**National Fire Fighter Near-Miss Reporting System**
**Reports Related to Mutual Aid**

**06-585**

**Event Description**

This is a rural fire department served by volunteers only. The week of Thanksgiving is known for shutting down schools and some businesses because of deer hunting season. This morning, the day before Thanksgiving, the alarm sounded for an MVA with entrapment. My department and another for mutual aid were dispatched. I, the safety officer of the first response station, was the first to radio enroute from my home and responded. While responding, I noted that I have heard no other units respond enroute either to their respective station or to the scene. I radioed for a second tone and requested a third station outside of the county to respond for mutual aid. Finally I heard one fire fighter from the first mutual aid station radio enroute to his station. At this point, two firefighters were responding to an MVA with (now) confirmed entrapment. The second mutual aid station from outside the county was responding but I had no radio contact with them so I was just hoping they had heard the alarm and were responding. In the end five members responded from the primary station, first mutual aid station was cancelled and the second mutual aid station arrived with an engine and rescue and six men. The primary station never got an engine on scene (only five firefighters in their POV). The point being made is that better planning to cover areas when rural departments are shorthanded needs to be looked at. If the units from outside the county had not responded, there would have been no engine on scene to fight any fire that could have started from spilled fuel and a spark. Three of the firefighters from the primary department were older women who gabbed at the side of the road. The two male Firefighters wore no TOG at all and assisted as best they could at the vehicle. All in all, it was not the finest showing for my department.

**Lessons Learned**

Better communications are needed between all members of the department so we all know who is available and who is not. More members need to be trained as drivers and pump operators in order to respond engines to incidents in our fire area or serve others through mutual aid.

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**10-722**

**Event Description**

My engine company was called for mutual aid from a neighboring department to assist with a two story apartment complex fire (sixteen apartments). Upon our arrival, there were three aerial apparatus elevated and flowing water on the two story apartment complex that had heavy fire and smoke coming from the attic. We checked into command and were assigned to assist another crew with pulling ceiling and fire suppression if the fire had breached the firewall in the attic.

The first crew took the second story “A” side apartment and began their assignment and we took the second story “D” side apartment. Conditions of the apartments upon our

entry were filled with light smoke and no fire was visible through thermal imaging cameras.

We entered the apartment in full PPE and SCBA carrying a 2 ½ inch attack line. When we got to the back bedroom and checked for extension, our camera showed that there were signs of possible fire coming through the firewall at the roof peak. We pulled the ceiling and started fire suppression. We notified command of the conditions and our actions. While performing fire suppression, a large section of firewall fell and we could see one of the towers flowing water. We noticed that they were moving their water stream through our area and we moved everyone back as the water stream came into the area in which we had just been standing.

We contacted command and had them contact the crews working on the trucks and make them aware of where we had crews working on the interior. We heard command make contact with the truck companies and inform them of where the interior crews were working. Unfortunately, the tower that had sprayed down our area was from a different mutual aid agency and was not monitoring the channel that the information was being broadcast on.

As we continued working on pulling ceilings, I had moved into a closet and was pulling the ceiling so we could get a better angle on the extension. As I was doing this, I heard a large amount of water flowing on the wall I was standing by and as I started moving out of the closet, I was hit by the elevated stream. I was thrown out of the closet, rolled into the bedroom and was pinned by the water against the bed and floor. The water hit me with enough force that it knocked my helmet off and water was forced into my SCBA mask. I had to pull my mask off enough to avoid breathing in water. I then gathered myself and crawled my way out of the apartment.

I was not seriously injured in this event but the potential was great and very real. I consider myself very lucky that I just felt stiff and sore from this incident. This type of event could possibly happen again if we don't do something about it, for instance multi-agency/multi-company training.

**Lessons Learned**

I feel that the lesson learned here was that communication is key. Making sure that all agencies are getting all the information and it is being received up and down the chain of command correctly is vital for good situational awareness. I also feel that training with mutual aid companies will help work out the little problems and help prevent big ones. This should involve multiple companies from multiple agencies.

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**10-396**

**Event Description**

I was first in on a three man engine crew responding to a structure fire. Upon arrival, we found a two-story townhouse with heavy smoke coming from the front door window and

the rear of the roof. At that time, I was working for a small department that only had eight firefighters on duty at one time. The mutual aid was approximately ten minutes away and was not called for until my engine company first arrived on scene. Also, earlier, before the fire, an employee had gotten sick and went home, which forced the shift commander to ride in the OIC position for the rest of the shift.

Myself, the OIC and engineer, arrived onscene and made an initial attack in the front door without a second unit being on location. Due to the legend of the townhomes and the plan of a fast attack, there was no walk-around done. While inside fighting fire, we were met with post-flashover conditions that consisted of heavy heat and heavy smoke. We also had reports of a victim inside the townhouse. Due to the conditions inside, we were not able to advance very far into the structure. Once the mutual aid department arrived onscene, they were assigned (by the OIC who was interior with me AND running command) to pull a 2 1/2 inch handline around the "C" side and protect exposures.

The mutual aid company began flowing water into the window of the involved unit because that's where they saw fire. They did not know we were inside and having the flames pushed down onto us. A third crew also made a fire attack by laddering the second story and going in through a bedroom window. One of the firefighter on that crew had one of their legs fall through the floor. Luckily, they were able to self extricate and proceed in extinguishment.

The fire eventually got placed under control. During overhaul it was noted by me and command, that the "C" side of the structure was three stories. The whole time we were inside the fully involved townhome, we were above a basement.

**Lessons Learned**

To me, this report includes three near-miss events. A walk-around should have been made regardless of the fire conditions, especially with the little manpower we initially had. If something were to have happened to me or my shift commander, there were no other units on scene to assist with a rescue situation. The walk-around could have given time for other responding units to arrive and for knowledge of the basement below, that may or may not of been on fire. Having the IC actually being inside and assigned to fire attack, was a huge risk for the safety of not only me, but every person on the fire ground.

The engine company on the "C" side of the structure should not have flowed water into the window of the structure occupied by firefighters. The exposures were not being protected. The principal of fighting the fire from the unburned side was not put into play and almost cost lives and property.

The firefighter who fell through the floor got lucky! Regardless if they should have been on the assignment of fighting fire through the top floor window, extreme caution should have been used.

We were able to contain the fire to the one unit, but only by the grace of God. There were no occupants inside the structure and we risked at least three lives in order to save an unsaveable townhome.

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**10-489**

**Event Description**
We were dispatched to a structure fire in a rural part of our district. Upon arrival we found a 2-story residential eighty-year old house with heavy smoke coming from the rear of the structure. The officer assumed command, the engineer stayed with the engine and another firefighter and I pulled 1 ¾ inch line. The line went to the rear entrance, now with flames showing. We proceed to attack the fire. We were approximately twenty feet into the house and 5-7 minutes in when we heard a mutual aid engine also going interior to the second floor. Another minute or so went by when my partner said he thought I could handle the rest of the fire. He was going upstairs because his friends were the mutual aid and he wanted to say hi and mess with them. He proceeded even after I disagreed with him. I was then by myself when the wall opened up with even more fire. Luckily I was able to suppress the flames. Finally, a 3rd mutual aid engine arrived and entered my area to help and they were surprised that I was alone.

**Lessons Learned**
2 in means 2 in.

Stay together.

Don't assume when you see no more flames that the fire is out.

Teamwork.

Trust.

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06-46

**Event Description**
We were called for mutual aid for a fire in a three story assisted living complex approximately 1 hour into the incident. We were initially dispatched to assist with the provision of medical care to the evacuated occupants. Upon arrival, we were directed to establish a rehab area and for five of our seven personnel to assist with search and rescue. I identified that there wasn't an official staging area or command post. Additionally, our county-wide communication plan had not been implemented and the host department was operating off of one channel. There was no check-in process for firefighters entering the building, an accountability system had not been implemented,

nor was there anyone providing clear direction on the tasks that needed to be completed.

Based on this, we set up our own accountability for our people, and established a dedicated radio channel for them to use in the event there was a problem. They were sent to the third floor to perform secondary searches of that floor. Upon entering one of the units, one or our personnel felt softness in the floor and directed the others to leave the unit, at which time the floor gave away. He fortunately caught himself and two of his teammates pulled him to safety. The troubling part of this was that the situation with the floor in this area of the building was reported by two other teams to command, and yet because of the lack of organization and communication, they continued to send teams to this area.

A second near miss occurred a short time later on the second floor in the same area of the building. The firefighter was not seriously injured, but shaken up by the experience. I believe a lack of incident command, a lack of operational and organizational structure were the key factors in this event. 14 mutual aid fire departments responded to this incident.

**Lessons Learned**

We have a county-wide communication plan that must be implemented at incidents. The IMS must be implemented and used effectively. Accountability of occupants and responders must be a priority. We have convinced the host department to hold a critique of this incident in hope that all the departments will learn from it and hopefully implement effective strategies for managing large scale incidents.

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10-985

**Event Description**

Units responded to a mutual aid call with a neighboring volunteer fire department for a building fire. We were requested approximately 10 minutes after the initial call. We were the second engine to arrive with light brown smoke showing from a lightweight construction type building. The first engine crew had already made entry into the building. We were requested by the incident commander to take a backup line into the kitchen area to assist the first entry team with a possible fire in the kitchen. Due to the fact that we were operating on different radio systems, a request for a radio patch to fire dispatch was made so we would have communication with the incident commander.

We entered the building with an officer and two firefighters. Due to the smoke color, it was believed the fire had gotten into an area above the kitchen and was burning at the roof area. As we advanced to the kitchen area, tiles were removed from the drop down ceiling with pike poles to assure we were not advancing past the fire, as it had gotten into the ceiling. When we arrived at the kitchen area and met with the initial attack crew, we found light smoke down to the shoulder level. Ceilings were pulled and fire was seen in the inspection holes behind the fire crews where fire had not been seen earlier.

Crews were unaware that command was attempting to contact them to evacuate because of deteriorating fire conditions that could be seen outside. The radio patch had failed. The building collapsed minutes after crews left the inside.

**Lessons Learned**

Due to radio problems with the patch, crews were unaware that incident command was trying to evacuate interior crews. A RIT team was being assembled to go get the interior crews out. SOPs were changed, so now, when crews go mutual aid, a duty chief also responds and acts as safety officer for our units. The chief also monitors communication on our radio channels so we don't have errors such as the radio patch being lost or other communication problems.

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09-113

**Event Description**

On the night of December 1st, 2004, my crew responded to a well involved fire in a restaurant. Upon arrival, we had heavy fire venting from the "D" roof eave. I was sent inside on an attack crew to pull ceilings and check for extension. This restaurant was a mom and pop cafe that was a converted double wide office trailer. There was a second wooden single roof attached to the original metal trailer roof.

Once the fire was contained inside the restaurant, there was still fire burning in the dead space between the two roof lines. Inside the restaurant, there were 5- 2.5" x 2.5" square metal support columns. 2 of the columns on the "D" side were destroyed and missing. The other columns were exposed to high temperatures. Some were showing signs of metal fatigue and warping. A fire company from a mutual aid department was ordered to ladder the roof and attack the fire from the roof using saws and hooks. The incident commander never issued this order and advised the captain of that crew not to get on the roof due to collapse concerns. This crew ignored the orders of the IC and entered the roof anyway.

There were 6 firefighters on a severely weakened roof. All personnel were evacuated from the building while this attack was commencing. A RIT crew was deployed and assigned in case of collapse by the IC. Once this attack was completed and all personnel were off the roof, the crew was released by the IC. There was a lot of friction between the two departments at this time and the officer felt he did not need to obey the orders from an officer from another department.

**Lessons Learned**

After this incident, a meeting was held between both department chiefs. A mutual aid agreement was signed by both departments stipulating that all operations will be conducted through the incident commander. A unified command structure will be utilized by all departments involved. Overall, teamwork and cooperation were lacking on this call. The lives of the firefighters were jeopardized over petty grievances.

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09-223

**Event Description**
We were responding to a mutual aid automatic fire alarm with our ladder truck. We had a full rig of personnel. When arriving to a four-way intersection, for which we had the green light, we were greeted by a very long and loud air horn blowing. The long, loud air horn blow came from an engine also responding to the mutual aid call. Obviously the driver of the ladder truck jammed on the brakes and came to a stop so he didn't slam into the engine. The engine driver, who had the red light, just ignored it and kept on moving through the intersection, he was never going to stop! The driver of the engine never slowed down, didn't look, as was definitely not aware of his surroundings. He never even saw an 80,000 lb., 45 foot long, 11 feet high ladder truck also coming to the same intersection. It was such a close call, that the commanding officer of the ladder truck, felt compelled to not only notify the engine company's chief, he also filed a police report for reckless driving.

**Lessons Learned**
The main lesson learned was to make sure you proceed through EVERY intersection with due caution. It doesn't matter if you have the green light or not, you have to proceed with due caution, and be aware of what ALL the other drivers are doing. If possible, make eye contact with all drivers in the intersection.

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08-515

**Event Description**
We were responding emergency to a confirmed structure fire in neighboring department's territory (mutual aid). The engine was traveling northbound on a residential street. We were approaching a major intersection that was being controlled by a police officer. The engine had passed the fire location and was headed to a designated position in a parking lot located behind the structure. All northbound lanes were occupied by cars stopped at the intersection. The engine was signaling to make a left turn and was waved into the oncoming lane (far left side of the road / southbound side) by the police officer. A corner house with numerous trees blocked our vision to the traffic coming from the west. As the engine pulled into the oncoming lane, a tower [aerial apparatus] from the neighboring department came into view from the west and started making a right turn onto the southbound residential street. No advanced warning that a rig was coming from that direction was given by the police officer who was waving us through. Due to a large dip in the road, it was obvious to me that if the rigs did not stop in time, the bucket of the tower would come directly into the front windshield of my engine. The tower engineer applied hard brakes and my engineer steered our engine around the tower and continued to our position behind the structure.

**Lessons Learned**
When responding in my own district, I have a good idea what direction the other incoming rigs will be coming from. I can communicate via radio when there is a

potential that two rigs might get to a blind intersection at the same time. In this situation, I was going into another jurisdiction and was not aware of where other rigs could be responding from. I should have been talking on their radio channel advising that we were nearing the intersection. Especially, since our visibility was blocked!

Knowing that I was passing the fire to take up a position in the rear of the structure, I should have anticipated other rigs coming into the scene from any direction. Also, I shouldn't have put all my faith in the police officer who was waving us into the intersection. The police officer didn't realize that another rig was approaching from our blind side.

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10-206

**Event Description**

My department responded mutual aid to another town for a structure fire. The fire was a good distance away in an old two-story farm house. There was a firefighter standing below the second story window attempting to break the glass with a pike pole. He had no SCBA, helmet, or PPE. The PPV blower was pushing smoke back into the house. The other department had no accountability, no SCBA use, no ICS. Our chief took control of the scene and began making the scene safe. Other departments also tried to help, but had no PPE.

**Lessons Learned**

We realized that some surrounding departments have very little training. Whenever we respond with them, we send a safety officer also.

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07-1105

**Event Description**

We responded to a small house fire in town. We had good hydrants and proper water supply. The fire was in the attic. We had a quick response (4 personnel) and started to make an interior attack on the attic. We needed more manpower to continue the attack, but we kept changing our bottles and going in until help arrived. Once I came out, I noticed no one was in command and several other volunteers from different agencies had arrived. I took command, but we do not have an accountability system in place (still don't) and I did not know who was qualified to make entry. I am also a full time Captain in a near-by metro area. I assigned two companies to make entry and continue to pull ceilings and attack the fire. I also assigned vertical ventilation. One main problem was the construction of the house, it had 3 ceilings in it (drop ceiling, plywood, tongue and groove). We did not have RIT because no one had been trained in RIT yet. We did however have 2-in-2 out. About 2 hours into the fire we were doing overhaul operations when a crew of two in the living room were pulling a ceiling joist out (I don't know why) and the ceiling and roof collapsed on the two firefighters. About 10 people ran into the structure, some with SCBA's, some without, and started digging for the firefighters. At

this time, it was light smoke and no visible fire. However, it was smoky enough that everyone should have been wearing an SCBA. It was complete dismay and loss of control. No matter what I (Command) said, people were out of control. Fortunately, we recovered our firefighters and they only received minor injuries.

**Lessons Learned**

1. Every fire department needs to use the Incident Command system.
2. Every fire department needs to have a working accountability system.
3. Use a trained Safety Officer.
4. If you run with mutual aid, you need to train together. Have some way to identify who is FF-I standard or who can and can't make entry.
5. Get rid of 10 codes
6. We need training on basic fire attack skills and overhaul.
7. RIT should be part of basic firefighter training.
8. Building construction classes
9. SOGs in place for accountability, safety, command system.
10. The good ole boys need to change their ways or get out, that's what is holding up our county; the old Chiefs that can't change with the times.