



National Fire Fighter Near-Miss Reporting System:

Reports Related to High Rise Incidents

February 2012

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**Report Number:** 05-0000220

**Report Date:** 05/27/2005 14:10

**Synopsis:**

FF loses contact with handline

**Demographics:**

**Department type:** Paid Municipal

**Job or rank:** Assistant Chief

**Department shift:** Straight days (8 hour)

**Age:** 43 - 51

**Years of fire service experience:** 24 - 26

**Region:** FEMA Region IV

**Service Area:** Urban

**Event Information:**

**Event type:** Fire emergency event: structure fire, vehicle fire, wild land fire, etc.

**Event date and time:** 05/16/1997 20:00

**Hours into the shift:** 13 - 16

**Event participation:** Involved in the event

**Weather at time of event:**

**Do you think this will happen again?**

**What were the contributing factors?**

- Human Error
- Individual Action
- Fatigue
- Teamwork
- Decision Making

## What do you believe is the loss potential?

- Life threatening injury

### **Event Description:**

During a working fire on the seventh floor of a high rise commercial office building in (city, state deleted), I advanced a hand line into a telemarketing office on fire. My partner and I got separated. He returned back to the stairwell and I was alone on the line. I put down the line momentarily because I thought I had heard someone in the office area and lost the hand line. I began to search for the line and found myself going into office cubicles set up for multiple telemarketing callers. It was a maze of chairs and office cubicles. The warning bell on my SCBA began to ring indicating low air. I had no partner and lost contact with the hand line. I cut panic off and focused on finding my hand line as I knew it was my only chance of getting out alive. With tremendous luck I found the hand line and quickly chased it down to the stairway just as I ran out of air completely.

### **Lessons Learned:**

1. Never leave or lose contact with your hand line or safety rope, particularly in a commercial structure. It is your means to outside the IDLH and into safety.
2. Always remain in contact with your partner through constant communication.

**Report Number:** 07-0000780

**Report Date:** 03/08/2007 16:11

### **Synopsis:**

Improper interior high rise operations.

### **Demographics:**

**Department type:** Paid Municipal

**Job or rank:** Battalion Chief / District Chief

**Department shift:** 24 hours on - 48 hours off

**Age:** 43 - 51

**Years of fire service experience:** 21 - 23

**Region:** FEMA Region VIII

**Service Area:** Urban

**Event Information:**

**Event type:** Fire emergency event: structure fire, vehicle fire, wildland fire, etc.

**Event date and time:** 03/02/2007 08:15

**Hours into the shift:** 0 - 4

**Event participation:** Told of event, but neither involved nor witnessed event

**Weather at time of event:** Clear and Dry

**Do you think this will happen again?** Yes

**What were the contributing factors?**

- Command
- Decision Making
- Communication
- Human Error
- Situational Awareness

**What do you believe is the loss potential?**

- Life threatening injury
- Lost time injury

**Event Description:**

Crews responded to a report of a "notifier" alarm at a local hotel. The first arriving crew reported to the lobby and was told by a custodian that there was heavy smoke on the sixth floor. There was no smoke or flames showing from the outside of the hotel. The crew went up the stairwell to the 6th floor and encountered heavy smoke. They masked up and proceeded down the hallway to the fire room. They opened the door and smoke came out from the room. The crew did not take a high-rise/standpipe pack with them. They had no hoseline protection when they opened the door. They did not inform command of what they had found or what they had started to do. This is against our established department SOP's. There was no life safety threat and the fire floor was evacuated.

**Lessons Learned:**

1. Crews will take standpipe/high-rise pack on all alarms in buildings with sprinkler/standpipe connections. This is done regardless of what is showing from the outside.
2. Crews must communicate with the IC and keep informing him/her of every condition and move they are making.
3. Crews will review the SOP for high-rise incidents.

**Report Number:** 08-0000051

**Report Date:** 01/29/2008 16:06

**Synopsis:**

Rope rescue from highrise.

**Demographics**

**Department type:** Paid Municipal

**Job or rank:** Lieutenant

**Department shift:** 24 hours on - 72 hours off

**Age:** 43 - 51

**Years of fire service experience:** 17 - 20

**Region:** FEMA Region II

**Service Area:** Urban

**Event Information**

**Event type:** Fire emergency event: structure fire, vehicle fire, wildland fire, etc.

**Event date and time:** 10/01/2007 08:00

**Event participation:** Told of event, but neither involved nor witnessed event

**Weather at time of event:** Clear and Dry

**What were the contributing factors?**

- Decision Making
- Situational Awareness
- Communication

**Event Description:**

The fire was on the top floor of an 11 story multiple dwelling fireproof highrise. The firefighters assigned to the roof from the 1st and 2nd ladder companies, ascended to the roof level for possible ventilation operations. They brought the life saving rope with them to their position. They observed an occupant inside the fire apartment at a window and communicated this information to members inside the building. The two roof firefighters then advised the Incident Commander that they were preparing for a possible life saving rope rescue. The ladder company officer in the fire apartment then transmitted that the fire was knocked down and directed the roof firefighters not to remove the person via the life saving

rope. Immediately following this communication, the roof firefighters transmitted “we are going over; we have a woman at the window.” One of the roof firefighter lowered the second roof firefighter on the life saving rope to the top floor window. The life saving rope was not attached to a substantial object and the life saving rope was deployed over the railing/fencing that lined the perimeter of the roof. The occupant was removed from the fire apartment through the interior. The fire was confined to a burning television.

**Lessons Learned:**

1. The life saving rope evolution shall only be attempted as a last resort when all other avenues have been eliminated.
2. Any attempt to perform the life saving rope evolution “MUST” be in strict accordance with existing procedures and guidelines.
3. Under no circumstances should a life saving rope evolution be attempted if:  
a viable substantial object is not available, the effectiveness of the anti-chafing device would be compromised due to building construction (protruding facades, exposure of the life saving rope to sharp surfaces), there are not enough members at the lowering point and at the adjoining windows or floors below to ensure a successful pick-up and retrieval of the firefighter and victim.
4. Communications between the members with the rope, members operating inside the building, and the Incident Commander (IC) are vital in all life saving rope operations.
5. Upon determining that a life saving rope rescue is the only available option, the IC may need to dispatch additional resources to the descent point as well as the floor below the pick-up point.
6. The IC must coordinate the interior operations and the life saving rope rescue attempt.
7. Portable radio communications, especially critical communications, must be acknowledged to confirm receipt.

**Report Number:** 08-0000064

**Report Date:** 02/04/2008 17:14

**Synopsis:**

Live fire exercise injures 2 training officers.

**Demographics:**

**Department type:** Paid Municipal

**Job or rank:** Training Officer

**Department shift:** 24 hours on - 48 hours off

**Age:** 34 - 42

**Years of fire service experience:** 21 - 23

**Region:** FEMA Region IV

**Service Area:** Urban

**Event Information:**

**Event type:** Training activities: formal training classes, in-station drills, multi-company drills, etc.

**Event date and time:** 04/18/2005 13:05

**Hours into the shift:** 0 - 4

**Event participation:** Involved in the event

**Weather at time of event:** Clear and Dry

**Do you think this will happen again?** Yes

**What were the contributing factors?**

- Training Issue
- Decision Making
- Equipment
- Procedure
- Staffing

**What do you believe is the loss potential?**

- Life threatening injury
- Lost time injury

**Event Description:**

On April 18, 2005, under the supervision of the Training Chief, members of Recruit Class XX were to conclude their 14-week academy with a full day of live fire scenario based training. Assisting in this training were members of Engine X, Truck X, two members of the Recruit Training Staff, one off-duty firefighter, and several members detailed to light-duty assignments. One additional reserve engine (Engine XX) was used in support of this event.

The day began with a high-rise evolution using the five story-training tower. A burn barrel was placed on the fifth floor (stoked with a minimal amount of class A materials for smoke generation – the fire was contained within a burn pan and controlled using a pressurized fire extinguisher - the tower is open air concrete masonry, noncombustible); a second “simulated” fire was set-up on the second floor (within a Denver Prop) using the department’s synthetic smoke machine. Two victims (rescue manikins) were positioned on the fifth and second floors respectively to simulate trapped occupants. Safety personnel were assigned to each floor of operation including two members on the fifth floor, one member on the

second floor. Members of the Recruit Class were assigned to their respective apparatus with a qualified driver and staged at Station X on XX Drive to await a simulated dispatch.

Engines X, XX, and Truck X were dispatched to a reported high-rise fire with victims reportedly trapped. Engine X (including two members of Recruit Class XX) arrived on scene and was assigned to lay a supply line from the yard hydrant and support the fire department connection (FDC), upon completion of this assignment, they were to deploy an attack line (using a high-rise pack) from the fourth floor and advance it to the fifth floor to knockdown any remaining fire within the burn pan - this assignment was carried out without incident.

Engine XX (including two members of the Recruit Class) was assigned to deploy a 35' ground ladder to the Bravo side of the building and remove a victim trapped on the second floor, the victim was successfully removed and a second assignment for salvage of the fourth and fifth floors were also given – these assignments were completed without incident.

Truck X (including two members of the Recruit Class) was instructed to place the aerial in service and initiate a rescue from the fifth floor, a secondary assignment for salvage of the third floor was also given; both assignments were completed without incident.

All participants were released for a brief lunch break and requested to return at 13:00hrs. The crews of Engine X and Truck X were returned to service to be replaced by the crews of Engine XX and Truck XX to complete the schedule training for the day.

At 13:05hours the Training Chief briefed the respective crews of Engine XX and Truck XX and made the necessary assignments to complete the assigned task. Several small-scale incidents were conducted including a dumpster fire, car fire, animal rescue, and a medical assist involving a school bus fire. Each incident was conducted without incident. A post-incident briefing was conducted and units were once again staged at Station X for the “grand finale” burn.

Prior to initiating the final “live-fire incident”, the Training Chief assigned two members of Truck XX as the designated RIT team, a safety line was put in place and four (4) members were assigned for ignition/interior safety (Two per floor of operation). Two fires were subsequently set (one on the first floor and one on the second floor of the burn building). The Training Chief served as the Incident Commander/Dispatcher and units were dispatched accordingly.

Upon arrival, Engine X (including two-members of the Recruit Class) was assigned to initiate a fast attack/search on Division 2 (Second Floor). Truck X (including two-members of the Recruit Class) was assigned to perform an aerial rescue of a victim visible from the second floor (Charlie side of the building). Engine XXX (including two-members of the Recruit Class) was assigned to lay a supply line to Engine X, and pull an attack line (from Engine X) for fire attack/search of the Division 1 (First floor). All assignments were actively in progress and being performed as requested.

As Truck XX (aerial ladder) was being deployed, the two instructors (Interior Safety Crew members operating on the second floor) were visible from the Charlie side window. As a crew member (Recruit Firefighter) assigned to Truck XX ascended the aerial ladder, it was noticed that the aerial ladder was not extended/positioned sufficiently to reach the Charlie side window – several attempts were made to communicate (verbally) to the firefighter ascending the aerial ladder to position himself on the safety steps to allow for further extension. At the same time, it was noticed that the two instructors visible at

the Charlie side window needed to exit the structure due to rapidly changing conditions. Confusion ensued and the two members were forced to retreat onto the aerial ladder due to extreme heat conditions. The two instructors safely exited via the deployed aerial ladder and the incident was concluded without further incident.

Following this incident, a briefing was conducted with members of The Recruit Class and the instructional staff. Two first aid reports were completed for the two instructors injured in this incident, and two damaged property reports were submitted.

**Lessons Learned:**

Investigative Findings:

- Two (2) members of the instructional staff received minor burns to their back and shoulders – one injury would subsequently require medical treatment.
- Two (2) protective helmets (one in-service helmet, and one training helmet) and coats received extensive thermal damage, while the pant leg of one member was also damaged due to burning debris on the floor.
- An excessively large stock of class “A” combustibles were staged within the burn building including stacked pallets and other related combustibles.
- Staged class “A” combustibles were positioned in areas that potentially blocked secondary means of egress for interior crews thereby creating an unnecessary safety hazard.
- An unanticipated rapid-fire spread occurred when a secondary fuel set ignited near the interior stairwell obstructing the primary path of egress for the instructors operating on the second floor.
- Interior personnel (instructors/students) were not equipped with radios for emergency communications.
- A safety line while in place, was positioned at ground level and NOT charged prior to ignition – no safety line was in place for instructors operating on the second floor.
- No ladders were deployed for secondary means of egress for crews operating within an IDLH environment.
- An inadequate number of qualified/capable personnel were on scene to support the training scenario being conducted.
- No designated safety officer was on scene.

Preventative Recommendations:

- Limit the amount of combustible fuels staged within the building for each incident. No pallets or other such contents shall be permitted to obstruct primary or secondary means of egress.
- The lead instructor and designated safety officer shall conduct a formal walk-thru to assess fuel placement prior to ignition.

- A safety briefing shall be conducted prior to each burn to include: ignition sets, order of sets, escape plans, attack plans, and scenario objectives.
- Back-up crews of sufficient personnel (Minimum of four) shall be available to relieve interior safety crews – this shall be above and beyond the designated RIT team.
- A safety line shall be positioned on each floor of operation during ignition; no instructor shall be permitted to remain in the building while crews are responding from a remote site.
- RIT team personnel shall be required to conduct a 360° evaluation of the structure every 10 minutes to properly assess the progression of the incident and the condition of the visible crew members.
- RIT team personnel shall be assigned to set-up secondary means of egress (i.e. ground ladders) if not already established by active participants.
- All interior crew members (including students/instructors) shall be equipped with a radio for personnel safety and related incident communications.
- All “Close Call” incidents shall be adequately documented and reported to the Chief’s office for review.

**Report Number:** 08-0000097

**Report Date:** 02/19/2008 15:50

**Synopsis:**

Crew experiences zero visibility taking elevator to fire floor

**Demographics:**

**Department type:** Paid Municipal

**Job or rank:** Captain

**Department shift:** 24 hours on - 24 hours off

**Age:** 34 - 42

**Years of fire service experience:** 17 - 20

**Region:** FEMA Region VII

**Service Area:** Urban

**Event Information:**

**Event type:** Fire emergency event: structure fire, vehicle fire, wildland fire, etc.

**Event date and time:** 12/06/2007 14:30

**Event participation:** Witnessed event but not directly involved in the event

**Weather at time of event:** Cloudy and Snow

**Do you think this will happen again?**

**What were the contributing factors?**

- SOP / SOG
- Procedure
- Decision Making
- Situational Awareness

**What do you believe is the loss potential?**

- Life threatening injury

**Event Description:**

The department was dispatched for a fire alarm with smoke reported on the 5th floor of a five story class one building. The occupancy is a multi-residence, 100 unit, 150' x 150', U shaped building constructed in the early 1900's. It has two stair wells and two wet standpipes. The on-duty Assistant Chief arrived and established command. He observed light smoke rising from the B side. The first arriving engine was running with an acting Captain that day. The acting Captain had 28 years of experience. He and a firefighter with 7 years experience entered the lobby. A police officer met them and reported the problem as smoke in apartment 518.

The crew carries forcible entry tools and high rise pack. The fire fighter suggested taking the stairs to investigate. The acting Captain over rode this proper procedure and decided to take the elevator to the 5th floor. The police officer said he would come along to assist. When the elevator opened on the 5th floor they were met with heavy smoke banked to the floor. It was zero visibility but not great heat. The door would not close and return to a lower floor. Possible because of equipment dropped in the doorway. The fire fighters donned their face pieces but the police officer was in an IDLH situation. The fire fighters told him to stay put and they left the elevator to find an apartment to enter for shelter. They found an apartment they could enter, returned to the officer and lead him to the apartment. The officer at this point was having much trouble breathing. The acting Captain shared his facepiece with the police officer as they crawled to the apartment. The apartment was on the A side. A female occupant was in this apartment. A 105" ladder was raised to this apartment window and the officer with smoke inhalation exited out onto the ladder. Due to his smoke inhalation he had difficulty and almost fell off the ladder.

The original fire fighters returned to the hallway with the high rise pack and crawled towards apartment 518. The apartment was fully involved and had burned through the entry door and extended into the hall. The fire was extinguished without any great difficulty from this point. Additional units arrived during this time to establish ventilation and search and rescue operations on the 5th floor.

The police officer was transported to a hospital and admitted with smoke inhalation. Due to the experience and abilities of these first fire fighters they were able to think their way out of this bad situation and recover to have a happy ending. It was a very bad broken play that turned into a "Hail Mary." If other members of this Department with less experience and ability had made these same mistakes it would have ended in at least a fatality of the police officer.

**Lessons Learned:**

The building had a pre-plan in the first arriving command vehicle with diagrams of all floors and information on stairs, stand pipes and apartment locations. Use the pre-plan! It might be a real fire not a pan of food over cooked. It was not used until the fire had been knocked down. The Incident Commander and all fire crews CAN NOT read smoke and fire conditions in this type and size of building from the exterior. The apartments on the B and C sides have windows of wired glass that did not break under the intense fire conditions. This helped hide the fire and smoke conditions in the fire apartment. Do not be surprised to find a working fire when you have been dispatched to a fire! Never take the elevator in a 5 story building when dispatched to a fire alarm. Walk the stairs. Never take police or civilians into an area that could be hazardous to them.

It comes down to being fully engaged, situational awareness, make smart decisions, and follow SOP's. Make tactical decisions on worse case scenarios. Follow your training and use the pre-plan on all responses. When a working fire occurs it will come as second nature.

**Report Number:** 08-0000154

**Report Date:** 03/25/2008 08:04

**Synopsis:**

Exterior crews operating on High Rise fire advise fire being drawn back into unit.

**Demographics:**

**Department type:** Paid Municipal

**Job or rank:** Lieutenant

**Department shift:** 24 hours on - 72 hours off

**Age:** 43 - 51

**Years of fire service experience:** 21 - 23

**Region:** FEMA Region II

**Service Area:** Urban

**Event Information:**

**Event type:** Fire emergency event: structure fire, vehicle fire, wildland fire, etc.

**Event date and time:** 02/01/2008 00:00

**Event participation:** Told of event, but neither involved nor witnessed event

**Weather at time of event:** Clear and Dry

**What were the contributing factors?**

- Teamwork
- Situational Awareness
- Communication

**What do you believe is the loss potential?**

- Life threatening injury

**Event Description:**

Units responded to a reported fire in a 19 story fireproof high rise multiple dwelling. Upon arrival, fire was venting out a second floor window. When the first ladder company exited the stairway on the second floor, they encountered a smoke and heat condition in the hallway. The inside team entered the hallway to locate the fire apartment and conduct searches and confine the fire. Advancing into the apartment, the inside team located the fire in a rear bedroom but was unable to confine the fire. The first engine was still in the process of stretching a hose line when the ladder company chauffeur of the first ladder company started monitoring conditions from the exterior and noticed a change in fire behavior. Fire that was venting out the second floor window a short time earlier was now being drawn back into the apartment. This information was conveyed to the first ladder, inside team now operating in the apartment. The officer, aware a charged hose line, was not in position and that fire conditions were now changing. He suspended the primary search and ordered the inside team out of the apartment. The team closed the apartment door behind them. The fire eventually involved the entire apartment before a charged hose line was in position at the apartment door.

**Lessons Learned:**

1. Wind driven fires can occur on any floor; even lower floors.
2. Continually monitoring radio transmissions will increase situational awareness.
3. Members operating outside buildings should report changes in fire behavior to units operating inside buildings and the Incident Commander. Information on fire direction, travel and intensity may prompt units to alter tactics. It is essential that any change in tactics be reported to the IC. These communications must get through.

4. Maintaining control of apartment and stairway doors is critical to a safe operation.
5. Effective radio communications prompted the first ladder officer to alter tactics. Training and effective communication improve decision making.
6. Conditions on the fire ground can change quickly. Have an alternate plan to ensure member's safety if conditions deteriorate.

**Report Number:** 09-0001106

**Report Date:** 12/17/2009 11:53

**Synopsis:**

Lack of training causes difficulty.

**Demographics:**

**Department type:** Paid Municipal

**Job or rank:** Fire Fighter

**Department shift:** 10 hour days, 14 hour nights (2-2-4)

**Age:** 43 - 51

**Years of fire service experience:** 17 - 20

**Region:** Canada

**Service Area:** Urban

**Event Information:**

**Event type:** Fire emergency event: structure fire, vehicle fire, wildland fire, etc.

**Event date and time:** 02/28/2008 02:00

**Event participation:** Involved in the event

**What were the contributing factors?**

- Procedure
- Situational Awareness
- Decision Making

- SOP / SOG
- Training Issue

**What do you believe is the loss potential?**

- Life threatening injury
- Lost time injury

**Event Description:**

This is a report of an incident that I was involved in that could easily have resulted in multiple fire fighter deaths. As far as near-misses go, this was very close. I had worked as a nozzle man out of one of our downtown fire stations for about a year. Sadly, my department had given me no training as a nozzle man and had no documented procedures on high-rise strategy and tactics. Each platoon performed their high-rise operations using their own unique methods. Since the incident there has been lots of talk, but little has been done to rectify the causes that created this situation. We did get an in-station computer course on elevators.

Immediately on arrival, FF [1] and I entered the lobby of the high rise building. The pump crew had already been to the alarm panel and was headed for the elevator when we joined them. The information that came over the radio was that the panel was showing an alarm on the 32nd floor. I entered the small North West elevator with Captain [1], Nozzle man [1], FF [1], FF [2], Probationary FF [1].

As we ascended in the elevator, word came over the radio from Lt. [1], that a light on the panel was showing an alarm on the 19th floor as well. Captain [1] made the decision to check the 19th on the way up. When we exited the elevator on the 19th floor, we checked for any indication of trouble. The floor was free of smoke: This stop gave us an idea of the buildings floor plan. The six of us re-entered the elevator and headed to the 32nd floor. When the elevator door opened on the 32nd floor, there was a blast of heat and dense black smoke that instantly filled the elevator. I could not see the other fire fighters standing next to me. Opening the elevator appeared to create a chimney effect. FF [1] made several unsuccessful attempts to close the elevator door. It appeared that the elevator was in normal operation mode, which means that the door must fully open before it will close. All six fire fighters in the elevator dropped their hose packs, high-rise packs and helmets in an attempt to mask up. I managed to don the face piece but had considerable difficulty getting the regulator to dock with it. After taking several breaths of the seriously contaminated atmosphere, I called out that I was going to attempt to find the fire door to the hallway. My hope was to find clear enough air to finish docking my regulator. I made the assumption that each floor plan was similar and that the fire door to the hallway was on my left. Upon leaving the elevator, I immediately moved in that direction. I found the door and after a few seconds found the door handle and opened the door. Just inside the fire door a woman was standing in her doorway asking what was happening. I escorted her back in her apartment and asked her to remain inside until I returned. I docked my regulator and reentered the elevator lobby trying to find the rest of the fire crew. The elevator doors were closed. I attempted to open the doors but could not. I moved back into the hallway and found Capt. [1], Nozzle man [1], FF [2]. I still did not know where FF [1] and PFF [1] had gone to. My concern was that they were still in the elevator and in trouble. It was at this time that I was told that they had gotten the elevator to the 31st floor and that they were running hose from the standpipe there to the 32nd floor. Nozzle man [1] was breaking glass in the house fire hose cabinet and he handed me the nozzle. The fire was knocked down quickly. Immediately after the fire was knocked down the door to the West stairwell was opened and the crew was re-united on the hallway side of the fire door. PFF [1] and I did a quick overhaul. I meet with nozzle man [1] in the hallway

and we moved our crew to the roof for fresh air via the West stairwell. The peak readings on the detector that I saw where: 1950 PPM CO and 13.5% O2. I discussed the readings with nozzle man [1] and we re-entered the stairwell to let Capt. [1] know that we where heading to the ground level to see EMS. We were transported to the hospital, spent some time on oxygen, got some blood work done and we were cleared for light duty by the doctor. District Chief [1] gave us the rest of the shift and the last night shift off.

**Lessons Learned:**

Primary personal learning was that my training was completely inadequate and that our nonexistent SOP's were also completely inadequate.

Additional Learning

- 1: Improve fire code enforcement (elevator controls)
- 2: develop consistent protocols (any protocols)
- 3: stop a floor below (or 2)
- 4: ensure fire control of the elevator (if not, hump the stairs)
- 5: pre-connect regulator to the face piece
- 6: review radio communications volume controls and feed back benchmarks emergency situations (may days, accountability .....)

The response of my administration was sad, really. I set up this chronology for use during the so called critique, and to help me understand how the time line played out. According to the communications logs, from the time we opened the elevator door to the time that overhaul was complete was 6 minutes. It certainly felt much longer.

**Report Number:** 10-0000560

**Report Date:** 03/25/2010 14:41

**Synopsis:**

Hose from hose cabinet at apartment fire proves unreliable.

**Demographics:**

**Department type:** Paid Municipal

**Job or rank:** Fire Fighter

**Department shift:** 10 hour days, 14 hour nights (2-2-4)

**Age:** 25 - 33

**Years of fire service experience:** 0 - 3

**Region:** FEMA Region I

**Service Area:** Urban

**Event Information:**

**Event type:** Fire emergency event: structure fire, vehicle fire, wildland fire, etc.

**Event date and time:** 03/25/1997 00:00

**Hours into the shift:** 5 - 8

**Event participation:** Told of event, but neither involved nor witnessed event

**Weather at time of event:** Clear and Dry

**Do you think this will happen again?** Yes

**Event Description:**

We responded to a building fire in the sixth floor of a large brick apartment building. It was a room and contents fire. The first arriving company proceeded to the fire floor without a high-rise pack and encountered heavy smoke conditions on the fire floor. Arriving at the apartment involved in fire, the crew grabbed the building's safety hose that was attached to the standpipe in a cabinet in the hall and charged the line. The old, cloth-jacketed hose line ruptured shortly after the crew had entered the apartment and began fire attack. After losing water pressure, the crew soon found themselves cut off from exit inside the apartment and had to make their way to the balcony and await rescue via aerial ladder.

**Lessons Learned:**

Fire crews must remember, never rely on building safety hose, always bring in high-rise packs on suspected fires in high-rises.

**Report Number:** 10-0000585

**Report Date:** 03/26/2010 15:07

**Synopsis:**

Communication error has potential to harm.

**Demographics:**

**Department type:** Paid Municipal

**Job or rank:** Fire Fighter

**Department shift:** 24 hours on - 24 hours off (4s & 6s)

**Age:** 34 - 42

**Years of fire service experience:** 4 - 6

**Region:** FEMA Region I

**Service Area:** Suburban

**Event Information:**

**Event type:** Fire emergency event: structure fire, vehicle fire, wildland fire, etc.

**Event date and time:** 03/23/2006 17:30

**Hours into the shift:** 9 - 12

**Event participation:** Involved in the event

**Weather at time of event:** Clear and Dry

**Do you think this will happen again?** Yes

**What were the contributing factors?**

- Human Error
- Individual Action
- Communication

**What do you believe is the loss potential?**

- Minor injury
- Property damage
- Life threatening injury

**Event Description:**

The company responded to a box alarm of an apartment fire in a high rise building. The fire was a chair on fire. It was quickly extinguished and after overhaul it is determined that the chair would be sent out the window. I was asked, as the man on the ground, if the parking lot was clear. I responded it was and the chair was sent out into a totally different parking lot. It came out a window in the parking lot behind me.

**Lessons Learned:**

- Always make eye contact (if possible) with the person dropping the object.
- Confirm what side of the building we are talking about (A side, B side...).
- Do not assume.

**Report Number:** 10-0000588

**Report Date:** 03/26/2010 15:18

**Synopsis:**

Elevator rescue procedure turns dangerous.

**Demographics:**

**Department type:** Paid Municipal

**Job or rank:** Fire Fighter

**Department shift:** 24 hours on - 72 hours off

**Age:** 34 - 42

**Region:** FEMA Region I

**Service Area:** Suburban

**Event Information:**

**Event type:** Non-fire emergency event: auto extrication, technical rescue, emergency medical call, service calls, etc

**Event date and time:** 03/26/2010 03:09

**Event participation:** Involved in the event

**Weather at time of event:** Not reported

**What were the contributing factors?**

- Training Issue
- Human Error
- Decision Making
- Situational Awareness
- Procedure

**Event Description:**

My engine was dispatched to a high-rise, elderly housing complex, with an elderly woman trapped in the elevator, in distress. Older elevators have a small door which we pried open to get to the other elevator. I stepped out of the elevator and opened up the other elevator door. The woman pushed in the stop

button, I pulled it out. I then walked out of the elevator, standing on a steel beam between the two elevators. As soon as I stepped out of the elevator, the elevator shot down from the seventh floor. One second earlier and I could have been killed.

**Lessons Learned:**

The first lesson is to never try this again. Never pass through from elevator to elevator. We now have an SOP stating that we shut down power to the elevator and call the elevator company. This event bothers me to this day, knowing that I could have lost my life for trying to help a conscious person in no apparent danger.

**Report Number:** 11-0000089

**Report Date:** 02/15/2011 12:43

**Synopsis:**

Radio communications inhibited by water at hi-rise fire.

**Demographics:**

**Department type:** Paid Municipal

**Job or rank:** Lieutenant

**Region:** FEMA Region V

**Service Area:** Urban

**Event Information:**

**Event type:** Fire emergency event: structure fire, vehicle fire, wild land fire, etc.

**Event date and time:** 01/28/2011 00:00

**Event participation:** Involved in the event

**Event Description:**

During the course of a working fire in an eight story high rise, all radio communications were blocked due to a faulty radio. In this instance the incident was de-escalating. However, due to the nature of this if we had been operating in a more aggressive mode, all companies may have been compromised. The Engine officer had been operating under a flowing sprinkler head which thankfully held the fire in check until the standpipe stretch was made. During this time he said that his radio had been soaked by the water flowing. It was at approximately the same time that no one was able to communicate via radio.

The fire-ground radio channel we use sounded like there was an open microphone. The Incident Commander was able to see who was calling him on the faceplate of his mobile radio in the command vehicle, but no voice was heard. The engine officer noticed that his radio was making buzzing and clicking sounds and he turned it off, which then allowed all communication to begin again. This whole scenario lasted several minutes.

**Lessons Learned:**

The very next day the staff who handles radio maintenance began to look into the problem. They examined the suspect radio and found no obvious visual defects. They then gave the radio a dousing with water and were able to replicate this scenario exactly. What we found is that our department is in a consolidated dispatching center with numerous cities. After being awarded a sizeable grant a few years ago, all radios for the cities were upgraded to a digital radio that operates on the MARCS system. When the equipment was purchased, the lapel microphones specified were not water resistant and not rated for firefighting use. Since the incident, all lapel microphones have been removed and are being replaced with water resistant firefighting rated microphones. Fortunately this incident was past the initial stages and was de-escalating when the failure occurred. Thankfully no one was hurt- this time.