



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

**June 2012 Reports**

[www.firefighternearmiss.com](http://www.firefighternearmiss.com)

| Report Number | Synopsis                                              | Page Number |
|---------------|-------------------------------------------------------|-------------|
| 12-0000156    | Hose break occurs during pump training.               | 2           |
| 12-0000157    | Injury incurred while loading hose.                   | 2           |
| 12-0000158    | Pressure fitting fails on air compressor.             | 2-3         |
| 12-0000159    | Lawn mower damaged by bay door.                       | 3           |
| 12-0000160    | Engine hydroplanes during response.                   | 3-4         |
| 12-0000161    | Hole traps FF during overhaul.                        | 4           |
| 12-0000162    | Officer steps through floor during fire attack.       | 4           |
| 12-0000164    | Helmet protects FF from impact of hard suction.       | 5           |
| 12-0000165    | Safety rope becomes an entanglement hazard.           | 5-6         |
| 12-0000166    | LDH damaged when crossed by apparatus.                | 6-7         |
| 12-0000167    | Collision averted with law enforcement.               | 7           |
| 12-0000170    | SCBA regulator fails during training scenario.        | 7-8         |
| 12-0000173    | Roof operations complicated by inexperienced officer. | 8           |
| 12-0000174    | Porch collapses during overhaul.                      | 8-9         |
| 12-0000176    | Civilian motorist encroaches into right of way.       | 9           |
| 12-0000177    | Dirty lens nearly causes FF to fall.                  | 9-10        |
| 12-0000179    | Chain breaks during daily check of chainsaw.          | 10          |
| 12-0000180    | Improperly worn hood results in FF injury.            | 10-11       |
| 12-0000181    | Rookie FF improperly dons hood.                       | 11          |
| 12-0000182    | Driver avoids accident with good SA.                  | 11-12       |
| 12-0000185    | Radio left on bumper of apparatus.                    | 12          |
| 12-0000187    | Attic fire overcomes interior team.                   | 12-13       |

Report Number: 12-0000156

Synopsis: Hose break occurs during pump training.

Event Description: We started the afternoon pump progression training with a scenario where I needed to flow the truck deck gun towards an oil tank. This was to be done from tank supply and then switch to hydrant supply. After flowing water in the deck gun RPM mode, I switched to pressure mode. It was very quick after doing so that I realized I was almost out of water and hadn't been able to connect my hydrant supply. The computer alarmed to tell me that the truck was almost out of water and went back to RPM mode. I did not realize at the time that I was no longer in pressure mode. I connected the hydrant supply and started flowing water through the deck gun again. I was then tasked to start flowing the pre-connected portable master stream which is connected to the back of the truck and fed with two lengths of hose. As I was trying to increase the engine throttle to reach my correct pump discharge pressures, I failed to realize that I was quickly losing my residual pressure. Both appliance gauges were reading low pressures. I continued to increase the engine throttle to 1400 RPM, but there was no change in pump discharge pressure. Not realizing I was starting to cavitate the hydrant supply line, the captain came to the pump panel and asked me to shut down the deck gun. As I shut down the deck gun the portable master stream pump discharge pressure quickly jumped, which activated the automatic shut down on the appliance and the hose blew apart on the back of the truck. The coupling stayed on the truck and the hose separated about two inches from the coupling. It looked like someone had taken a knife and made a perfect cut through the hose. Thankfully no one was at the back of the truck, but just a few seconds before a firefighter had just tightened the coupling on the truck.

Lessons Learned:

- 1) Communicate with the captain that the deck gun will drain the tank supply too fast without securing a hydrant.
- 2) Make sure to run the automatic pressure governor in pressure mode.
- 3) Always watch your residual pressure.
- 4) Slow down and think about drive, supply, output.

Report Number: 12-0000157

Synopsis: Injury incurred while loading hose.

Event Description: While loading hose on the engine, I pulled a muscle on the left side of my back.

Lessons Learned: I will be more aware of my position as I'm lifting and twisting to try to prevent these types of injuries.

Report Number: 12-0000158

Synopsis: Pressure fitting fails on air compressor.

Event Description: Our department had recently relocated our breathing apparatus compressor which involved the addition of high pressure air lines. Pressure in the lines can be up to 4500 psi. During a technician training class one of the high pressure fittings blew off. The fitting was behind the fill station and all six people in the room were protected from the blast. Had the fill station not been between the occupants, the outcome could have been much different. Although all the fittings in the line were visually inspected by a qualified technician, this one fitting was overlooked for pressure testing.

Lessons Learned: Double check all connections and ensure all fittings are pressure tested.

Report Number: 12-0000159

Synopsis: Lawn mower damaged by bay door.

Event Description: I took the lawn mower out of the storage room to mow the lawn and I left the mower very close to the overhead door. The mower then rolled several inches and came to a stop when it hit the door. When the door was opened the handle of the mower caught on the door brace and was lifted off of the ground eight feet. As the door began its bend or turn at the top, it fell the entire eight feet and damaged one wheel.

Lessons Learned: Be aware where the tools are and pay attention as the door goes up.

Report Number: 12-0000160

Synopsis: Engine hydroplanes during response.

Event Description: While at the local hospital we were dispatched to an automatic aid for a rollover MVC on the interstate with a neighboring department. Typically, this department has trouble getting EMS during the day, but usually can get an engine out on calls like this. Therefore our department tries to get two ambulances out to assist. The hospital is about eight miles from the scene of the accident. Another ambulance crew responded from our station at the same time we were responding. It was a good day for staffing for us, with four members on the engine and another paramedic on standby if needed. It was raining with rush hour traffic coming out of the city. Weather conditions were bad, putting us as responders at risk. I was traveling on the interstate at approximately 65 mph and had to make an evasive maneuver. When I did this, I began to hydroplane. I was able to control the slide and proceed to the collision scene. We came upon another collision and stopped to investigate. There were no injuries, so we proceeded to the original call. The other engine had reached the original collision scene and advised that we could go in service. Then, we were dispatched to another MVC, just past the original call. We made patient contact and transported without further incident.

Lessons Learned: No matter who is driving, the crew needs to speak up and say to slow down. I heard other traffic on the radio that there was another collision. Driving safety needs to be addressed at all

times. If we don't make it to the scene of the collision, we have failed our department and the community we serve.

Report Number: 12-0000161

Synopsis: Hole traps FF during overhaul.

Event Description: We had finished extinguishing and overhauling a house fire. While performing initial investigation into cause and origin, I stepped into a hole in the floor that had been covered by debris. Luckily there was a low bar in the kitchen that I grabbed. I only went up to my knee, but could have fallen all the way into the basement. The basement had a ten foot ceiling.

Lessons Learned: Keep situational awareness at all times. There was no fire and no smoke.

Report Number: 12-0000162

Synopsis: Officer steps through floor during fire attack.

Event Description: An officer was operating with a crew of four split on two hand lines in a defensive operation of a story and a half split level single family dwelling. The officer and crew were at ground level on the bravo side working on extinguishment under the supervision of a battalion chief. Heavy smoke conditions existed so all crews were using SCBA and had full PPE properly donned thus requiring multiple rotations throughout the duration of the incident.

About one hour into operations and after several crew rotations the officer lost situational awareness. He left one crew to check on the other two firefighters operating the second handline nearby (15 feet away) when the officer stepped into the structure via an opening created by a sliding glass door that had fallen in. The officer went through the floor with one leg and partially one arm (left side) up to his waist. The officer was unable to radio a Mayday but called out for help and was rescued by his crew and pulled to safety with no injuries. The floor he fell through was above the seat of the fire (basement lowest level).

Lessons Learned: We interviewed all firefighters and officers involved as a part of the investigation and learned that the lieutenant lost his bearings in the smoke when he went to check on the other half of his crew.

- 1.) Crews were operating too close to the structure (collapse zone).
- 2.) Despite the defensive nature of the fire attack, complacency can cause division officers/crew leaders to let their guard down.
- 3.) We intend to ramp up situational awareness training

Report Number: 12-0000164

Synopsis: Helmet protects FF from impact of hard suction.

Event Description: During a water movement drill, the training involved shuttling water via tenders to a portable tank array. We were dropping water into a central tank and moving the water from the main tank to adjacent tanks using a hard suction hose with a jet attachment. The hard suction hoses were secured to the tanks. At the time of the incident, a hard suction hose was shut down and adjusted. When put back into play, the hard suction hose was not strapped back down. When the jet was activated, the water pressure from the jet forced the hard suction to come out of the tank and it struck a firefighter on the back of the helmet. The helmet protected as designed and no injuries were sustained.

Lessons Learned: Always wear proper protective equipment, even during routine training operations. Proper tie downs need to be in place prior to applying hose pressure. When adjustments are made to working equipment, always have someone double check them and confirm with safety officer/command.

Report Number: 12-0000165

Synopsis: Safety rope becomes an entanglement hazard.

Event Description: The fire department planned a series of training events involving firefighter safety and survival. One of the events was to practice emergency rope bailout using the second story window of a training building. A second safety rope was attached to the firefighter's SCBA to prevent a fall if the firefighter was unable to maintain control of the bailout rope. The safety rope was attached to an anchor point and used a mechanical fall prevention device that stops the rope in the event of a fall. When the firefighter exited the building, he loaded the safety rope causing the system to lock the attached mechanical fall protection device. The safety rope routed across his neck and began to strangle him as he was hanging from the system with his entire body weight. Other members participating in the training were able to put a ladder underneath him and allow him to remove the pressure on his neck before he went unconscious. In the event that had failed, the safety rope would have needed to be cut which could have resulted in an uncontrolled fall. In addition to strangulation, the sudden loading of the safety rope across the firefighter's neck could have caused a serious or fatal injury due to direct trauma.

Lessons Learned: A review of the incident identified the following recommendations to prevent this from reoccurring:

- 1) Develop detailed lesson plans that describe the specific equipment and exact technique for performing the training exercise.
- 2) Confirm that instructors are qualified to conduct the training.
- 3) Ensure proper use of any equipment and that manufacturer's guidelines are followed.
- 4) Develop SOPs and / or procedures that cover all department training.
- 5) Ensure an "Instructor - In charge" is designated for all hands-on training events.
- 6) Provide for adequate staffing, lesson plan review, and instructor preparatory time for training.

- 7) Empower all members to suspend any training evolution they believe to be unsafe until safety issues are resolved to everyone's satisfaction.
- 8) Perform a risk / benefit analysis of all hands on training evolution to ensure it can be conducted safely based upon the lesson plan.

Report Number: 12-0000166

Synopsis: LDH damaged when crossed by apparatus.

Event Description: Ladder Company [1] arrived at a working fire just behind Ladder Company [2]. Both companies were tasked with bringing their own water and to set up for a defensive fire attack and exposure protection. Ladder Company [2] took their hydrant and was laying 5" supply line in the right lane of traffic on a narrow two lane road with no shoulders. Ladder Company [1] was following in the opposing lane of traffic, approximately 200' behind; with the intent of continuing the hose lay if Ladder [2] exhausted their supply hose. Two medic units and multiple passenger vehicles crossed the uncharged line between Ladder [2] and Ladder [1], bringing all those vehicles into Ladder [1]'s lane of traffic. The medic units and the passenger cars were unable to maneuver around Ladder [1] due to the narrow roadway, the closest intersection for Ladder [1] to turn around in was approximately 400' behind, but due to congestion around the incident the operator decided against doing that. The medic units and the passenger cars were also unable to reverse direction based on congestion around the fire building.

Ladder [1]'s operator decided, without conferring with the crew as they were out of the apparatus assisting with placement, to cross the uncharged supply line, maneuver around the medic units and passenger cars, then re-enter the opposing lane of traffic and continue into the scene. There was no risk of the supply line being charged with the truck on top of it as Ladder [2] was still in the process of laying line. It became obvious to the operator as the line was being crossed that one coupling would need to be passed prior to reentering the opposing lane of traffic. Ladder [1] straddled the uncharged 5" line and proceeded forward at a slow speed. As the trucks rear dual wheels passed the coupling, the snow chains on the apparatus caught the coupling. The driver noticed the hose in front of Ladder [1] got several bumps in it, followed shortly by a radio transmission from the Ladder [2] hydrant crew advising that the hydrant was compromised. Ladder [1] did not move until the crew ensured that the hose was not still caught on the snow chains, and then proceeded into the incident to complete their assignment.

Results:

The hydrant was turned 90 degrees. The hydrant crew was uninjured when the hydrant was twisted despite being in close proximity to the hydrant.

A later arriving unit used the hydrant and the hose that was still on the roadway, the section that was caught by the snow chains failed. No injuries were reported as a result of the burst hose.

There was minor damage to the snow chains on the apparatus. This damage was repaired in quarters by the crew.

Lessons Learned: Although other apparatus in our fleet are able to clear a 5" coupling by straddling it, Ladder [1] will not.

Know your equipment's capabilities and limitations. If it's a possibility an apparatus will have to straddle a coupling, train on it prior to having to do it on an incident.

Examine all possibilities and remain calm. There is almost never one clear answer to problems when they arise. I believe I made the best choice given the circumstances, although in hindsight it was far from the perfect choice.

Constant communication with spotters (company officer) is crucial. This allowed the company to adapt quickly once the snag happened, prevented further damage, and allowed the apparatus to operate effectively on the scene.

If possible, relay to later arriving units and IC that the hydrant and hose are compromised. Radio traffic did not allow this to happen on this incident.

Report Number: 12-0000167

Synopsis: Collision averted with law enforcement.

Event Description: Our truck was responding second due to a motor vehicle collision in a rural area. The incident commander on scene requested law enforcement for traffic, as the incident was located just past a hill with a blind curve. The incident location was communicated by address, but there are few houses to keep track of the exact location. As our apparatus neared the scene and crested a hill we were met by a law enforcement car backing up the other side of the hill at a high rate of speed in our lane of travel. The law enforcement officer quickly reversed direction of his car and moved to the other lane as my driver slammed on the brakes. Fortunately this incident did not result in a secondary collision.

Lessons Learned: The law enforcement officer was tasked with blocking traffic on this blind curve because of the reduced visibility of the scene. He focused on the task and never thought that, as he reversed direction, that he might meet oncoming traffic before he could get into position. A better solution would have been to travel in the other lane with the flow of traffic rather than coming against it. For the fire apparatus, recognizing blind curves and being prepared to stop in case of hazards in the road is also important.

Report Number: 12-0000170

Synopsis: SCBA regulator fails during training scenario.

Event Description: While conducting live fire training with a basic firefighter student in a class A burn prop, the student had their SCBA regulator disengage from their mask during interior operations. The heat levels on that floor were severe enough to cause severe respiratory damage and possibly death, without proper SCBA protection. The student had not ensured that their SCBA mask mounted regulator had completely "clicked" into the mask. This caused the mask to completely blow off the unit. The group leader was able to take the student to a lower level of the building that was not a hazardous atmosphere.

Lessons Learned: All basic students should have their mask mounted regulators checked prior to entry. This event is going to be integrated within our NFPA 1403 instructor course for emergency actions with a student mayday and SCBA failure.

Report Number: 12-0000173

Synopsis: Roof operations complicated by inexperienced officer.

Event Description: An acting captain (a firefighter usually assigned to an engine) was in charge of a tower ladder company that was dispatched to a house fire at a two story type V vacant house. En-route information was relayed that this was possibly an attic fire. Upon arrival this company was given the assignment of securing utilities and asked to give a conditions report of the roof. Two firefighters went to secure utilities while the driver/operator worked on setting up the aerial. The acting captain was prompted to don his gear and make his way to the aerial. The firefighters returned and gathered tools and the two firefighters and acting captain made their way to the bucket of the aerial. As the driver/operator maneuvered the aerial out of cradle from the pedestal, the other crew members adjusted the tools and took a quick assessment of the scene. The driver/operator stopped maneuvering the aerial because he could no longer safely move them closer to the roof because of limited sight. At this point, there was a delay in the decision of who would be taking over the final movements of the aerial into place at the roof. Further, there was disagreement between the two firefighters and the acting captain as to whether or not a parapet ladder should be used on the roof. Eventually, it was decided that they should use the parapet ladder and they proceeded to place the parapet ladder in the bracket on the front of the platform bucket. The acting captain climbed down the parapet and broke the light weight concrete tile with a trash hook then sounded the roof decking. At this point, a roof report was relayed to command and command asked the acting captain to watch the roof from the bucket.

This Near Miss occurred because the staffing allocation allowed a firefighter who is not regularly assigned to the tower ladder to be the company officer. The firefighter was not required to keep up his knowledge and not evaluated at any regular interval.

Lessons Learned: Personnel that act in positions of higher responsibility need to keep their knowledge base current. Personnel who are not assigned to specialty units (Ladders, Haz Mat, Tech Rescue) should not be used to staff in any position unless they are properly trained.

If a department has specialty apparatus and the expectation is that anyone can staff those apparatus, the department needs to provide regular training for those who are not regularly assigned to those apparatus.

Report Number: 12-0000174

Synopsis: Porch collapses during overhaul.

Event Description: We responded at 0306 hours to a commercial strip mall that was Type V construction, with fire extending through the roof. The strip mall was not sprinkled. The roof was a flat roof, with mission tile and a mansard porch on post and beams. The main body of fire was on the Bravo/Charlie corner and was well in to the light weight wood truss roof.

The incident commander declared a defensive strategy and ordered a second alarm assignment. The fire quickly spread through the roof and accompanying occupancies. There was visible fire extending through the roof that caused the truss system to collapse. This resulted in three unsupported exterior walls. Fire crews tried to make a stand at the fire separation walls, between the occupancies, with elevated master streams and were able to confine the fire to four out of the ten occupancies in the strip mall.

During post control overhaul, fire crews were working from the Alpha side of the building through exterior doors and windows. It was during this time that the incident commander and safety officer noticed that the mission tile porch and roof assembly ran the entire length of the building. The order was given to all crews to stay clear of the overhead hazard and maintain a safe perimeter. Approximately 30 minutes after this order was given, a crew was working on the Alpha side, encroaching the established safe perimeter. With no warning, the porch collapsed, sending firefighters running for cover. Three firefighters had the porch literally fall at their feet. The incident commander called for a PAR and all members were accounted for. The incident commander then established a new, larger safety zone and had the safety officer do a face-to-face with all division leaders. No one was injured.

Lessons Learned: Focus on situational awareness; constantly monitor changing conditions, strict enforcement, observation, and closer scrutiny of crews "drifting" near high risk activities. Review of mansard/tile porch roof construction.

Report Number: 12-0000176

Synopsis: Civilian motorist encroaches into right of way.

Event Description: While returning from routine driver training, approximately a mile from our station we encountered an elderly male in a POV crossing the center line approaching a bridge into our lane. We had to move safely toward the emergency lane to prevent a collision.

Lessons Learned: All personal in the apparatus learned to drive defensively, scanning ahead watching for other motorist actions. We have to remember every time we get into a vehicle that we are only six feet away from potential injury or death.

Report Number: 12-0000177

Synopsis: Dirty lens nearly causes FF to fall.

Event Description: We were dispatched and responded to the first confirmed structure fire of my career. The fire was extinguished without incident. As I was making my way to the A/B corner of the structure from inside the house, visibility was poor. I was walking when I felt a hand grab me, and a voice shouting stop! I was about to walk off what used to be a porch. The fall would have been five feet. With the added weight from my bunker gear and SCBA, it would have been a hard hit. I explained to my lieutenant that I wasn't able to see a thing. He advised me to take my gloved hand and wipe off my face piece, cleaning off the soot, which helped my ability to see much better. From that point I have always

remembered that simple but effective piece of advice, and make sure that I wipe my face piece clean whenever in a structure fire.

Lessons Learned: Wiping your face piece & keeping it clean will remove the soot, helping you to see better. Teach rookie firefighters the ease and importance of keeping their face piece clean by the simple act of wiping it with a gloved hand.

Report Number: 12-0000179

Synopsis: Chain breaks during daily check of chainsaw.

Event Description: While doing our morning apparatus and tool check of our chain saw with a bullet chain, I had a catastrophic failure of the chain. After checking the tension of the chain and movement along the sprocket, the saw was started and idled for a few minutes. After the idle period it was run at full throttle with the brake off. Approximately 30-45 seconds into this the chain broke and wrapped around the saw. A length of chain approximately 24"-30" wrapped around the saw, got caught on the sprocket housing and flew back, narrowly missing me. The chains failure was in the metal and not at a rivet. Our department has been using reconditioned chains; however it is unclear if this was a reconditioned chain.

Lessons Learned: Not using reconditioned chains, if, in fact, that was a contributing factor. Wearing full PPE while doing rig checks could minimize injuries if it were to happen again.

Report Number: 12-0000180

Synopsis: Improperly worn hood results in FF injury.

Event Description: Crews arrived on scene and laid a dry line from the hydrant to be picked up by the next-in engine. After laying a supply line, Firefighter [A] forced entry to the structure while Firefighter [B] and the officer stretched a 150 foot attack line to the front of the residence. At this time there was heavy smoke venting from Side "C" as well as smoke beginning to push from the eaves. Crews entered the residence and found heavy smoke banked down approximately half way to the floor on Division One. Crews proceeded to Division Two to attempt to locate the fire. At the top of the steps, crews encountered high heat and zero visibility with no sign of visible fire. A window at the top of the stairs was broken and the fire began venting. Once vented, visible fire was seen and knocked down using a straight stream. Very high heat conditions still existed inside. At this time, the truck crew was attempting to make their way to the roof as well as horizontal ventilation on division two. The attack crew consisting of Firefighter [A], Firefighter [B], and the officer continued to knock down the room of origin, as well as hydraulically ventilate through a window in the fire room of origin. Smoke and heat conditions improved dramatically. Shortly thereafter, the initial attack crew exited the structure. Once outside while rehabbing, Firefighter [B] stated his neck felt funny at which time multiple burns were

found. The firefighter was then treated by EMS and transported to the hospital. All firefighters were wearing full PPE at the time of the incident.

Lessons Learned: Upon an investigation, it was found that the Nomex hood the firefighter was wearing did not come down as far as did the hoods of the other two firefighters that were with him. The burned firefighter stated he does not believe that he had his neck strap fastened, allowing open skin to show. The firefighter also sustained burns on his ears and one on his wrist. The cause of these is undetermined.

We have found that it is imperative to make sure all firefighters are wearing their PPE completely and correctly at all times. In addition, the firefighter's Nomex was wet, which could have led to steam burns.

Report Number: 12-0000181

Synopsis: Rookie FF improperly dons hood.

Event Description: I was in rookie school as I had recently been hired and our class was assigned to take part in structural fire control training at our burn building that day. Our class was divided into groups of four and had a lead instructor for each group who was an experienced firefighter. We had a lot of training to do that day, like every day of rookie school, and were pressed for time. Speed was a skill that was being assessed and there were multiple groups being evaluated that day. Before making attacks, it was the responsibility of each rookie's partner as well as the instructor to check each rookie's PPE. Somewhere between attacks, the Nomex hood of a rookie in my group had shifted off his mask exposing his forehead. Our group made an attack on a single room pallet fire, switching nozzle control four times. He suffered a minor burn on his forehead.

Lessons Learned: There were many things learned from this PPE malfunction. Teamwork was stressed more in our school and so was making sure each firefighter's partner checked each other's PPE before any exposure to heat. We also learned from this potential serious injury better knowledge of our PPE and the importance of taking the time to ensure all PPE is working properly as well as worn properly.

Report Number: 12-0000182

Synopsis: Driver avoids accident with good SA.

Event Description: While returning from a call, Engine [1] was traveling west on U.S. [name omitted]. As the unit approached the reduced speed zone in the area of the intersection of U.S. [name omitted] and State Route [name omitted] the units speed was reduced to 45 mph by the driver, Firefighter [A]. As the unit approached the above mentioned intersection, a four-door sedan proceeded to make a left turn from the southbound lane of State Route [name omitted] into the eastbound lane of U.S. [name omitted]. Unit [1] was forced to take evasive action to avoid a collision with the aforementioned sedan. Air brakes were applied by the driver with enough intensity to lock the rear drive wheels, leaving a skid

mark in the west bound lane of U.S. [name omitted] approximately 15-20 feet in length. The air horn was also used during this incident and was activated by the passenger, Firefighter [B].

Lessons Learned: No collision occurred, however, if one had, the life of the driver of the sedan would likely have been lost. The training and experience of the driver of Unit [1] is the most apparent contributing factor in preventing a collision. Had a lesser trained or less experienced driver been behind the wheel, a collision would have been more likely to occur. A vehicle of such mass and length does not handle or respond in the same manner as that of a smaller, lighter vehicle. The driver's ability to maintain control of Unit [1] during this incident is evidence of the training and experience he has obtained. The ability to operate fire apparatus such as Unit [1] is a skill that takes time and effort to learn and master. Let the above incident be testament as to why the [name omitted] Fire Department devotes time and fuel to the training of driver/operators for the apparatus owned by the department.

Report Number: 12-0000185

Synopsis: Radio left on bumper of apparatus.

Event Description: A radio was left on the front bumper of an apparatus. The vehicle left the station for a training detail and, while enroute, the radio fell onto the roadway. A second department vehicle following behind was able to retrieve the equipment without incident.

Lessons Learned: All equipment should be stored properly in the apparatus. Loose equipment should not be placed on an apparatus.

Report Number: 12-0000187

Synopsis: Attic fire overcomes interior team.

Event Description: We were dispatched to a porch fire. Upon arrival we found a 2-1/2 story balloon construction single-family dwelling. The house was heavily involved. The fire was contained and two firefighters were in the attic doing overhaul. The conditions at the time were good with the attic clear and the first and second floors clear of fire and with very little smoke. During the overhaul the 1 3/4" line to the attic was shut down to switch over to class A-foam. The two firefighters in the attic said that the smoke was becoming heavier and they could see fire coming up the attic stairway. The second floor became increasingly heavy with smoke and fire began to come through an interior wall on the second floor. The two firefighters in the attic began to feel heat and asked that the hose line be recharged. It was immediately recharged and a second hose line was pulled to the stairway to the attic. Two other firefighters made entry to rescue the original two firefighters in the attic. Everyone made it out of the house safely.

Lessons Learned: Always have a RIT team in place.  
Never shut down a hose line without backing out crews to a safe location.

Have adequate staffing on scene.

Review emergency traffic SOP's.

Never let your guard down and get complacent, even during overhaul operations.

Have a backup hose line readily available.