



National Fire Fighter Near-Miss Reporting System:

January 2012 Reports

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Report Number: 12-0000001

Synopsis: Low-pressure hose failure found during daily check.

Event Description: During a regular daily/weekly check of an SCBA on the first-due engine the low pressure hose on the face piece regulator failed. The firefighter checking the SCBA brought the issue to my attention. No obvious external damage to the hose was found. In 20 years, I have never experienced such a failure on our SCBA.

Lessons Learned: This goes to prove how important regular inspection of our equipment and PPE is. All of our SCBA are checked daily on first due apparatus and weekly for all other apparatus. They are flow tested annually by authorized SCBA technicians and maintenance records are kept for the life of the SCBA.

Ensuring we have strong standard operating procedures and that they are followed may have prevented a bad situation. Had this daily check not been performed, the failure may have occurred during operations at an IDLH event.

Report Number: 12-0000002

Synopsis: Citizen delivers IED to firehouse.

Event Description: Shortly after shift change, a knock at the office door was answered to find an elderly citizen apparently in need of some sort of non-emergency assistance. The citizen was immediately asked in out of the cold by a very compassionate acting officer. The patient turned toward his vehicle, nonchalantly explaining that he had found an unexploded pipe bomb outside his home, which he promptly first dropped to the pavement clumsily, than handed to the acting officer. In his hand he held an unexploded, wick-fused, iron pipe bomb roughly the size and shape of a couple rolls of nickels placed end to end. The ends were crudely sealed to form an effective capsule. The wick/fuse was apparently constructed using several segments of M80 type fireworks fuses crimped together with steel crimps forming a wick about 6" long, each segment being about an inch or so. The wick had apparently burned to the first crimp and self-extinguished.

All of this was being explained to the acting officer as the citizen had closely examined the device prior to transporting it to the local sheriff station and then my fire station, having found no one available at the sheriff station. The device appeared, to the acting officer, to be stable and relatively innocuous as its fuse was unlit, and he had no intention of lighting it intentionally or otherwise. Further risk evaluation led the acting officer to decide not to leave the device outside where the public could come into contact with it but instead to bring it into the controlled environment of his office where he could keep an eye on it while he contacted the appropriate authorities to deal with the device. The acting officer sat the device on the desk, recorded the citizen's information and thanked him, advising him that should he find himself in a similar situation in the future his best course of action would be to leave the device where he found it and call 9-1-1 so that the proper authorities could mitigate the hazard as safely as possible (this particular bit of irony was wasted on the acting officer at that time...it has since been COMPLETELY recognized).

The acting officer contacted the non-emergency law enforcement line, explained the situation and was told an officer would respond shortly. Within 5 - 10 minutes a sheriff unit arrived and asked if somebody

had reported a pipe bomb. The acting officer explained that, yes, he had called it in. The sheriff asked where it was and the acting officer indicated it was in the office, about 15 feet away, in full view. At this point, the acting officer was advised to leave the building, and ensure no other personnel were inside, immediately. On discussing the situation further with the sheriff, it was determined that the device was to be robotically removed from the structure, placed in a sandbag bomb chamber, "vented" (one end removed), and then blown in place in the parking lot (now evacuated) of the fire station. Bomb technicians arrived with the robot; the device was removed and destroyed under shelter without further incident. This occurred while Fire and Sheriff personnel and apparatus denied public access from any direction for 100 meters.

The sheriff's parting advice was direct, brief and to the point. "Next time just put it down, walk away, and call us. You can't protect the public if you blow yourselves up.

Lessons Learned: 1: We don't always go to emergencies, sometimes they come to us. These are the most dangerous as there is no time or normal cues (alarm tones, sirens, radio traffic etc.) to prompt the subconscious conversion from day-to-day, to high risk situational awareness. Stay Situation ally Alert AT ALL TIMES.

2: ALL EXPLOSIVES ARE LIVE AND UNSTABLE UNTIL PROVEN OTHERWISE---PERIOD---THE END.

3: IED's can be intentionally disguised to look harmless and stable for the specific purpose of injuring those that "fall for it" (that wick-fuse may well be a simple diversion while another detonation method is employed).

4: Firefighters are neither bulletproof nor bombproof.

Prevention / Correction

1: Periodic and regular awareness training for fire personnel regarding explosives and IED's.

2: Clear guidance (SOG's SOP's) for dealing with explosives / IED's happened upon either emergency calls or throughout the performance of non-response activities.

3: Public education regarding procedures for dealing with explosives. JUST CALL 911.

4: Active learning by department personnel (especially those in charge of the well-being of others) about any and all possible risks they may face. (Even a non-booby trapped garage-made wick-fused pipe bomb has the potential to "sympathetically detonate" from a vehicle backfire, nearby static charge, or even being dropped on the pavement by a Good Samaritan).

5: Remind your firefighters that they are neither bulletproof nor bombproof on a regular basis.

Report Number: 12-0000003

Synopsis: Truck check reveals improper hose load.

Event Description: While performing a routine "Truck Check" it was discovered that the bumper (trash line) was repacked from hose testing and 1 1/2" hose had been packed instead of the normal 1 3/4" hose. Although appearing to be a minor issue to some of our younger members, a brief class in flow and friction loss revealed the difference in the capability of flows with the different hoses. It was an easy issue; however all of our 1 1/2" hose is white and only used on our forestry unit whereas the 1 3/4" hose is either orange or yellow as this is the size of hose carried on all pumpers for pre-connected attack lines. If this wasn't discovered prior to an incident it could have resulted in personal injury due to the fact that the crew may have thought they were flowing a 1 3/4" line instead of the 1 1/2" line providing a reduced flow. This was followed with a brief training exercise and update to all members about the difference in hose size color and use to hopefully prevent a recurrence of the event.

Lessons Learned: All 1 3/4" hose is either orange or yellow and all 1 1/2" hose is white. It was a matter of someone not paying attention when repacking the hose. After this event, all the hose storage racks were marked for the appropriate size hose to be stored and the colors of that hose.

Report Number: 12-0000004

Synopsis: Pre-collapse indicators recognized by attack crew.

Event Description: The first due engine company arrived on scene of a large two-story house fire. The building was half-involved and pressurized black smoke was coming from all sides of the building. Before stretching a hose line, an explosion was heard. A neighbor informed the first-arriving unit that the fire started in the basement and there was someone trapped on the second floor. The first-arriving engine stretched a 1 3/4" hand line and entered the building through the front door with the first-due ladder company. Ten to fifteen feet into the building, one firefighter noticed fire visible through the floor that the crews were walking on. The two crews quickly backed out of the building and began defensive operations from the front porch. A couple minutes after going defensive, the interior floor inside the front door collapsed into heavy flames. A short time later, the roof structure over the front porch collapsed near several firefighters, close enough to knock off the helmet of one firefighter. After these near misses, defensive operations continued without incident.

Lessons Learned: Departments should review SOGs and make sure SOGs are in place that address victim survivability and hose line selection. Company officers and company officer candidates should be required to review case studies of different types of fires and procedures appropriate to various fire scenarios.

Report Number: 12-0000005

Synopsis: Oncoming unit avoids striking FFs in path.

Event Description: On January 13, 2012, we were sent to [address deleted] for a reported dwelling fire. I was driving Truck [1] and as we approached the scene, we were advised to position on the alpha side of the dwelling. As we were passing Tanker [1] (already on the scene), three of Tanker [1]'s crew members came running out from in front of their tanker carrying a porta-tank. They walked right into the Truck [1]'s path. I slammed on the brakes of the truck. Luckily, we were moving slowly enough that I was able to stop before hitting any of the crew members. The three members got out of the way and we continued with our assigned position.

Lessons Learned: Expect the unexpected. As with intersections, always expect someone to come from a blind area into your pathway. Be moving in such a manner as to be able to stop as quickly as possible.

Report Number: 12-0000006

Synopsis: Fire officer slips while mounting apparatus.

Event Description: A Fire Captain slipped while mounting the fire apparatus during an activated alarm response, hitting his knee on the mounting step. He stated he heard a pop and then felt pain in his right knee

Lessons Learned: Instruct all crew members to use handles when mounting and dismounting fire apparatus.

Report Number: 12-0000007

Synopsis: Water tank found empty after training drill.

Event Description: I was taking my Apparatus Operator (AO) final exam and had one more event to do. It was a blitz attack with the deck gun. I used the entire tank of water for the evolution. I passed the test with flying colors, and then proceeded to load our 5" inch hose from the previous events. At the same time a TRT drill was being conducted, which we were supposed to take part in, but the AO test lasted longer than expected. After loading the 5" inch hose, we proceeded directly to the drill. After the drill, my company popped two medical calls back to back. As we were heading home after the second call, a box alarm came in. We were very close and ended up being the first arriving engine. Two pre-connect lines are pulled right away. I charged both lines and made sure there were no kinks or anything tying up the lines. I return to pump panel to find my tank level lights blinking red, telling me I was almost out of

water. I radioed to command and stated I was almost out of water. I thought at first that the fire attack had gone through my whole tank already. I then realized I did not fill my tank after my AO test. I was able to establish a water supply from the next-in engine quickly, but there was still no excuse for my mistake.

Lessons Learned: There are many lessons to be learned from this event. I believe this could happen to anyone. First lesson would be to slow down. Just because there are millions things that have to be done, doesn't mean you need to go 100 mph to do them. The engine schedule that day was packed with things to do, and I rushed trying to finish them all quickly. I needed to slow down and check my boxes on the daily checklist. I should have first filled my tank and then loaded my hose. I should have checked and made sure my engine was back in service and ready to respond. Just because you have things to do whether it's personal or simple stuff around the station, there are tasks that need to take priority first. Training is very important, but in this case training should of came second and my engine's preparedness first.

Another lesson that could apply would be not to become complacent. Follow the same routine every day at work, such as simply checking the equipment in the morning as soon as you get to work, checking that you have water in your tank, and your life pack has fully charged batteries. Then get a cup of coffee. Never assume everything is fine on the engine, it can come back and bite you. The crew coming off might say everything is fine, but they might have forgotten to fill the tank or restock the EMS kits. They might not mean to do it, but after a long night of calls, it can happen very easily. Now it falls on you, so checking your boxes could save you a lot of heart ache one day.

Report Number: 12-0000008

Synopsis: Vehicle speeds through accident scene.

Event Description: Our engine and medic unit had responded to a traffic accident on a divided highway. The engine company was providing blocking with the operator side facing the highway traffic in the slow lane. The patient refused care/treatment/transport and the medic crew had left the scene. There was a State Patrol officer and a local County Sheriff unit with lights on behind the engine on the shoulder of the highway. The engine company with a crew of three (Company Officer, Engineer and Boot) was putting the last of their equipment away as I, the engineer, was going to pick up my wheel chocks. I was facing traffic trying to keep my situational awareness. I bent over and looked down to grab the wheel chock.

As I did this, I realized that something had not looked right. I looked back up to see a vehicle in the slow lane rapidly approaching the engine. I began walking back to the tailboard area of the engine when I realized the driver of the vehicle wasn't getting over. I dropped the wheel chock and ran. I am not sure how close the vehicle came to me or my engine, but it was close enough to give me the shakes for a few hours. The engine was not struck and I was the only witness to the incident. I had put my traffic vest on prior to leaving the apparatus in full PPE for a traffic accident. Upon exiting the apparatus, the vest fell off the sides and shoulders, which were held on by Velcro. I went to the non-traffic side and put a different vest on. After setting the chocks, the vest came apart again. I left it off at this point.

Lessons Learned: Place the apparatus where all occupants can enter and exit safely (nosing the apparatus in, instead of out into traffic). Develop SOP/SOGs for having two members watching traffic if a member (typically the engineer) must exit or enter the apparatus from the traffic side to help maintain situational awareness. Stress the importance of wearing the ANSI rated traffic vest. Train on vehicle positioning (I do not think we have actually practiced it but have only discussed it). Set out cones as an extra way to notify drivers that a highway lane is closed ahead.

Report Number: 12-0000009

Synopsis: Member struck by exhaust removal hose.

Event Description: I am a Deputy Fire Chief for the [department name omitted] located in [name omitted] Township five minutes outside of the city of [name omitted]. Last evening my department had what was reported to me as a Near-Miss Incident. My department, which is all volunteer and has a live-in program, responds to nearly 2000 runs per year. This incident occurred during a response for reported gas inside a residence. The live-in crew was about to respond when the home responders started to arrive at the engine house. The engine crew, who had filled all the seats on the first due engine, started out at the same time a home responding member attempted to verify if the rig was full or not and gain access to a seat. While in this process, the exhaust hose connected to the apparatus on the officer side started to move with the apparatus as was normal. The member was then hit by the hose and almost lost his balance, which could have led to him falling to the ground and under the wheels. This incident was reported and a policy is being developed to address any potential future incidents. No one was injured during this incident.

Lessons Learned: The lesson learned from this is that situational awareness needs to be more elevated. There are many policies in place for verification of seating on the apparatus. We do use a riding assignment board and an officer is always assigned to each apparatus. Both members have been counseled as to what is expected and both have given input as to how they feel this could be corrected.

Report Number: 12-0000010

Synopsis: Good SA protects FFs at structure fire.

Event Description: Our department responded to a residential structure fire reported from a neighborhood near our headquarters station. Upon arrival we were faced with a heavily involved garage fire that was spreading into the attic of the house. We started a fire attack on the burning garage from the exterior with a 2.5" hose and a team consisting of two firefighters and myself. During

the attack, our team positioned themselves on the empty driveway and had moved to within several feet of the burning garage. Our assistant fire chief was functioning as an operations manager from the front yard, giving direction to crew members entering the front door. As he was doing this, he noticed from the side of the garage the brick veneer wall above the garage door had begun to bow out and was leaning towards our location in the driveway. From our vantage point we could not see that the structure supporting brick veneer had burnt away. During our initial attack the extent of damage to the structure was somewhat hidden by the flames and smoke. As we began to knock the fire down, the assistant fire chief recognized the signs of an unsupported brick veneer wall that was in imminent danger of collapse. He immediately came over and moved our attack team back roughly 15 feet away from the garage. Not more than 30 seconds after we repositioned, the entire brick veneer wall pulled away from the destroyed framework and collapsed onto the driveway with debris tumbling right up to the feet of the hose team. Both the chief and I ran up to the firefighters checking for injuries and found them to be ok. From our vantage point in the driveway the wall appeared flat and gave no signs of potential collapse.

Lessons Learned: The importance of recognizing the potential for structural collapse during a fire cannot be overstated. Adhering to the principle of knowing the collapse zone and staying clear becomes critical. Residential structures built using brick veneer should always be suspect to failure when a heavy fire condition exists in the area of the wood framing adjacent to the wall. Always play it safe and keep personnel away from these such veneer walls should you discover those significant conditions and consider the time the fire has acted upon them. Acting immediately and not waiting to see what happens is the final step. Step in, use a "lean forward" attitude and correct the situation before something goes wrong.

Report Number: 12-0000011

Synopsis: Rescue unit avoids hitting chief.

Event Description: Friday evening at approximately 20:17 hours, I, as pump operator positioned the engine in front of a structure. I exited the vehicle and, after applying the brake and engaging the pump, grabbed a portable radio. I attached the radio to my bunker pants and went to the rear of the engine and removed a section of 5" hose to the coupling. Initially, I took the 5" to the driver's side, changed my mind and then took it to the passenger side intake and connected it. When moving from the driver's side to the passenger side, the radio flew off my bunker pants and landed approximately 10' away from the pump panel on the blacktop. As I came back around I went to pick up the radio. As I was bending over, I looked to my left and, within arm's reach, was Rescue [1], stopping just before they struck me.

Lessons Learned: Always be aware of your surroundings. Never take anything for granted. Keep apparatus further away if possible when arriving on scene. Ensure proper communications are given and understood.

Report Number: 12-0000013

Synopsis: Hidden power line surprises crew.

Event Description: During a response to a fire involving a vehicle and grass, I was spraying water in the vehicle to put the fire out. There was a large sparking event in the vehicle. I thought it was some molten metal that had sparked so I continued putting the fire out. There were several more sparking events. I looked around and could not see any sign of any electrical systems in the area. At this time we got the fire put out, tipped the car on its side using a rope, set the car back down, and continued walking around the vehicle mopping up. It was the next day that I was informed that the sparking we observed was from a live, 440 volt, underground electrical system that had somehow been exposed. This could have killed or injured one or both of us.

Lessons Learned: We later found out that this was a wire that someone had put in place to illegally tap into the electricity. No way to prevent another incident like this. This wire should have never been exposed. I should have recognized the sparking was electricity, but we were out in the middle of some agricultural fields and the last thing we expected was an electric wire in that location.

Report Number: 12-0000014

Synopsis: Situational awareness of officer protects crew.

Event Description: Our engine and medic were dispatched to an ALS call at a government complex in our first due. The patient was found quickly, assessed, and packaged. As another firefighter and myself moved the cot towards the medic unit into the street and around the engine, a pickup truck whipped around the blind spot created by the engine. My officer had been watching us as we moved the patient, so was aware of the pickup truck for a split second before I was. The officer jumped out from behind the engine to make the driver of the pickup truck aware that we were there, and the driver was able to stop, albeit only a few feet from myself and the patient. The driver of the pickup truck seemed unaware until that moment that the rigs were there, even with their emergency signals active.

Lessons Learned: If our officer had not been looking out for us, and keeping an eye on what was going on behind the engine, it is extremely likely that the cot (with patient) and myself would have been struck by the vehicle. To prevent this in the future, traffic control devices could be used, and other personnel not directly involved in moving the patient could be used to watch the road and traffic flow around the rigs and personnel.

I also learned, no matter how light traffic is, how slow a road is, or how controlled the facility you have responded to, you should absolutely always expect there to be vehicles which could strike you.

Report Number: 12-0000016

Synopsis: Patient wakes up with gun in hand.

Event Description: This morning the engine and paramedic crew responded to a medical alarm with no contact. We were advised of key location information over the Mobile Data Computer and upon our arrival we checked for the key but did not find it. I asked if the alarm company had any contact information for a key holder before we forced entry into the residence. I was advised that they located a possible key holder at the residence. A police officer responded to see if they had a key for the residence. The police officer returned with a key for the home and entry was made. Upon entry into the home, the police officer and I announced our presence with no answer or indication anyone was present in the home. A secured door was located on the first floor in the northeast corner of the home. The lock was a simple push lock and it was unlocked using an ink pen. The police officer opened the door and saw an elderly man come up from the bed with a gun and the police officer announced that there was a man with a gun. The police officer attempted to talk to the subject. I informed the police officer that I was notifying dispatch of the man with a gun and additional back-up personnel. I then began to work on how to get the rest of the crew out of the living room and out of the house safely. I advised the crew one at a time to head across the living room back towards the front door and out of the building. Additional police officers arrived on location and after a short time they advised that the scene was secure. The patient had been tased once in the stomach. The "Taser" probes had been removed by police officers prior to our re-entry. Paramedics treated the patient and transported him.

Lessons Learned: It is important when responding to medical alarms to ensure we are requesting the assistance of law enforcement, especially if there is a need to force entry or even use a key provided. You can startle a homeowner and they might have a gun and use it. Worse yet, they might be unstable due to a medical condition. Staying aware of your surroundings and keeping a way out to retreat in the event that the incident goes south is very important.

Report Number: 12-0000018

Synopsis: Electrical hazard goes unnoticed by busy crews.

Event Description: Units responded to a commercial building for a report of an electrical short and smoke inside the structure. Upon arrival, the IC assigned an engine company to the interior of the structure to investigate and a squad company to R.I.T. and to complete a 360 of the building. Interior

crews reported an all clear primary search with no smoke or fire inside the building. The squad company reported that the metal power pole running up the rear of the structure was blown off of the electrical pedestal and the main power line was down on the chain link fencing near the "C/D" corner of the building.

A truck company was assigned to the roof to check for fire and damage. Ladders were placed on the "D" side near the "A" corner and also the "C" side near the "B" corner. One firefighter had already climbed the ladder to the roof at the "B/C" corner when personnel from R.I.T. noticed that the ladder (aluminum) was resting against part of the building's wiring that ran parallel to the roofline. This could have led to injury or death for the firefighter. A third ladder was placed on the "B" side near the "C" corner away from the lines and the truck company completed the assignment. To keep bystanders away from the rear of the structure, caution tape was placed from the "B/C" corner of the building to the chain link fencing of the commercial business to the south.

After all companies had completed assignments and were reloading equipment, it was also noted that the chain link fencing contacting the main power supply was conductively connected to the same fencing the caution tape was attached to. The fencing was contiguous all the way down to a third business to the south although it was difficult to see due to smaller structures and items that prevented view. Had this fencing been energized by the fallen power line, firefighters and civilians could have been injured or killed as well.

Lessons Learned: The truck company looked for overhead power lines prior to throwing ladders, but failed to see the wires that the ladder was resting against at the roof line. Be aware that something caused the electrical power supply to violently blow out the steel electrical pole from the panel and to watch placement of ladders in relation to ALL wires running to and from the building. Crews were advised of the need to remain clear of the "C/D" corner of the building where the main power line was lying on top of the chain link fencing, but crews did not have the foresight to look at where the electricity could have been routed to when working on the "B/C" corner fencing.

Report Number: 12-0000019

Synopsis: Alert tanker driver averts collision.

Event Description: A tanker was blocking the slow lane of a two-lane major highway. Traffic was very heavy. A transport truck was unable to merge into the fast lane and slid on the ice trying to stop. The tanker driver noticed this happening in the rearview mirror and moved the tanker forward. The transport missed the tanker by a foot. Pylons were destroyed and the truck driver never slowed down. We are still investigating adding reflective chevrons to the back of the blocker and also a raised traffic arrow.

Lessons Learned: Better traffic situational awareness is called for on major highways, along with proper use of a blocker vehicle. The blocker vehicle should be unmanned once situated. Pylon and flare markings are recommended as well.

Report Number: 12-0000020

Synopsis: Proper PPE usage prevents tragedy.

Event Description: I was working at a structure fire at a brownstone style apartment. Upon arrival, I was ordered to do a VES (Vent, Enter, Search) on the third floor and look for victims and fire. As I approached the tip of the ladder, the fire self-vented and I was quickly engulfed in a firestorm. I slid the rails to the ground and was ok. The only thing that saved my life that day was my SCBA. I climbed the ladder with it on and my face piece in place, something we as a department don't normally do. Anyway, I am thankful that the big man was watching out for me or I could have been one the statistics we talked about in class.

Lessons Learned: The value of our PPE and SCBA can never be underestimated or ignored. I am living proof that SCBA does save your life when in trouble.

Report Number: 12-0000021

Synopsis: Responding unit strikes car in intersection.

Event Description: Engine [1] was responding to a reported structure fire. They were responding eastbound on a major thoroughfare with all light and audible devices functioning. As they approached a large intersection with heavy traffic, they were given the green light by the [traffic control system] system, which aided in clearing the intersection for successive travel to the fire. As traffic cleared, the engineer on E-[1] slowed down and confirmed his path was clear. As he proceeded through the intersection a car darted out in front of the engine causing a T-bone collision. Immediately after checking to see if everyone on the engine was ok, they proceeded to check the car that was struck. They found an elderly victim that was trapped and in cardiac arrest. The crew was able to rapidly extricate the lady and started CPR. Unfortunately, in this case it was too late. The victim was pronounced at the scene.

Lessons Learned: This was a terrible tragedy that couldn't be avoided. The driver of Engine [1] did everything he was supposed to do and still the collision occurred. The only thing we can control as firefighters is ourselves. This incident is still under investigation and we are trying to figure out why the victim proceeded into the intersection. CISM is being provided to all members on scene.

Report Number: 12-0000022

Synopsis: Exercise routine overcomes FF during drill.

Event Description: On Valentine's Day my officer decided that it would be a good idea for us to start a new tradition regarding physical fitness. He came up with a program called "Valentine's Day Massacre". It was a spin-off of some "Cross Fit" routine he saw on the internet. We all thought he was crazy and that this was another way for him to try to motivate us to exercise. He explained it was a team building drill and that it was mandatory that we do it. We did. It started with a bunch of sprints then progressively got harder and incorporated all the skills and tools we use on the engine. After a bunch of leaps, jumps and throws we finished with a full section of 5 inch hose over our shoulder and had to climb the hill in the park. As we did it, the new firefighter started having chest pain. He pushed through and didn't want to quit. He finished the drill and we evaluated him and then transported him to the hospital. He suffered a minor heart attack and is currently on light duty and possibly facing disability forced retirement.

Lessons Learned: Physical fitness is a part of our world and it is important. Common sense has to play in to the decision to work out and the officers must realize that there are limitations. This incident could cost this guy his career. The officer was disciplined.

Report Number: 12-0000023

Synopsis: Engine crew involved in traumatic collision.

Event Description: My department was dispatched to a reported apartment fire. Engine [1] was responding emergency eastbound on [street name deleted] when it entered the intersection and was involved in a serious collision. Engine [1] struck a sedan traveling northbound; both Engine [1] and the car went through the intersection and struck two other stationary cars in the westbound to southbound turn lane. Engine [1] advised they needed a truck company for extrication, three cars were involved and all firefighters were okay. Dispatchers immediately alerted resources to the collision scene and back-filled the fire group assignment with Engine [2]. The original scene could be handled by Engine [3] and Truck [1], freeing up closer resources for the collision scene. Meanwhile, Engine [1] extricated the driver of the most heavily damaged vehicle who was found in traumatic arrest. The crew from Engine [1] began CPR and the patient was quickly transported to the hospital and was pronounced dead. An EMS Supervisor and second ambulance evaluated the crew of Engine [1] and the occupants of the two other cars involved; none were injured. Eastbound traffic was closed while supervisors conducted their investigation. Multiple witnesses confirm that Engine [1] was traveling at a reasonable speed with all

emergency lights, siren & horn when it entered the intersection with a green light. Police did not find the crew at fault in this tragic event.

Lessons Learned: No matter how hard we try to stay safe, accidents will and do happen. This is a tragedy that nobody can prepare for. The fact that these guys had to work the scene and perform CPR after the collision is incredible and shows that we will overcome adversity. My prayers go out to the families of all involved.

Report Number: 12-0000024

Synopsis: Hydraulic hose fails on extrication tool.

Event Description: My crew was performing extrication training at a local car crusher. The crusher is great. They donate as many cars as necessary to help facilitate our training objectives. During this day we were doing a "Bat Wing" cut that one of the firefighters was taught at a class he attended. During the cut, one of the hoses burst and sprayed hydraulic fluid in the eyes of the operator. At the time he forgot to put his safety glasses on his eyes and kept them on his forehead. The fluid caused severe inflammation of his eyes and the firefighter was laid off for the rest of the shift.

Lessons Learned: Safety equipment is only as good as the user. The equipment we use is prone to failure and this firefighter did not effectively use his PPE to his advantage. Further review also revealed that the hose was noted as looking "frayed" the day before, but nobody reported it and nobody caught it on the daily check. Communication would have been useful.

Report Number: 12-0000025

Synopsis: Crews resuscitate FF during cardiac arrest.

Event Description: Units responded to a house fire. Upon arrival an aggressive interior attack was made. During the attack the fire vented through the roof and units regrouped in an attempt to extinguish. At this point the operation went defensive until controlled. After the fire was controlled and after firefighters circulated through rehab, units were picking up equipment and repacking hose lines in an effort to return to service. During this time a firefighter collapsed and fell to the ground. Despite being outside the hot zone, another alert firefighter realized that a medical event was occurring and issued a "MAYDAY" call. The sick firefighter had collapsed to the ground and was apparently having a seizure that eventually led to cardiac arrest. Paramedics from his department that were on scene immediately initiated ALS procedures, shocking the firefighter at least twice. When the firefighter was prepared for transport he was talking to on-scene personnel but was unaware of what happened. The

firefighter was transported to the local hospital and treated and remained in the hospital for several days. Doctors have indicated that had he not been treated immediately or had he been at home, he most likely would have died as he had suffered what was known as a "widow maker" heart attack. A great job was done by all on the scene. Despite sheer pandemonium due to the collapse of a brother, personnel pulled together and saved the life of a brother. The firefighter who issued the MAYDAY call did so without hesitation and felt it was the sole way to get the attention of those on the scene and secure emergency care for the sick firefighter.

Lessons Learned: Be prepared for anything and always expect the unexpected.