synopsis: Engine goes into a spin during heavy rain.

Event Description: Wednesday, [date omitted] at 1600 hours I learned a very big lesson on how you should never take Mother Nature for granted when driving code 3 in a fire truck.

At 1552 multiple tones when out for a residential fire on the north side of town, Captain [A], Firefighter [A], and Firefighter [B] - with Firefighter [B] driving at the time - responded from Station [1] on the south side in [highway number omitted]. When the bay door open I noticed that it was raining very heavily out and I immediately turned off the engine brake. We proceeded to respond up [street name omitted] and turned left on to [street name omitted].

At the time of the response the vehicle traffic was heavy and the flooding on the side of the street was deep. I kept my speed at around 20 mph to sometimes reaching 30 mph in good areas. The posted speed limit on [street name omitted] is 35 and I never reached it or went over it. The rain and vehicle traffic was too much and I made very sure that my speed and safety was my number one concern. As we proceeded to come around a turn on [street name omitted] just past [street name omitted] close to [street name omitted] I let off the gas to slow down and right at that time I felt my right rear tire start to drift and lose traction. At that time (thinking it was the right idea) I stepped on the brake. When I stepped on the brake we proceeded to spin out of control in 2 ½ complete rotation while crossing the street. I did everything I could to NOT panic, and let off the brake to let the truck spin. I down shifted from 3rd gear to 2nd gear in an attempt to slow our momentum while peppering the brake and trying to steer out of our situation.

I don't know if it was anything that I did, or if God was looking down on my crew and me at the time, but we came out of the situation without hitting anything or anyone. I consider myself deeply blessed and

have learned a very big lesson on driving in the rain. Could I have been going slower? Yes, but I believed I was driving a safe enough speed in the given weather. Apparently my new perspective on what a new SAFE SPEED in the rain has been changed and it is much different now. If I can get anything out of this, it would be to never overestimate the rain and you're driving condition. And that if you think you are driving a safe speed, then slow down just a little bit more.

I am sorry for putting my crew, myself, and all other pedestrians in danger. I can assure you that this will never happen to me again.

Lessons Learned: If I can get anything out of this, it would be to never overestimate the rain and you're driving condition. And that if you think you are driving a safe speed, then slow down just a little bit more.

Report Number: 12-0000038

Synopsis: Hose violently fails during pressure test.

Event Description: Our department performs annual hose testing during the slower time of the year (winter/early spring). As many departments do, we divide up the workload so not one shift performs all the duties. Even while testing we divide up the load i.e. some test, others roll hose/unload hose etc. We use a commercial hose tester and perform the testing in the apparatus bay area. The tester is capable of testing four sections of hose at a time and we do not exceed the NFPA recommendation of 300'. We use a nozzle to cap the end of the hose. During the test the pertinent hose information (id number, checking for leaks etc.) is gathered for record keeping.

We were testing a section of 3" hose and rolling up a previously tested section. During the test the 3" hose catastrophically failed. The two firefighters that were rolling up the hose were only about five feet away from the hose being tested. They said the nozzle passed them at about chest height and landed in the middle of the bay. The end of the hose was outside the bay door and traveled half its distance in the air. The firefighters rolling hose did not get injured.

Just prior to the failure some of the other firefighters noticed a strange noise but did not know what it was or where it was coming from. After the event, they recognized the sound as the outer shell fibers tearing under the pressure. The damage to the hose was a six inch hole in the side where the hose has been packed flat.

Lessons Learned: We are not going to prevent a section of hose from failing or personnel from getting wet. However, we can prevent the end of the hose from flying through the air.

1. Situational Awareness:

When we looked at the situational awareness we realized that we never think about the hose suffering a catastrophic failure and hose/nozzle traveling through the air. We decided that checking for leaks needs to be done from a distance instead of walking next to the hose/nozzle/pump. Small leaks can be detected by observing mist, water trails, new wet areas on the ground etc. Recognition of the

tearing jacket will not be forgotten by those involved. However, how do you describe that sound for others to recognize? If that sound is heard the test must be immediately stopped.

2. Procedure:

After the testing was complete we took time to see how this could have been prevented. We decided to secure the nozzle with a section of rope tied to the back of a piece of apparatus. We tied the rope to the apparatus then tied a knot on the rope. This provided a moveable point for different lengths of hoses. The loop is then passed over then through the bale and around the end of the nozzle. This keeps the bale shut and in the event of the bale accidentally being opened, the nozzle reaction will allow the bale to be automatically closed. This process does not slow down the testing nor is it very complicated to perform. In the event of a failure, the hose will still move, however it will not get off the ground and if it does, it will only be for a second. Once the initial pressure is relieved the pressure will drastically drop and the chance of injury is much less. The other concern was the middle of the hose. A longer section being tested will allow for some lateral movement. There can be a good chance the hose could knock someone down. Depending on the configuration, the hoses can be wrapped together with a rope or webbing. The weight of the second hose will keep the damaged hose from traveling a great distance thus reducing the chance of injury.

3. Human Error:

It is difficult to keep up with the dates and test pressures. When we were taking out the section of hose we noticed that the hose did not say the same thing as the hose we had been testing. The side of the hose was stamped "Tested to 600 PSIG 2/87". For those who are up on their dates, after July 1987 the pressure tests changed. On another stamp we could barely make out was "...Test to NFPA No. 1962". Prior to July 1987 hose is to be tested according to what NFPA states. After July 1987 hose should be tested to what is stamped on the hose. It is obviously important to make sure you are familiar with when the hose was manufactured and what it is to be tested. You can say we became complacent with what we were doing and did not pay attention to the different hose. Just today as we are testing more we noticed some 5" hose that was to be tested to 225psi instead of the typical 200psi we had been testing. It was newer hose mixed in with older hose and we completely overlooked it.

Report Number: 12-0000040

Synopsis: High winds blow hose load off engine.

Event Description: Our engine was enroute to a traffic accident on a four-lane highway with high winds reported to be 50 mph with 80 mph gusts. The hose bed cover tarp failed and was ripped from the bed. The company continued to the call. Once on scene the crew checked the hose loads and confirmed they were loaded properly and the ends tucked back far from the edge of the bed. The engine was then requested to a second call and responded. The engine company remained in service due to multiple incidents, limited staffing, and a power failure to one fire station caused by weather. While the engine was traveling down the highway, a gust of wind picked up two of the three hose loads and tossed them off the bed. The quick recognition by the engineer of the situation and his quick actions to pull to the right shoulder off the highway resulted in only 800 feet of supply hose, both three and five inch, on the

side of the highway. The result was no damage to the engine and, more importantly, no damage to the numerous civilians traveling the highway at rush hour.

Lessons Learned: Equipment checks are critical. Always be aware of the weather conditions. When repairing equipment, make sure it is with the best/proper equipment and that the repairs will hold up to even the toughest conditions.

Report Number: 12-0000041

Synopsis: Fleeing motorist drives through fire scene.

Event Description: On [date omitted] while operating with five fire departments on the scene of a structure fire. We received a second call for a vehicle fire. A stand by department took that call. During this call it was determined that a white [vehicle] was seen leaving the scene. This vehicle approached the scene of the initial call and proceeded to disobey orders from fire police to stop. He drove through the scene running over hoses and a ladder. He later struck a member who was directing traffic. That member was not injured. While being pursued by law enforcement, he attempted to make a second pass at the scene. He was stopped before this could occur. He had barely missed five firefighters in the first pass. Thank God, no one was injured. He was arrested on the scene.

Lessons Learned: Maintain situational awareness and expect the unexpected. Even when you think you are doing everything you can to ensure safety on your scene someone can find your vulnerabilities.

Report Number: 12-0000042

Synopsis: Seatbelt prevents injury during vehicle accident.

Event Description: During the morning hours of [date omitted], (our department) [department name omitted] dispatched to assist with a chimney fire in [location omitted]. Shortly after the response of the engine, the company was dispatched for a motor vehicle accident in [location omitted]. The rescue and lieutenant arrived to find a member of the company who was responding to the station for the earlier dispatched chimney fire had lost control of the vehicle on the snow covered roadway and struck a stone bank. Luckily, the firefighter was not injured, but the vehicle was totaled. The firefighter was wearing a seat belt.

Lessons Learned: Be mindful of road conditions at all times. Always take the time to buckle your seat belt.

Report Number: 12-0000043

Synopsis: Semi totals engine at scene of MVC.

Event Description: While operating at a MVC on the interstate during mop up, a semi-tractor trailer driver was not paying attention and rear ended our initial attack pumper. One firefighter at the driver's side of the apparatus stated that the sidewall of the trailer brushed the side of his boots. All members were wearing their high visibility vest and proper PPE. The apparatus appears to be a loss but all members returned home safely.

Lessons Learned: That even wearing all the proper PPE, our situational awareness must never cease. That the public still fails to heed to warning lights on apparatus. Fortunately, everyone went home.

Report Number: 12-0000044

Synopsis: Chimney collapses onto roof near working crews.

Event Description: While operating at an attic fire in a 6,400 square foot single-family dwelling, two close calls occurred that are worth noting. Units went on scene with nothing showing. We had an audible water flow alarm from the sprinkler system, water coming out of the ceiling in the area of a fire place and a fire burning in the fire place. Initially the attic checked clear (unknown to the firefighter, there was a second, partitioned attic space that include the chimney chase) and the TIC didn't pick up heat. We think opening the attic scuttle introduced enough oxygen to get into the other attic space, increasing the intensity of what was a deep seated and smoldering chimney chase fire. The firefighter in the main attic space called for and got a hoseline, which he used to keep the fire from advancing into that space. At the same time, crews were pulling additional attack lines to the second floor in preparation of pulling ceilings and to the roof for vertical ventilation. Only then was smoke now visible from the outside of the structure.

As the first vent hole was going in, we got heavy pressurized smoke. The Vent group felt they needed a bigger hole because solar panels restricted the first one so they moved to the other side of the ridge. As this transpired, the smoke turned to heavy flame pushing out the vent hole. As the crew sounded to their spot the firefighter who was leading the way and sounding the roof reached back, handed off the rubbish hook and grabbed the saw from his officer. As he positioned to make a cut, he fell through the roof, fortunately hitting an interior wall about four feet below the roof line. He was immediately pulled out and the roof was evacuated with no injuries.

As ceiling were being pulled below and hose lines were being introduced the chimney, which consisted of stucco and brick façade, failed. It tipped to one side and partially disappeared into the ceiling area. A communication was made that the chimney had failed and was in a precarious position. Crews pulling ceiling inside identified it and flagged it off as the fire was being extinguished. Ultimately, the fire was held to the concealed, inaccessible attic void and the only injury was an unrelated ankle injury.

Lessons Learned: Don't trust newer construction roof sheeting when you know you have significant heat and/or fire under it. Half-inch OSB is junk. Get your people off sooner under these circumstances. In retrospect, the first hole would have been sufficient.

I'd never given it much thought, but there's only a few studs holding up those (in some cases really heavy) ornate chimneys we see protruding out of homes. Weighing 500 pounds or more, they need to

be considered as a fall potential in any attic fire, especially when the fire is suspected to be in the area of the chimney chase. Had the chimney not been hung up on an interior wall and fallen into the second floor where folks were operating it could have easily killed someone.

Report Number: 12-0000045

Synopsis: Driver ignores FF's order to stop.

Event Description: While on the scene of a single vehicle auto accident, my captain instructed me and my engineer to handle traffic control. My engineer and I had our reflective vests on and the cones were set out in the proper placement. While I had cars stopped, there was another car that bypassed the stopped traffic and was headed right for me. The car was going about three to five miles per hour. I had yelled for him to stop numerous times. He was about to hit me until I moved into a ditch to avoid it. The driver had opened the door and a smell of alcohol was evident. I asked him to put his car in park and he said that his brakes were going out. He had not put his car in park until my engineer came running up and helped him do it. My engineer yelled for the cop that was already on scene and the cop came running up to help. The driver was arrested for driving under the influence. The weather was overcast and rainy.

Lessons Learned: The lesson that I learned was to get out of the way sooner.

Report Number: 12-0000046

Synopsis: Two FFs become disoriented during fire.

Event Description: It was a normal day at work and we had just finished checking off the trucks and finished all the station duties. A call came in as a structure fire. When we got to the scene, I looked over and I saw a four-story building that's every bit of 100 years old with smoke billowing out of the top windows. It's an old cigar factory.

I got out of the truck geared up, fully protected, and ready to go. My captain told me and my partner to check the top floor to see if we could see the fire and if it's small enough to put out with an extinguisher. We grabbed a high rise pack (a hose line, an axe, and a halagan) and an extinguisher, and went to check it out. We took the stairs and the more we went up the thicker the smoke got. We turned on our flashlights, which didn't help much, but it was better than nothing. We got to the top floor, and it was extremely smoky, but no fire. We could barely see, so we walked straight in WITHOUT doing a left hand search (staying on the wall to the left the whole time). We were just searching for the glow of the fire. The deeper we went in, the thicker the smoke got, to the point where I couldn't see my hand that was a foot in front of my face.

Not seeing the fire and not really knowing where we were going, we decided this was pointless. It was very dark and confusing. We decided to go back down and reassess the situation, get a ventilation fan and new airpacks (which at this point had about 25 minutes left on them), and report to the captain that

there's a lot of smoke and zero visibility. So we walked back to where we had come from, or where we thought we had come from, to try to find the stairwell. We found a wall, so we kept feeling down the wall and found some sort of room. I grabbed onto my partners jacket and yelled, "Where's the stairwell?" In a semi-panicked, muffled voice, he yelled "Man...I don't know!"

At this point so much was going through my head: 1)We're lost, 2)We have 20 minutes of air left, 3) If we run out of air we'll be dead in no time from smoke inhalation, 4) It's an old concrete building with one or two windows, but the windows are on the other side, 5) It's near impossible to break through a concrete wall, 6) We could call a mayday, but we don't know where we are on the top floor, so how would they find us?

The thought crossed my mind, "Is this really how it's going to end?" I felt helpless and, for the first time, I feared for my life. I said a sub-conscious prayer and tried not to panic .We did all we could do. We had to keep feeling down the wall until we could find the stairwell. It had to be somewhere in the general area. We kept shining our flashlights and after what felt like was a lifetime, the longest 10 minutes of my life, I saw a doorway and a railing shining off from the beam of my partners light. I yelled, "THANK GOD!" and we headed down the stairs in silence. I'm not sure what my partner was thinking but it had to be close to what I was thinking, which was "DID THAT REALLY JUST HAPPEN?"

I walked outside appreciating life and thanking God we made it out OK. I took a 10 minute break and got back to work, eventually putting the fire out and ventilating the building. It was about a four hour ordeal for all of us. The fire was determined to be caused by workers who were taking apart an old machine with blow torches and caught some old caked up tobacco on fire.

I will never forget this day. I learned some lessons and gained even more respect for everyone who does this job. After we were back at the station, when it was all said and done, a veteran firefighter asked me with a smirk on his face "So do you still wanna do this job?" My response? [Heck] YEAH.

Lessons Learned: Always stick to the wall or use a rope (which I carry with me now)and always put safety first.

Report Number: 12-000047

Synopsis: Tactical channel not properly assigned by dispatch.

Event Description: Our communications plan was changed by dispatch at the receipt of a first alarm assignment to a structure fire. The message only appeared on the Mobile Data Terminal (MDT) and was never broadcast over the air to responding units. Out of the ten units that were dispatched, only three were correctly assigned and using the right radio channel once on scene. The building was fully involved with crews working inside and the incident commander was unable to communicate with everyone.

Lessons Learned: Check the MDT for the communication channel plan. If it's a different tactical channel than what appears to be normal, check with dispatch en-route so everyone hears the change. After giving the size up, announce the tactical channel and command channels on the radio so everyone is in the same page.

Report Number: 12-0000048

Synopsis: Floor fails during attack on house fire.

Event Description: The fire department was dispatched for a structure fire. While operating in a two story single family dwelling with a full basement, a firefighter fell through the floor and was transported with an injury and minor burns. The occupant of the house was a “hoarder” and this caused several obstacles. Staffing was not optimal on scene, due to recent budget cuts.

Lessons Learned: Perform a better size up prior to the attack.

Report Number: 12-0000049

Synopsis: Basement fire causes first floor burn through.

Event Description: We were engaged in an offensive attack on a two story single family dwelling with a full basement. The floor burned through during the attack and a firefighter fell through to the basement. The firefighter suffered injuries and was transported to the hospital. Recently we have fell victim to budget cuts that have reduced staffing and this incident could be the first of many.

Lessons Learned: Always do a size-up. Make sure you sound the floor in front of you.

Report Number: 12-0000051

Synopsis: Chainsaw malfunctions following service.

Event Description: I had just finished cleaning and reassembling a chainsaw after our roof ventilation training. After ensuring that the saw was put back together correctly and adjusting the chain tension, I started the saw to test it. The saw was running at full speed for approximately 15 seconds when the chain came off and bound up on itself. The only damage noted was to the bullet chain itself. The drive lugs were damaged and prevented the chain from sitting in the grooves of the bar of the chainsaw.

Lessons Learned: Always wear proper PPE (gloves and eye protection). Re-check for chain adjustment after testing your tools.

Report Number: 12-0000052

Synopsis: FF gaining access to firehouse causes damage.

Event Description: (Engineer's Narrative) In the process of leaving the station for the afternoon, I accidentally left my access key card in the building as I was getting ready to leave. I was swapped with another engineer for the afternoon and no one was at the station and no vehicles with access keys were available. Having realized my vehicle keys were in the building, I attempted to pull open the door that was magnetically locked. This particular door had a faulty magnetic lock for the past year and was previously very easy to open. However, this was not the case at this time. In trying to forcefully open the door, the stress fractured the glass.

(Officer's Narrative) This station's personnel had been at the library for training. Upon returning to the station, we immediately noticed that the glass from the fire rated door leading into the bay was cracked. We thought someone had tried to get into the station and I submitted an unwanted incident report to the shift commander. This engineer should have left a note or tried to call one of us to let us know this had happened. There is a whiteboard right next to the door. Upon hindsight, we also could have called him to see if he knew anything about it. His relief had left the station at 1315 to join the company at the library and reported that the glass was intact when he left. Some of these doors will open fairly easily with a slight tug, but the engineer did not know this door had recently been repaired.

Lessons Learned: This was purely an accident and unintentional in nature. In my haste I made a snap decision that was wrong and I take full responsibility for the door. As a result, I will take an active role in repairing and/or paying for the damages to the door.

Report Number: 12-0000053

Synopsis: Auto extrication training causes injury to FF.

Event Description: While training on vehicle extrication, a firefighter was injured while removing the plastic trim from around the doors. In doing so, the fire fighter's wrist struck a piece of exposed metal. This required the firefighter to receive stitches at the local hospital. The firefighter was wearing all PPE at the time of the incident. This incident was not due to negligence on the firefighter's part. All city and fire/rescue policies were followed correctly.

Lessons Learned: After the incident occurred, we went over the hazards associated with vehicle extrication and looked at how these types of accidents could be prevented.

Report Number: 12-0000054

Synopsis: Injury sustained by FFs while lifting patient.

Event Description: Two firefighters responded to this incident on a rescue apparatus. Both of them assisted in moving a patient via a backboard from the vehicle to the EMS unit. While moving the patient out of the ditch, one firefighter slipped and felt a strain in his back while preventing the patient from hitting the ground. He and another firefighter were the only two holding the backboard while moving

the patient 10 feet from the vehicle to the roadway. They had to continue carrying the patient 400 feet to the ambulance with five personnel. After successfully getting the patient to the ambulance, the other firefighter felt a strain in his back on the lower right side. They both said they were sore, but did not want to see a doctor.

Lessons Learned: Carrying a patient on a backboard 400 feet is a strenuous task. Due to power lines in the roadway, it appears that this may have been their only option. They were correct in using five people to carry him down the roadway, but they should have used more than two people to get him out of the ditch onto the road. This reinforces our policy of maintaining physical fitness. Both firefighters have been working out consistently and this may have prevented further injury.

Report Number: 12-0000055

Synopsis: Portable radio damaged after being lost.

Event Description: I was notified that my portable radio assigned to me was found on the street in front of the station. It had been run over and sustained damage. I was unaware of where I had misplaced it to allow the damage to occur.

Lessons Learned: I am making changes in my daily procedure to keep up with my personal equipment assigned to me. I realize that it was my responsibility to keep up with the portable radio.

Report Number: 12-0000056

Synopsis: Leaking sprayer exposes FF to chemical.

Event Description: An engineer was using a backpack sprayer to apply concentrated bug killer to the outside cedar trees at the station. The sprayer developed a leak at the back near the hose, exposing his uniform and back to the product.

Lessons Learned: Check your equipment to ensure serviceability prior to use.

Report Number: 12-0000057

Synopsis: Standing by for EMS results in heat exhaustion.

Event Description: We responded to a teenage party that had been raided by the police. There were three patients complaining of anxiety and one with cuts to the arm. The fire department had no patient contact due to EMS already being on the scene. Fire department members were on the scene standing

outside in the heat and humidity for over two hours. After being released by PD, I noticed one engineer was resting on the tailboard of the apparatus. His condition was questioned while EMS was on scene and he was in need of medical attention. He had signs of heat exhaustion. He was transported to the local hospital for treatment.

Lessons Learned: None reported by submitter.

Reviewer Comments:

Remember that Rehab is not just for personnel in the IDLH atmosphere. Driver operators, command post members, etc. can fall victim to extreme conditions and must be monitored along with all personnel.

Report Number: 12-0000058

Synopsis: Section of hose breaks while conducting training.

Event Description: We were pump training on the drill field and had a 100' section of 4" hose coming off the hydrant with a gated wye on the end. We were flowing water out of the gated wye during a hydrant assist valve evolution. After the evolution was complete, I went to shut off the gated wye. As I attempted to close both valves of the gated wye together, the left valve closed more causing the line to sweep to the left and knocked me off my feet. The hoseline swept back and forth, striking me in my right knee and right forearm before I could get to my feet. The hoseline was then shut down at the hydrant. The section of hose was damaged in the event. It developed a hole near the coupling where it swept back and forth on the ground.

Lessons Learned: This incident could have been prevented with better judgment. With the high pressure coming off that hydrant, the line should have been shut down using the hydrant.

Report Number: 12-0000059

Synopsis: Apparatus sustains damage in parking garage.

Event Description: I went into a parking garage while driving a department pick-up truck. I got out of the truck and checked clearance before entering and the clearance was OK. When leaving the parking garage, I placed the truck in reverse and a concrete truss caught the left rear circular rotating light on the truck bed cap and broke the base.

Lessons Learned: Apparently not all trusses are the same distance from the ground. In the future, avoid taking the taller vehicles into parking garages.

Report Number: 12-0000060

Synopsis: Rescue truck collides with pick-up.

Event Description: The rescue truck was traveling south on [location omitted] and struck a pick-up truck which failed to stop at the stop sign. The right front bumper of the rescue struck the left front end of the other vehicle. The bumper of the rescue was pushed in, affecting the aim of the right-front headlight. When the other vehicle spun around, the left-rear taillight made contact with the right-rear wheel flare on the rescue. The rescue was traveling non-emergency, returning from a call, at approximately 30 mph at the time of impact. The rescue came to a stop partially in the oncoming lane and partially off the road. The other vehicle spun around into a grass field at the corner of the intersection, then drove out of the field and stopped at the stop sign. Both occupants of the rescue were wearing seat belts and were uninjured. The driver of the rescue contacted dispatch via portable radio to report the accident and request police and EMS. After the rescue was released from the scene, it returned to the station. Drivability was not affected by the collision.

Lessons Learned: The engineer was driving within the speed limit and both occupants were wearing seatbelts. The engineer reacted quickly and had actually changed course of the rescue truck trying to avoid the accident, but was unable to. The engineer's actions resulted in avoiding a T-bone collision which would have resulted in injury, possibly severe, to the driver of the pick-up. This accident was beyond his control and he is not at fault. The driver of the pick-up was cited for failure to exercise due care. All safety policies and procedures were followed by the crew of the rescue.

Report Number: 12-0000061

Synopsis: Ladder training results in FF injury.

Event Description: While conducting a ladder bail-out evolution, my left elbow encountered a "burning and sharp" pain as my elbow twisted. My hand was gripped on to the fourth rung and as I swung my body around. The lower portion of my arm stayed planted as the upper part twisted. I was unable to securely grab the rails of the ladder with my hands while sliding down so I tried to grab a rung thus causing an injury to the inside of my left hand near the thumb.

Lessons Learned: The shift commander was on site when the injury occurred and observed no violation of safety procedures, this injury is the result of an accident.

Report Number: 12-0000062

Synopsis: Wire causes roof ladder to snap back.

Event Description: My crew responded to a reported residential structure fire. On arrival, a small two-story residential house had heavy fire showing from the exterior on the Charlie/Delta corner. The fire

had already run up the exterior of the home and into the eaves. After completing my 360 of the structure, I determined the best location for vertical ventilation operations was on the Charlie side of the structure. I had my crew deploy the extension ladder and roof ladder for operations.

The main body of fire originated on the Charlie side. During my 360, I identified that there was no fire in the main living occupancy but the fire had extended into the attic. The wind was also a contributing factor. The fire on the Charlie side had been extinguished and there was still moderate to heavy smoke coming from the eaves and attic vents.

I placed my large trash hook for roof operations. I hooked the roof ladder over my left shoulder, placed both hands on the beams, and started to climb the extension ladder. As I got to the roof line, I was approximately waist line high above the eave; I placed the roof ladder on the roof and started to slide the ladder up the pitched roof. On the first push, I grabbed the rung and pushed hard to get the roof ladder hooks high enough to reach the peak. However, just as I pushed the ladder it shot back with as much force and hit me in the shoulder. I was still holding on to the extension ladder with my right hand but the force was so much my hand slipped off the extension ladder and now the roof ladder was coming back as well. While reaching for the extension ladder with my right hand I was not able to regain my grip and I bumped the trash hook that was hooked on the ladder. I grabbed the trash hook to prevent it from landing on me and I was able to reposition the roof ladder on my shoulder to prevent it from possibly dislocating my shoulder as I fell.

I started to fall backwards and decided to push my feet off the rungs; which forced my body to upright itself and I was able to use my shins and slide down the beams. Just before I hit the bottom, I rolled the roof ladder forward to prevent it from jamming into the ground and landed on my feet. When I landed, my left foot hit a snow pile and my heel slipped causing me to fall on my seat. The fall was approximately 18 feet and no one suffered any injuries.

I immediately was able to get up and re-climb the extension ladder. Just before I did, I looked up the ladder and was not able to identify why the ladder bounced back. There was a glare on my mask from the sun and there was still moderate to heavy smoke. As I got to the top of the extension ladder, again I placed the roof ladder on the roof. I looked on the roof to see if I might have hit an exhaust vent or other object on the roof. There were no such objects on the roof. I started to move the roof ladder up the roof and I noticed a copper wire through the smoke. It was a small thin wire and it ran horizontally across the roof. It was coming from the gutter. Directly to the right of the extension ladder was a satellite for cable and the wiring for it was in the gutter. The wire had again landed across the top rung in between the hooks on the roof ladder. I had to reach out and remove the wire from around the hooks and top rung. The rest of the vertical ventilation operation went successful.

Lessons Learned: While climbing the ladder keep the tip of the ladder vertical and place beam to beam. Also, identify the area around the extension ladder before placing SCBA mask on to begin operation. Lastly, when placing the roof ladder on the roof slide the ladder to a point where one can identify possible hang ups and then finish with the final push.

Report Number: 12-0000063

Synopsis: Kinked line causes water delay.

Event Description: In January, we received a call of a residential fire alarm sounding showing second floor smoke detector activation. Our standard response of two engines and an aerial were sent. Upon

arrival, we found an audible alarm sounding at a 3-story residential structure. Nobody was home at the time of the call. After checking the outside of the residence due to the door being secure and no key holder to respond, the alarm reset itself. Approximately 1 minute later the alarm activated again and dispatch advised that they were now receiving it as third floor smoke detector activation. At this time, we were able to observe a very light amount of smoke coming from a third floor window on the "A" side of the structure.

Command called for another engine, a rescue, and the shift commander to respond. The engine and tower crew forced entry into the residence and found the first floor to be clear. Both crews went up the stairs to the second floor and encountered very light gray smoke at the ceiling level and started a search of the second floor but could not locate any fire or heat. We then went to the third floor, attic, of the structure and again found light gray smoke at the ceiling level but could not locate any fire. The engine firefighter then started checking the area with a thermal imaging camera but still found no heat signature. I started feeling a change in heat at the ceiling level and noticed the smoke starting to increase but it was still very light gray.

The engine firefighter then checked the entire attic area for a heat signature before finally finding that the floor was starting to look white through the camera. We started back toward the stairs and found that smoke conditions were beginning to change to darker smoke as we went back down to the 2nd floor. Upon arrival on the second floor landing, we found what appeared to be a small fire located in a bedroom. I made entry into the bedroom, along with the firefighter off the engine, with a water fire extinguisher while the engine officer called for a 1-3/4 handline to be pulled to the second floor. It appeared that I made a knock down with the water extinguisher but ran out of water. We exited the bedroom and waited for the handline to arrive. As we waited, we could feel the heat conditions continue to intensify.

When the handline arrived, I took the nozzle and made entry into the bedroom again. At this time, the fire was still contained to ½ of the bedroom, but had grown. I opened the nozzle and immediately lost water (later found to be caused by a kink in the line at the bottom of the stairs). I immediately advised that I had lost my water and called for the line to be charged and for someone to go and check the line. The heat continued to intensify but I was unable to back out of the room due to several firefighters in the main hallway trying to get into the bedroom. I then noticed that my mask had blacked out and I was unable to wipe it clean with my glove.

The fire appeared to grow substantially at this point, I believe the smoke lit off, I covered my face piece up with my arm and hit the floor and yelled to back out and that I was in trouble. I was still unable to back out. My handline then charged again and I was able to put the fire out quickly. We were able to break out two windows and vent the heat out. I exited the structure to find that my helmet was melted, my lens of my SCBA facepiece was melted and cracked, my hood was discolored and I had burns and discoloration to the shoulder and sleeves of my turnout coat. Immediately, I was sent to be checked by the EMS unit on scene. I had received only a very minor burn to the side of my face and to the knuckles on my right hand. I was treated at the scene and released.

Lessons Learned: Members need to improve situational awareness, and be assigned tasks instead of observing. There were too many firefighters in the main hallway to allow for immediate egress from the involved room, which led to a blocked exit leading to exposure to extreme heat and nowhere to go. More attention needs to be paid to hoseline management techniques to make sure that kinks are removed while line is being pulled so that water is not lost during fire attack. Communication to other members needs to be improved as well as communication to command that conditions are deteriorating and members are in trouble much earlier in the event.

Report Number: 12-000064

Synopsis: Car intrudes into helicopter landing zone.

Event Description: A BLS ambulance and two ALS engines were dispatched for a pedestrian struck. A chief officer responded as well. After finding a priority one trauma, a helicopter was requested for medevac to the hospital. The closest fire station was chosen as the landing zone (LZ) and one of the two engines was designated to handle the LZ.

Personnel from that fire station and the battalion chief were in quarters at the time of the request. An officer from the fire station met with the LZ unit and recommended using the lanes of traffic in front of the fire station apron as the LZ.

The grassy hill behind the station was considered, but not chosen based on the historical practice of using the paved area in front of the station. And there were concerns about the slope of the hill to the rear.

Prior to the arrival of the helicopter, the engine, ambulance, and battalion chief arrived at the fire station. The battalion chief positioned to block traffic at the intersection to the south. Traffic from the north was blocked by private security from the community to the north. When the helicopter announced that they were two minutes out the engine moved and parked perpendicular to traffic and next to the battalion chief's car. The two units blocked all of the northbound lane, the southbound left turn lane, and part of the southbound through lane. Approximately one and half lanes of southbound roadway were not protected by a vehicle.

As the helicopter was touching down (less than five feet off the ground), two privately owned vehicles entered the intersection and proceeded north. They both crossed the double yellow line, two opposing lanes of traffic, and went around the engine and chief's car. The first car drove under the rotor "disc" of the helicopter and the second car was stopped by the crew of the engine.

As soon as the pilot saw the first car, he throttled up, but didn't gain any altitude until the car had driven by the helicopter. The helicopter then relocated to the high grassy hill behind the fire station.

Lessons Learned: Delays frequently occur during helicopter medevac operations. The relocation to the grassy hill probably added four minutes to the transfer.

Open areas are almost always preferable to landing aircraft in traffic lanes.

The requirement for an LZ landing unit is an engine, truck, or squad with three personnel. This is usually adequate for a field, but is not enough for any roadway.

At least one crew member needs to be dedicated to being a "lookout" for changes to surroundings.

Always expect drivers to behave irrationally. Build your plan on the assumption that all drivers are under the influence and distracted.

To prevent drivers from entering an area, there needs to be 100% closure of the road with a physical barrier. If there is room for one car to maneuver through, it will.

Even when a third party (like the community security gate) accepts responsibility to block traffic, we need to provide our own redundancies. We need to ensure that we build a safe work zone for our crews, and for those of our colleagues in the aircraft.