



National Fire Fighter Near-Miss Reporting System:

March 2012 Reports

www.firefighternearmiss.com

Report Number	Synopsis	Page Number
12-0000065	Training officer forgets to check PPE prior to burn.	2
12-0000066	Characteristics of gasoline ignored during leak.	2
12-0000067	Teamwork overlooked during ladder training.	3
12-0000068	Officer walks through smoke without using SCBA.	3-4
12-0000069	Officer injured removing tree from power line.	4-5
12-0000070	Fire intensifies rapidly following ventilation.	5-6
12-0000071	LDH breaks apart during training.	6-7
12-0000072	LEO fires weapon during firefighting operation.	7-9
12-0000073	Pram falls in the snow with patient.	9-10
12-0000074	Good SA helps spot electrical hazard.	10
12-0000075	Power line falls across engine at structure fire.	10-11
12-0000076	Saw head detaches during operation.	11
12-0000077	Propane tank found venting on patio.	12
12-0000079	Tanker overturns enroute to structure fire.	12-14
12-0000080	Diver runs out of air during ice dive.	14-15
12-0000081	ARFF super tanker rolls during response.	15
12-0000082	Survival skills pay off for FF in trouble.	15-16
12-0000083	Concerned citizen delays fire attack.	16
12-0000084	Fire station destroyed by tornado.	16
12-0000085	Damaged natural gas line causes problems at a structure fire.	17-18
12-0000086	Interior hose crew jeopardized by exterior fire attack.	18-19
12-0000087	Interior attack inhibited by exterior crew.	19
12-0000088	Freelancing puts ladder crew at risk.	19-20
12-0000089	Simultaneous interior/exterior attack.	21
12-0000090	Accident scene results in FF injury.	21-22
12-0000091	Porch collapse traps FFs during rescue.	22
12-0000092	High CO levels found following incident.	22-23
12-0000094	Passing truck hits low hanging cable endangering on scene personnel.	23
12-0000096	Building integrity compromised during training fire.	24
12-0000097	Deck gun swings loose during pump operation.	24-25

Report Number: 12-0000065

Synopsis: Training officer forgets to check PPE prior to burn.

Event Description: While conducting live fire training I did not do a walk-through of the burn building which had a prop on the second floor which was a factor leading to this event. This was a live fire training session in which search and rescue training was being conducted. The lead instructor was moving from division one to division two when he noticed the liner from his turnout pants had dislodged from the exterior. It was not in place covering his lower back. While moving up the stairs he realized that his back was being burned.

Once on the second floor and heading to an emergency exit, he tripped over a couch that was not previously on that floor which caused him to fall over onto his head. Becoming disoriented he suffered further burns to his back by the delay in exiting the building. Once the exit was located, he left the structure.

Lessons Learned: Check the building prior to starting live fire training session.

Always work in teams of two.

Follow policies.

Check PPE prior to entering.

Report Number: 12-0000066

Synopsis: Characteristics of gasoline ignored during leak.

Event Description: While on scene of an auto accident with an active fuel leak, one crew was off to the side dealing with the fuel leak. All patients were clear of the area with a vehicle leaking a small amount of fuel from a 30 gallon tank. A firefighter was on a charged hoseline with turnout gear and SCBA with no mask and was close to the leak. The engineer was attempting to stop the leak wearing no turnout gear. A second firefighter also attempting to stop the leak and was reported to have been soaked head to toe with fuel. During the after call critique, the Hazardous Materials Team stated that if you have to get wet from fuel to stop a leak, you have to get wet. The rest of the units were treating patients away from the vehicle and fuel leak.

Lessons Learned: There is a real lack of respect for fuel and its potential. Our risk management profile was not being used - lots of risk with almost no gain. The lack of experienced supervision was absent and everyone was focused on the rest of the incident. Lack of training is very much a big part of this situation. Bad practices, poor supervision, lack of experience, and a lack of training all contribute. I have to wonder how everything would have went if the fuel had flashed and our firefighters were severely burned.

Report Number: 12-0000067

Synopsis: Teamwork overlooked during ladder training.

Event Description: Training with my assigned company this shift, we had been utilizing a 14 foot roof ladder on the roof prop for RIT Practice. When the ladder was brought up to the roof, it was handed to a crew member on the roof from the fourth floor exterior balcony. This way the ladder did not have to be wrestled within the interior stairwell to get it up to the roof.

At the conclusion of the training drill, I attempted to return the ladder to the same exterior balcony from the roof. However, there were no personnel there to receive it as we were conducting additional drills within the stairwell. Rather than wait for a crew member to receive it, I attempted, foolishly, to lower it to the balcony floor to let it rest there until I made my way down to that level. As it came to a rest on the balcony floor, the ladder came to a very brief stop. I assumed that it would stay; however, it then pin-wheeled over the fourth floor railing, and landed on the third floor, again coming to a brief stop. It pin-wheeled again, running parallel to the tower structure, and came to another brief rest on the top of the protruding sign. The ladder finally rolled off, pin-wheeled again, and struck the ground tip-first, breaking the tips. There was no damage to the railings, building, or signage.

The company officer, who was managing the training, was informed of the damage. He tagged the ladder as damaged for the Training Division.

I must add that this was entirely my fault. Rather than exercise patience and wait for the appropriate time to pass the ladder down correctly, I tried to handle it myself. It led to the damaged ladder. It was a preventable incident, and recommendations for future handling of a similar scenario were discussed with the company officer.

Lessons Learned: The importance of patience and planning when returning equipment to its proper place has been addressed. Reliance on teamwork is a hallmark of fire service success. Shortcuts, even in a simple task as returning a ladder to storage, can lead to mistakes and costly errors. Continued reliance on teamwork would have led to a more favorable result in this case.

Report Number: 12-0000068

Synopsis: Officer walks through smoke without using SCBA.

Event Description: We were dispatched on a second alarm residential structure fire. As we arrived in staging, the IC requested our unit to the scene and assigned me and my crew to division "C" at the rear of the home. This fire was being fought as a defensive attack and each division had a unit assigned for exposures. At the time of my assignment, we had an elevated stream flowing water into the center of the structure with no visible fire from the exterior. I requested that my crew standby for a minute while I did my hot lap to decide what kind of handline to pull and what our overall objective was going to be. I was wearing full PPE with my SCBA on my back and my mask hanging around my neck. As I walked down the sidewalk on the "D" side of the structure, there was a fair amount of smoke coming from the area where a sliding glass door used to be. I decided that I could make it through the smoke in a short period of time without donning my mask and breathing off of air. I quickly walked through the area. My

engineer was standing in a location to watch the conditions change rapidly in the area that I had just walked through. I was unaware of the change in conditions and was briefed following the incident.

I have been a Captain for 11 years and have done many hot laps around the structure. I calculate risk on a daily basis and have been fortunate that it has always worked out. In this case, based on the information that I received, I was lucky that I did not get injured and certainly was not the best example for my crew.

Lessons Learned: Some of the lessons learned in this incident would be to maintain situational awareness and make better decisions based on the potential and not what has always worked for you. During training exercises at the tower, I perform hot laps around the building and never wear my mask because there is no smoke and I want to save my air for interior operations. This will change. Practice makes permanent. The bigger lesson is that IDLH atmospheres are not always inside a structure or confined space. My role as a company officer is to make sound decisions and lead by example. On this day I failed to do both of those.

Report Number: 12-0000069

Synopsis: Officer injured removing tree from power line.

Event Description: In January, [date omitted], my engine responded to a report of a downed power line. We had been having a high wind event for several days and had gusts over 80 miles per hour that morning.

On arrival, I made contact with a sub-contractor for the power company who was on scene and had shut down all power to the area. We checked the scene and found a large tree that had broken off about half way up. The top half of the tree was now supported by a wooden fence and the power lines, which were running down the alley. The fallen part of the tree was 30" in diameter and had fallen in such a way that the power line, which was normally 15' above the ground, was now only five feet above the ground.

After confirming again that the was power off, I asked the line foreman if he could clear one of the two crews from our scene in order to assist a second engine company who had live lines in a tree that was currently on fire. I felt after assessing the scene that we could remove the downed tree and clear the line at my location. As the line crew left the scene, I had my firefighter and engineer move up to my location in the alley to start removing about eight feet of the tree that was overhanging the fence and blocking the alley.

Although we do not have a protocol for assisting the local power company with tree and branch removal, I felt that it would be appropriate for several reasons. First, I was the one who requested that the power company crew clear the scene to assist one of our other crews. This left the remaining crew short-handed. Second, my engineer and I are both certified Class B Fallers through the National Wildfire Coordinating Group and have had a lot of training and experience with chainsaw work. Third, we had a firefighter on our crew with limited saw experience and I felt that this would be a good training opportunity. (I just had no idea how good of an opportunity it would turn into.)

After removing most of the overhanging tree, we had about eight inches left to cut in order to free the line. My engineer climbed on top of the downed section of the tree so that he could make the last cut. I remained on the ground to watch for any problems and to make sure we did not cut the line. At the time we felt that, once freed, the line would come up about six to twelve inches.

When my engineer was about three-quarters of the way through the final cut, the saw bound in the tree. After a discussion we decided to use a pry bar to open the cut just enough to remove the saw. As my engineer and firefighter started to pry open the cut I reached over the line with my right hand to remove the saw. This is when the last of the wood that was holding broke loose.

An eight inch thick, 30 inch diameter disc of wood struck me in the face, broke my nose, cut my face in several places, and gave me a mild head injury. My right elbow was broken by the line as it snapped back up to its original height. I was knocked to the ground, with my helmet and the wood disc landing about 15 feet away down the alley. I was transported to the hospital and ended up with over 250 stitches in my face and my arm in a sling. I have been on light duty for the last six weeks.

Lessons Learned: Though we talk about the dangers of power lines, we often overlook the amount of tension in the system. In this case, I spoke with the power company after the incident and the representative I spoke with said the tension on the line could have been in the tens of thousands of pounds. Based on what I experienced, I can say that the reaction was a LOT more than I had expected. The power company also explained that, in cases like this, they secure the line with rope before removing the load. Once the load is removed, they release the line in a controlled manner.

Be careful of the unknown.

Report Number: 12-0000070

Synopsis: Fire intensifies rapidly following ventilation.

Event Description: We are a small, suburban combination department in a highly populated area. The call came in a 19:33 on a Tuesday evening just as we were giving crew assignments for our weekly paid-on-call training that starts at 19:30. Our department's response to reported fires is with two engines and a truck and we use an auto-aid engine and truck from our neighboring communities. On fire alarms, we routinely respond with just an engine company from our own staffed personnel. Our policy for fighting a fire is the first engine on the scene is designated for fire attack and is tasked with stretching the initial hoseline, the truck gets the front of the building and is responsible for search and rescue and ventilation, and the second engine is tasked with establishing a water supply and pulling a backup hoseline.

We were dispatched for a residential fire alarm in an area of town with very large single family homes. The house we were dispatched to had an elaborate home security system with 14 operating cameras both inside and outside the home covering the exterior of the home on all sides. On arrival, I took command and staged across the street. I had a very large two-story wood frame structure that was approximately 6500 square feet. There was nothing showing from three sides and a setback of approximately 150 feet from the street. I had a truck (ladder-tower) staffed with four and an engine staffed with four and they were right behind me. Both apparatus staged in the driveway. The captain on

the engine company reported seeing a "light haze" coming from the rear of the house. The captain of the truck started a 360 survey of the structure and reported "heavy fire conditions" inside the structure in the rear. The call was then elevated to a working fire and a squad/pumper responded from my station and an automatic aid engine and truck responded from neighboring towns. Each unit had a crew of four personnel.

The truck company went to the rear of the house while the engine company stretched a 2 1/2" hoseline to the front door and began to force entry. The truck company, hearing the banging of the irons from the front, ventilated some windows at the rear of the house causing a fiery backdraft. The crew was anticipating the event and was out of harm's way off to the side. The engine company, using a Haligan tool and flat-head axe, began to force the door. The firefighter on the Haligan tool was on the wrong side of the tool and was standing directly in front of the door. After the door was partially open, the firefighter then tried to force the door open using his shoulder and finally kicked the door open. After the door opened, there was a short "in-rush" of air followed by a blast of hot smoke coming back out.

Lessons Learned: The firefighter's actions at the front door were not noticed on the scene, but were seen when we reviewed the security camera's video footage of the fire. When watching all the cameras simultaneously, we were able to see that a flashover had occurred in an interior room about 90 seconds prior to taking out the rear windows and the rear windows were taken out about 40 seconds prior to the front door being forced open. By opening the rear windows and letting a large quantity of heat out of the building, the firefighter at the front door was uninjured.

The entire incident was reviewed at the following department training. I was able to simulcast our radio traffic with the home security system to show the progress of the fire when we were dispatched and what we were doing on scene. The homeowner had recently installed new energy-efficient windows throughout the house. The windows held the smoke and heat inside leading us to initially believe the call was a false alarm.

The firefighter in front of the house using the haligan tool was in a position to be seriously injured or even killed if he had fallen forward when trying to force the door and fell into a backdraft. We have trained extensively on our SOP's, but have not had any recent time using a forcible entry simulator. The conditions inside were not readily seen from the front of the building despite a flashover occurring in an adjacent room to the entry foyer. The lack of visible smoke or fire led the crew to not become aware of the actual situation at hand even though, a report of heavy fire conditions had been reported by the truck captain.

We have used the video to reinforce the continued need for training and are in the process of purchasing a forcible entry simulator for use by our department as well as neighboring departments that also do not have such a training tool.

Report Number: 12-0000071

Synopsis: LDH breaks apart during training

Event Description: Our engine was at the fire training center for standpipe operations. I was the acting engineer on for the first evolution for driver/operator training. I conducted a reverse lay of 5" hose from the training building out to the hydrant that was 200' away. I broke the 5" hose from the bed and connected it to the large diameter discharge port on the officer's side. I dressed and made the connection to the hydrant and established water supply to the engine. The engine's crew called for water through the standpipe to the third floor. I supplied the 5" hose with 150 psi (per SOP) and had the crew flow water in order to check their pressure. The pressure was appropriate and I was waiting for my next orders.

While waiting for my next orders, the engineer (who was shadowing me) and I walked around the apparatus to chase any kinks in the hose. We noticed that the 5" hose that was feeding the standpipe had a 75 degree kink in it. As I tried to relieve the kink, the coupling failed at the engine. The engineer was knocked to the rear of the truck as the water pressure had blown his helmet off. I was pushed away from the engine by the water pressure of the large diameter discharge. The water pressure knocked my helmet and sunglasses off as I turned away from the coupling. After the coupling failure, the engineer went to pump and shut down the discharge. We self-assessed for any injuries and fortunately there were none. The commanding officer was notified of the failure and training operations were ceased until we could reestablish water supply to the standpipe. Water supply to the standpipe was established by using 2 ½" discharge on the officer's side and training was continued.

Upon assessment of the large diameter discharge, the failure happened at the 3" female swivel elbow adapter to the 5" Storz connection. There is a ring in the 3" swivel that was never found. Luckily, there were no injuries and no other property damage, but this was a near miss that I will keep with me for the rest of my career.

Lessons Learned: Do not take any equipment for granted. Everything we use can and will break or not function properly at some point. This was one of those catastrophic events that you can never anticipate. We have an SOP to wear helmets during pumping operations and now I know why! If that Storz coupling had decided to jettison straight out to where I was, I would have taken it directly to my head. A life threatening injury could have occurred and at the least, a traumatic brain injury. Never take safety for granted and always have an eye open for the unknowable.

Report Number: 12-0000072

Synopsis: LEO fires weapon during firefighting operation.

Event Description: At 1707 hours E[1] was dispatched in its first due to investigate an illegal burn. The call was a hold off for law enforcement as the department had history with the property owner being argumentative and confrontational. This property was known from several other fire incidents, and it contained a wide variety of hazards (sheds and buildings containing tires, acetylene, propane, ammunition, vehicles and other hazardous property). E[1] had an acting captain in charge. The weather was a typically hot and windy July late afternoon with gusts of 25-30 MPH. As E[1] moved down the street they noticed what had been a light smoke condition blow up into a large black plume coming from the area of the dispatched address. E[1] requested that the balance of a full alarm be dispatched.

Unsure if this smoke could be fire spread to an adjacent residential exposure, and due to the windy conditions promoting fire spread and potentially extreme fire behavior, E[1] stated they were moving in. Two more engines, two ALS ambulances, one squad and a battalion chief (acting-and author of this report) were added to the alarm. The department's fire chief (C[1]), who could see the smoke condition from his nearby office, added himself to the alarm.

E[1] arrived and reported several sheds fully involved with a tire fire and a downwind residential exposure. E[1] assumed command in defensive mode. Units began to arrive and an organized fire attack was implemented. The sheriff's department also arrived on scene and began closing the roads to allow for better FD access and crowd control. B[1] arrived and command was passed to him. He assigned C[1] as the safety officer. Command and accountability was declared on the alpha side of the property on the street adjacent to E[1]. Within about two minutes of assuming Command, B[1] was contacted from the Bravo attack group requesting the property owner be removed from the smoke and property.

As units were still setting up and implementing initial orders, Command walked to the "A/B" corner property gate bringing a sheriff with him and requested the property owner step out onto the street. The property owner did. Command asked the sheriff to remove and keep the property owner across the street, up wind and away from all FD personnel and apparatus. The deputy agreed and Command walked back over to the command post by E[1]. A few minutes' later four gun shots were heard by everyone on the fire ground. Command noted they were right behind him and peeked around E[1] to see the deputy standing less than 20 feet behind the command post with his weapon drawn. The property owner was down on the ground in front of him. The deputy was injured and Command quickly asked him if he had been shot and was told no. Command asked if the scene was secure and the deputy said yes. Command noted that the property owner had multiple gunshot wounds and was still breathing. Within seconds of the shooting and gathering this info, Command radioed to all personnel that there had been shots fired, that the scene was secure and to remain in their assigned areas. The safety officer was visible to Command and a quick off the air fireground PAR was completed between them because as they could see all FD personnel operating. All FD personnel were okay. The PAR was done off the air as Command was now ordering a second alarm, a helicopter and reassigning medics on the fireground to come out and begin treating the resident and deputy. This was done to not delay vital EMS treatment to the two injured parties and requesting needed additional resources. Additionally, despite the very close proximity to the shooting (less than 20 feet), only two engineers and Command were the only fire personnel operating even remotely close to direct line of fire, and Command had direct line of sight with them immediately after the shooting and could see all were okay.

Medical attention was quickly and efficiently provided to both the resident (flown to a nearby trauma center where he succumbed to his wounds a few days later) and the deputy (treated and released that day). No other civilian injuries occurred. The fire was contained to its origins with no exposure damage, which given the on scene arriving winds and fire conditions was an unexpected outcome. Lastly and most importantly, and there were no firefighter injuries throughout the incident.

Lessons Learned: A post incident review took place and the following lessons learned came out through the ensuing discussion.

Crews did an excellent job of staying on task and completing their assignments once they were assured by Command that the scene was secure. Only one firefighter free-lanced and started to come off the fireground to see what had transpired. He was quickly sent back to his crew.

Our crews did an excellent job containing the fire to its origins, and there was no structural exposure damage when damage to the adjacent structures would have been an expected outcome under the circumstances. The incident was initially managed by an acting Captain who did an excellent job setting up the initial line placements. This greatly assisted in making the continued operations effective and efficient.

The crews assigned to the ensuing EMS incident worked the incident without histrionics. Both patients were treated and removed from the scene efficiently and effectively. The crew members assigned to the shooting victim had all been on air on working hose lines when they were reassigned to EMS duties. They provided excellent and precise ALS to a critically injured patient within seconds of having been fighting fire. This is not an easy operational mode switch.

During discussions regarding whether E[1] should have waited to move in until the deputies had secured the resident, it became evident that throughout the ranks there were a few company officers and firefighters who had additional firsthand knowledge that the resident had made violent threats against fire and police personnel. None of these personnel had documented this information and forwarded it to Fire Alarm Dispatch so it would have been available to any responding units including those listed herein. It was also evident that holding off with the observed fire blow up in the windy conditions would have yielded an entirely different set of threats to firefighter and resident safety. We are looking into further training on reporting threats and sharing information with the sheriff's office so that all personnel can be made aware of known potentially dangerous situations.

An on the air PAR should have been conducted so all personnel away from the fire ground would have known that no fire personnel were involved in the shooting. A few minutes after getting the second alarm briefed Command had Safety notify Fire Alarm to pass this information on to all stations, but a few firefighters in the battalion had a 10 to 12 minute window where they did not know that a firefighter had not been shot.

Report Number: 12-0000073

Synopsis: Paramedic falls in the snow with patient.

Event Description: Medic [A] responded emergent to a medical assist at a retirement center with an engine from a neighboring agency on an auto-aid call. On arrival, the patient was found in the sitting area of an assisted living facility. She had her coat on, her purse and wanted to be taken to the hospital because she was nauseated and experienced bouts of vomiting earlier this am (the patient condition and treatment is unrelated to the incident). The medic [A] crew decided they could handle the situation and cancelled the Engine responding to the scene. The weather was very bad, heavy snow, approximately one foot of fresh snow this am. Medic unit [A] made a decision to keep the engine in service and handle patient care on their own. The patient was placed on the pram in a position of comfort with blankets and straps as required. The patient was transported to the ambulance on the pram.

The crew member reached to open the back doors of the ambulance, the pram wheels stuck in the snow and the pram flipped over onto its side. The patient stayed restrained to the pram, however went over with it. The patient landed in a foot of fresh snow and it cushioned her fall. The patient was uninjured from the fall. However, the crew learned a valuable lesson on resource management. The crew should

have waited for the responding engine and used the staffing to assist in loading the patient into the ambulance. It seemed like a good decision at the time to keep the engine in service and out of the elements. We must remember taking care of our citizens is our first concern, and this is why we have these resources.

The patient was transported to the hospital uninjured from the incident, and treated for her initial complaint of nausea and vomiting. The extra care and compassion the patient received en route assisted in making her feel cared for. The patient understood accidents happen, especially in extreme weather conditions. However, this could have been avoided, and I feel sharing it may prevent a similar occurrence in the future.

Lessons Learned: Utilizing personnel that are available on the call may not be adequate, always consider your environment, along with extraordinary circumstances such as weather. There is a reason we send an engine and a medic unit to medical calls, these circumstances are exactly the reason.

Treat the patient and the incident as the most important at the time, understand other situations may occur, additional calls, but there are mechanisms in place to deal with them. Multiple calls can be dealt with on a one by one basis as they occur. Take care of the one you are on now.

Every patient and member of the community deserves the highest level of care we have to offer, this is our mission. Remember situational awareness, effective communication, understanding your equipments limitations, and always watch weather conditions. Remember why we are there in the first place.

Report Number: 12-0000074

Synopsis: Good SA helps spot electrical hazard.

Event Description: While operating at a chimney fire in a one-story, wood-frame, ranch style house, the roof crew noticed a potential electrical hazard. An old and no longer used television antenna was found strapped to the chimney where the fire was, the roof officer noticed that the wire leading from the antenna was resting against the home's electrical service. Noting that there was a potential electrical hazard, the officer reported it to the IC who notified the power company.

After about 20 minutes the power company arrived and removed the antenna wire which had been in contact with the neutral leg of the service.

Lessons Learned: Once again we learn that no call is routine and situational awareness needs to be ever present. I submit this report as an example of a good 'heads-up' play by the roof officer.

The officer saw a hazard, reported it, took the necessary precautions, and allowed for its mitigation, all this with no injuries.

Report Number: 12-0000075

Synopsis: Power line falls across engine at structure fire.

Event Description: I was the incident commander at a structure fire involving two structures. The first structure had power lines burn through and drop across the top of our first-in pumping engine. Once I was advised of the incident, I communicated to all companies on the scene that we had a power line down on top of our pumping engine. I told the companies on the scene that we were abandoning the engine. We set up an additional engine for our pumping engine and continued suppression activities. We were short on resources and we did not use safety tape to mark the hazard area.

Lessons Learned: I feel that I should have got confirmation from each company that they understood the safety alert. We have a policy of declaring emergency traffic and getting confirmation. I should have made it the top priority to get the area marked with caution tape. I also should have assigned a safety officer to monitor the area. Fortunately, no one was injured and we marked it as a lesson learned.

Report Number: 12-0000076

Synopsis: Saw head detaches during operation.

Event Description: We had a reportable mishap while operating the [product name withheld]. The incident occurred when firefighters were performing hands-on training with the saw. About 30 minutes into using the saw, a firefighter wearing full PPE was using the saw to cut a wooden truss assembly that was scrap material. As he was cutting the material the entire saw head/blade assembly operating at full RPM became detached and fell to the ground. No injury was sustained but the potential for severe dismemberment and injury was extremely high.

Part of a sheared bolt fell onto the ground right next to the firefighter. Two mounting bolts hold the head assembly to the body of the saw. Interior inspection revealed the other half of the sheared bolt was still inside the front of the saw. The rear bolt was missing. It was determined that the rear bolt was not present before operation, or that the bolt vibrated loose and out during the operation. The manufacturer was contacted to see if there was any history of this happening. We were told there was one other occurrence.

[Manufacturer information is under review. Additional information will be added to this report as it is obtained.]

Lessons Learned: A close inspection of all bolts before operating the saw would have determined if the bolt was loose or missing and could have prevented the incident. Comprehensive periodic inspection of equipment is vital since you don't have time to do it during emergencies. It's not enough to do only a functional check to ensure a piece of equipment operates properly. Periodically all bolts and fasteners should be inspected. Was the sheared bolt defective or could it have vibrated loose during the first 30 minutes of using the saw? For extended use, maybe bolts and fasteners should be inspected every 30-60-90 minutes to ensure nothing has vibrated loose. This Near Miss was an extremely valuable lesson learned for our department and we are fortunate that no one was injured.

Report Number: 12-0000077

Synopsis: Propane tank found venting on patio.

Event Description: My fire department was dispatched for a reported structure fire in our first due. The first arriving chief reported a single story residence with heavy fire & smoke showing from the rear of the structure. I was the officer on the first in company.

When we arrived on location, we were instructed to enter the residence through the front door with an attack line and to begin fire suppression operations. The interior crew was able to put a quick knock down on the fire. While inside, the nozzle man noticed gas was helping feed the fire. At this time, we instructed Command to have the gas shut off.

Come to find out after we exited the structure that the gas feeding the fire was coming from a propane tank that was stored on the outside patio. The homeowner informed us that the propane tank did not have a shut off valve. Once the tank was removed from the structure, it was found that the pressure relieve valve had been activated. As a result, a second attack line was immediately put into service cooling down the tank. After some time, the tank was cooled off.

Lessons Learned: What was learned is make sure all important information is gathered from the homeowner as soon as possible. If there is a crew inside, and command is informed that there is a propane tank inside the structure, have command take the necessary steps to inform and protect the interior crew as well as all other crews operating on scene.

Report Number: 12-0000079

Synopsis: Tanker overturns enroute to structure fire.

Event Description: While in response to a working structure fire, I was paying attention to fireground radio transmissions. An interior fire attack was underway and the fire was advancing inside the structure, causing the on-scene truck company to connect its tank water to the on-scene engine company for additional water supply. No hydrants were in the area so my apparatus was to be the first water supply available.

While approaching the intersection, I shifted the transmission down two gears (9 speed manual transmission), applied the engine brakes for a section of the approach, and sounded the air horn twice. At about halfway through the turn, I knew the turn didn't feel right. I was going too fast. For a short second I considered going off the turn to the left into a gravel car lot, thought twice, and assumed to myself, "I might be able to make this." As the truck heeled to the right side stops, I knew this wasn't going to be good. At approximately three-quarters through the turn, the truck seemed to roll further to the right, as it approached a large tree to its right side. It seemed like slow motion as it went over, however the subsequent "crash" that still reverberates through my head was a tell-tale sign that I might be dead pretty quick.

Once the truck came to rest, I could hear several people shouting and approaching from the front. I was hanging upside down by the seatbelt, still fully seated. I reached down, released my restraint, fell against the roof of the cab. The windshield was destroyed, I immediately self-extricated from the cab through the windshield opening that was about one third its normal size. I grabbed my turnout gear from the cab, picked up a handheld radio, and announced the situation to dispatch and requested resources.

My helmet, which had been sitting on the passenger seat, was ejected from the cab, and stopped about 20 feet in front of the truck. Minor fuel leakage was stopped very quickly, additional resources arrived, and I was assessed by an EMS crew. Being a chief, the EMS crew reluctantly accepted my personal insistence on signing the refusal for treatment form, as I was saying, "I'm OK, I'll be fine". I took a look at the cab condition and intrusion, felt the bump on the side of my head, and realized if it were one of my people, I would make them go to the hospital for evaluation. Of course, by that time my wife was on-scene as was certainly not going to take me home.

I was transported non-emergency to the local hospital, treated and released with bandages on my rear right shoulder, and a big injection of acetaminophen.

I am lucky to be alive. I am glad it didn't happen to anyone else, I was alone in the cab, and that no one was close to the truck when it rolled over.

This is one of the most significant events in my 24 year fire service history, and my department. I am looking forward to receiving the State Troopers report, to compare his scientific application of the on scene evidence against what I thought was going on at the time. I have pledged to use this event to train all members of my department, and any other departments that want to hear it.

I can't get around the fact that I was going too fast for the turn. I've been around that turn, in that apparatus, responding to working fires, probably 100 times over the years. This time my number got pulled, and I lived to tell and teach about it.

The following Saturday was St. Patrick's Day, I was blessed enough to play catch with my Grandson and hear my Granddaughter say "Hi Grandpa!" With slightly different results, it would have been my funeral day.

Other pertinent information

I was driving a 1985 4000 gallon water tanker in response to a working structure fire. I was the single operator, no passenger. There was no event response within the past 24 hours. I failed to negotiate a left turn while turning from a state highway onto a county highway, (four lane highway with a center turn lane onto a two lane roadway). The intersection is light signal controlled and the signal was green in my direction of travel. There was no oncoming or crossing traffic in the area and no visual obstructions in any direction. This resulted in overturning the apparatus onto its right side, striking a large tree.

I was wearing factory lap belt.

I self-extricated from the apparatus after it came to a rest approximately three quarters upside down.

I came away with minor injuries and was treated and released at the local hospital.

There was heavy damage to the apparatus cab, water tank, and compartments.

The outside right rear axle tire blew just prior to apparatus going over the center of balance.

The apparatus was maintained as part of fleet maintenance by a Certified Emergency Vehicle Technician mobile service.

All department personnel are trained annually to NFPA and state specs for Emergency Vehicle Operation/Driving. The last annual certification was 11/2011.

Brakes were serviced within the past twelve months.

Four tires had been replaced within the past 12 months. The tire that failed was approximately three years old with no obvious loss of tread or excessive wear prior to accident.

Lessons Learned: 1. Never take for granted the situation you are in as "routine". Always anticipate what is going to happen next, before it happens.

2. Insist on a minimum of annual driver training/ refresher courses, test to standards and develop and follow department S.O.G's, especially if you're the one who wrote them. Review them often to keep them in the front of your mind when operating apparatus. Strive towards all department apparatus to be in current NFPA compliance, perform regular certified maintenance. Work towards not using "converted" vehicles for response apparatus.

3. All of the above, and have a plan in place in the event things go wrong.

Report Number: 12-0000080

Synopsis: Diver runs out of air during ice dive.

Event Description: I was the safety officer for this training exercise. The primary diver was using conventional SCUBA (80cf) with a pony bottle (19cf) bail out system. All divers are in dry suit and full face pieces. The primary diver had some challenges with weight issues and equipment configuration. The tenders in this case are new and we were boat based in about ten feet of water with thin ice conditions. After a few attempts due to equipment issues, the primary diver initiated the dive. We allowed the diver to go only about 20 lateral feet due to the challenges that were incurred. We had the diver on hard wire communication and after five sweep patterns, we advised the diver to start a slow ascent and we would do a lost diver drill with the safety diver. Suddenly and without any communications or rope signals, the primary diver started to pull himself in towards the boat. We noticed an emergency and told the safety diver to start towards the primary. The tender was told to pull the diver in also. The primary diver suddenly surfaced and removed his mask stating he had a mask failure. We had the diver exit the water and place his gear in the boat for examination. The primary diver suffered no injury.

On inspection of the dive gear, he had 2500 psi in his 80cf cylinder. His octopus worked fine. His face piece did not have any air going to it. We checked the switch block and noticed it was in the position for the pony bottle. I removed the regulator from the pony bottle and found it was empty. The diver was diving on his pony bottle system the entire time. He did not attempt to switch the block position and stated he would have removed his face piece and used his octopus, but in ice water, this is not as easy as it sounds. Later discussion found he had not been trained on the ice, had no pool time, and was not aware of the operation of the switch block. We are fortunate the diver was limited to lateral distance of 20 feet. At a greater distance, he may have had different results.

Lessons Learned: Divers must be trained and knowledgeable with their own gear. When the "domino" effect starts to take place, don't push on just to complete the dive. My gut feeling in this case limited the

diver to go out only 20 lateral feet. Follow your gut! Each member of a division/county wide team must communicate with each other regarding gear issues. We don't all have the same stuff, but must be aware of each team's configurations. This diver learned the hard way to get into the pool first with new gear.

Report Number: 12-0000081

Synopsis: ARFF super tanker rolls during response.

Event Description: The driver was operating an airport fire department emergency semi-tractor trailer super tanker that carries 6,000 gallons of water and approximately 500 gallons of AFFF foam, to a report of an aircraft on fire. The super tanker rolled onto its right side during the response while making a left turn onto an adjacent taxi way. The tank wall was breached and all 6,500 gallons of agent spilled across the taxiway and grass areas. Responders from the same organization were behind the super tanker when it flipped and witnessed the accident and deployed a mayday call on the radio. Responders reported problems with immediately accessing the cab of super tanker due to the engine running and drive shaft still spinning. On the opposite side of the cab, large amounts of foam and water were making it difficult to reach the cab. Within moments of reaching the cab, responders witnessed the driver climb out and down to the ground. ARFF units automatically responded and diverted to this emergency. They used bolt cutters to cut the battery cable to disconnect all power to the super tanker. Due to the super tanker operating on taxiways and less than 1/2 mile travel distances, seatbelts are not commonly used on airfield responses. The driver suffered minor injuries.

Lessons Learned: ARFF training quality has diminished significantly including driver/operator recurrent training. Seatbelts must be used even on airfield responses. There needs to be an increase of driver/operator training & requalification. Air traffic control personnel need training in recognizing the need to get the fire department priority airfield clearance on emergency responses.

Report Number: 12-0000082

Synopsis: Survival skills pay off for FF in trouble.

Event Description: My department was called to a structure fire with flame showing. Engines from [department name deleted] and the surrounding area responded for a working fire. The fire source was a boat that exploded while was being worked on by a mechanic. After the fire was brought under control, fire fighters went into the attic space above the warehouse to search for fire extension. One of the fire fighters lost his footing and fell through the ceiling. He was hanging on by his hands alone. He was over forty feet over the floor. Another fire fighter, who probably weighs around 120 pounds, came to his aid and grabbed the falling fire fighter by his air pack. This prevented him from falling to certain injury or worse until other fire fighters could bring ladders to safely bring the fire fighter down to rehab.

When asked what he did later by his captain, his reply was, "Just doing the job". The captain was never more lost for words and proud to have this young fire fighter as member of his fire department.

Lessons Learned: Training only brings you so far. Inner courage takes some to the place where they are called a hero.

Report Number: 12-0000083

Synopsis: Concerned citizen delays fire attack.

Event Description: We were dispatched for smoke coming from the garage and arrived on the scene of a two story single family dwelling, with an attached garage and heavy fire showing from the garage with extension to division two. Both garage doors and the front door to the home were open upon arrival. Just as we were about to make entry through the front door with a charged hose line, a citizen, approximately 20 feet away was trying to tell me something, but I was too far away to hear him. I motioned for him to come to me and walked toward him, and he advised me that everyone was out of the house. I communicated this information to my crews on scene. This took about ten seconds. I was now ready to make entry with my crew but just about three feet from the front door, there was an explosion followed by a second explosion one to two seconds later with lots of debris flying out the front door at us. I turned my head and made sure my crew was safe. I heard something falling but couldn't tell if it was the house or something else. Side A was intact but when I walked around to side B, that's when I saw the Bravo wall had collapsed from division two and the cockloft. Side Delta had blown out approximately nine inches with all the walls still intact

Lessons Learned: If first due, always perform a 360 of the structure. This was a lucky day for my crew and me due to a citizen trying to tell me something. Ten seconds saved our lives.

Report Number: 12-0000084

Synopsis: Fire station destroyed by tornado.

Event Description: On March 2nd 2012, our station was hit by an EF-3 tornado. The station took a direct hit and was demolished. Firefighter [A], a member with less than a year on the department, was inside the station when the tornado hit. He was in the only part of the station left standing and came out uninjured. Everything around him was gone. This was all caught on the dash cam of my Command SUV.

Lessons Learned: Firefighter [A] is very lucky that he was not injured or killed in the tornado. His instincts and training took over and he went to the part of the building that was the most sturdy to take cover. If he had not done so he may not be with us today. Our department is an all volunteer, non-taxing, department that relies off of donations only. This has made a huge impact on our lives and we will be struggling to keep our doors open. Our story is on our website.

Report Number: 12-0000085

Synopsis: Damaged natural gas line causes problems at a structure fire.

Event Description: We were dispatched at 23:59 hrs on a Sunday night to what was originally reported as an apartment building fire. Our engine arrived to find a three story ordinary construction, mixed occupancy, a 'place of assembly' on the first floor and residential space on the second and third floors.

Upon arrival, flames and smoke were visible from the delta side of the first division. The crew on the engine advanced a 1 ¾ hand line to the door on the delta side and forced entry to initiate fire attack. A short time later the operator of the engine radioed to dispatch reporting that we have a man down. When asked over the radio for clarification of the problem from our ladder truck (now about half way to the scene), the engine operator stated that firefighter [a] went through the first floor and fell into the fire in the basement.

Crews already on scene managed to place an attic ladder down into the hole in the floor and pull the firefighter out and onto the sidewalk where he was attended to by EMS. At this time, all personnel were accounted for and a second fire attack along with search and rescue operations was initiated.

Reports of a civilian being trapped on the second division prompted the search crew to check that area first. Conditions were zero visibility and there was a high level of heat on the second division upon entry. The search team officer radioed command and requested vertical ventilation and a positive pressure fan to the apartment entry door on the A side of the building.

Crews were having a hard time making headway of the fire on division one and quickly realized that the fire was being fed by a natural gas line in the basement. No gas meter was found outside; being an older building the meter was located in the A-B corner of the basement.

The search crew completed a primary search with no results and command once again spoke with bystanders who stated that the occupant's vehicle was parked outside and that he was not out yet. A secondary search crew was sent to the apartment in an attempt to locate the occupant. About six minutes later fire and smoke conditions worsened and the Incident Safety Officer made the call to remove all firefighters out of the building.

It was realized at this time that a second larger gas line was ruptured by the falling floor that collapsed. The gas company representative could not immediately locate the curb valve to isolate the gas and a fire crew was able to make entry into the basement through an exterior door and shut the gas off at the meter. At this time the remaining fire was extinguished.

It was later discovered that the occupant of the apartment was vacationing in Italy at the time of the fire. As far as the firefighter that fell into the basement; he was the second man on the hose line that was being led by a Lieutenant. The Lieutenant was sounding the floor and after he made it about three feet inside of the door he felt a soft spot on the floor and yelled 'hold on there's something not right with the floor' to the firefighter. The firefighter stated that he could not hear what the Lieutenant had said so he leaned forward to ask him to repeat, when the floor collapsed sending him over top of the Lieutenant and into the hole. The Lieutenant was able to hang on and even tried to grab the firefighter as he fell but was unable to keep a hold of him. Luck was on our side that night and both the Lieutenant and the Firefighter suffered only minor injuries and are back on the job.

After the fire we determined what caused the floor to go out so quickly. The building was owned by the owners of a chain of restaurants and they were using the basement of the fire building as a commercial Laundromat for the linens used by the restaurants. The fire is believed to have originated in the area of the dryers and ruptured the gas line early on. The building was not equipped with a fire alarm or sprinklers and it is believed that the fire had been burning for some time prior to being discovered.

Lessons Learned: Communication is key to safety. Never judge a book by its cover and always be prepared for out of the ordinary hazards.

Regular training and drills on proper search and fire attack techniques are needed to keep our skills sharp.

Don't be afraid to use the terms 'mayday' and 'firefighter down' on the radio.

Utility control is always key in fire operations and may not always be accomplished easily.

Code enforcement and fire detection/suppression systems do save lives.

Report Number: 12-0000086

Synopsis: Interior hose crew jeopardized by exterior fire attack.

Event Description: Fire conditions encountered on our arrival were heavy fire coming from two units on the first floor, and it also appeared that heavy smoke and fire was coming from two units on the second floor. Multiple cars were leaving the area and were also parked along side of the fire lane blocking access to a primary hydrant.

At 11:37 E [1] arrived on scene to find heavy smoke and fire showing from the first and second floors of an eight unit apartment complex. E [1] went fast attack and completed a "360" of the building. We then advised communications that E [1] would be working in an offensive mode. E [1] confirmed a working fire with communications as well.

E [1]'s firefighter-paramedic pulled a 1 3/4" attack line to the front door (A) side of the building. E [1] asked the second due engine to bring us a supply line and assigned M [1] [medic unit] to interior operations along with E [1]. They had an assignment of a primary search on the fire floors on the first floor. T [1] was assigned to ventilation. E [1]'s tactical priorities were rescue and fire control.

The battalion chief arrived on scene and assigned E [2] to division "D" and to check for extension and conduct a primary search.

Here comes the near miss: While the E [1] crew was inside extinguishing the fire, the crew assigned to division "D" pulled a 1 3/4" attack line and started flowing water into the "A" side of the building window, which is clearly wrong in many areas.

My firefighter-paramedic asked why it was so hot, as it seems the heat conditions did not match the fire conditions. I had no idea and nobody said anything until we saw the YouTube video.

These guys flowed water into the window of the "A" building while the fire attack crew on the first floor was inside putting out the fire.

They were never assigned to do this; their assignment was division "D".

Lessons Learned: If you're given an assignment, stay there and work until your assignment is complete.

The training chief needs to teach the basics to everyone.

Report Number: 12-0000087

Synopsis: Interior attack inhibited by exterior crew.

Event Description: Fire conditions encountered on our arrival consisted of heavy fire coming from two units on the first floor and it also appeared that heavy smoke and fire was coming from two units on the second floor. Multiple cars were leaving the area and were also parked alongside the fire lane blocking access to a primary hydrant.

Engine [1] arrived on scene of a two story apartment complex to find heavy smoke and fire showing from the first and second floors of an eight unit apartment complex. Engine [1] went fast attack and completed a "360" of the building, then advised command that Engine [1] would be working in the offensive mode. Engine [1] confirmed a working fire. The crew of Engine [1] pulled a 1 ¾" attack line to the front door (A) side of the building. Engine [1] asked the second in engine to bring a supply line and assigned Engine [2] to interior operations with Engine [1] with a priority of a primary search on the fire floors. Truck [1] was assigned to ventilation.

Battalion [1] arrived on scene and assumed command and assigned Engine [3] to Division "D" to check for extension and do a primary search. Engine [3] pulled a 1 ¾" attack line to the "A" side of the building and flowed water into a window, while interior crews occupied that room. This action put the interior crew at risk, as there was a communication breakdown.

Lessons Learned: Make sure and post up where you are assigned by command. If you don't, you may end up compromising the scene and putting firefighter's lives at risk. Following the instructions of command is critical to the safety of all personnel on scene.

Report Number: 12-0000088

Synopsis: Freelancing puts ladder crew at risk.

Event Description: Our department's aerial apparatus was requested to a neighboring jurisdiction for a second alarm at a church fire. The apparatus responded with a crew of four including the on-duty shift commander (captain), lieutenant and two firefighters.

Unknown until after the incident, the first problem incurred was that the firefighter assigned to the jump seat told the firefighter assigned to drive that he would drive instead. This action was not known at the time of the response by the captain who ordinarily responds in a separate car, but instead responded on the apparatus due to the second alarm request.

Upon arrival the aerial apparatus was directed to the B/C corner of the pavement, to ventilate the roof. The vehicle weighs 72,000 pounds and the captain advised the driver/operator to stay on a paved walkway as much as possible.

The vehicle was positioned as ordered and with changing fire conditions, the captain went to do a face-to-face with the incident commander as the vehicle was set up. The lieutenant and a firefighter readied the needed equipment to prepare to open the roof for ventilation. As the captain discussed operations with the I.C., orders were changed to ventilate the A/B area instead. With the aerial in position and firefighters ascending the ladder upon return to the truck, there was no operator on the turntable. The driver/operator took it upon himself to "hand-jack" a four inch LDH supply line some 200 feet away from the vehicle. Upon noticing this, the captain immediately assigned a department member from a dispatched ambulance to take the turntable position and the initial driver/operator was re-assigned to EMS.

Following the incident the captain and lieutenant met with the driver/operator about his actions. The concerns were the safety aspects of leaving firefighters in a position exposed to danger. The driver/operator felt that water supply was more critical and he felt that he "didn't have to babysit" the turntable. These actions violated department standard operating guidelines which state that the operator shall remain with the turntable anytime firefighters are working on the aerial ladder. It also violated the department's SOGs regarding chain-of-command in that the driver/operator had both a captain and a lieutenant that he could have consulted with before initiating his actions. It was stressed to the firefighter his responsibilities as the driver/operator and concerns over the safety of the firefighters operating on the aerial.

Lessons Learned: Following the incident, the captain and lieutenant met with the firefighter who continued to defend his actions based upon his perception of the safety concerns for water supply. Situational awareness and risk was discussed and given previous concerns and disciplinary actions, the firefighter was disciplined by the captain.

Sent through the chain-of-command, the department is investigating the firefighter's actions and considering further disciplinary measures. However, he has already been given copies of department SOGs covering these actions, had already received remedial training on operating the aerial, and more remedial training is now scheduled. However, the problem is not so much with the physical operation of the truck but of the situational awareness and the risk involved. As part of the remedial training, safety, risk vs. benefit, and the importance of situational awareness will also be addressed.

As a small department our firefighters have to perform multiple duties from EMS and driving many types of equipment. The department is concerned about his actions in similar situations, such as being the pump operator, or other positions of responsibility in which others are dependent on his actions. The department is in no position to single him out and assign him only to certain positions. One immediate action is to insure that he is always assigned to a crew with an officer.

Report Number: 12-0000089

Synopsis: Simultaneous interior/exterior attack.

Event Description: E [1] arrived on scene of a two story apartment complex and found two units on the first floor burning and two units on the second floor burning. The first engine arrived on the scene and went fast attack. The officer walked around the apartment complex and met his FF/PM at the front door of the involved apartments on the first floor. The captain on E [1] assigned the first due FF/PM unit on scene to assist with interior operations and to complete a primary search. He also asked for the second-in engine to bring a supply line. The B/C arrived within two minutes and assumed command of the incident and made E [1] Fire Attack on the first floor.

Here comes the near miss. The B/C assigned E [2] to Division "D" to check for extension and to do a primary search. E [2] pulled a 1 3/4" line off of E [1], then, instead of reporting directly to Division "D", these [firefighters] stopped at the "A" side of the building and flowed water into an open window on the first floor right where the fire attack team on the first floor was operating. It backed the crew out of the second unit that was on fire, delaying the primary search and fire containment, not to mention steaming the firefighters on the hoseline.

Lessons Learned: Our EOM emergency ops manual clearly states to never attack a fire from the outside while crews are working in the inside. This is kind of like the "candle to moth" syndrome, not to mention possibly hurting crews inside. This [firefighter] was assigned division "D" not "A"????

Here is the scary part, we actually reviewed / critiqued this fire with all members present. The training chief never spoke of this near miss and the B/C spoke of it very indirectly, kind of like "nice-nice", instead hours were spent discussing other actions less important.

It is all over YouTube so it was caught on tape for all the chiefs to see and nothing has been done, in fact this individual is putting together our truck standards.

I guess everyone makes mistakes and I can truly forgive, but the [firefighter] never apologized to anyone. I think this guy thinks it will go away and everyone will forget.

Report Number: 12-0000090

Synopsis: Accident scene results in FF injury.

Event Description: Our department, along with a neighboring department and a neighboring hazmat team, was working a multi-vehicle tractor-trailer accident with a fuel spill. As the incident progressed the IC determined that the highway should be shut down at the nearest exit ramp. A tapered cone detour was established and a law enforcement vehicle and a fire department staff car were set up behind the barricade approximately 100 feet, per departmental operations guide. This barricade was set up at approximately 0300 hours. At 0504 hours our communications center notified our department of a second MVC with pedestrian struck at the site of the detour. While en route the chief was notified

that it was a firefighter that was struck by a passenger vehicle that had run through the barricades. Upon arrival a firefighter was found against the guardrail with non-life threatening injuries. The firefighter was transported to the hospital and was discharged two days later.

Lessons Learned: The number one thing that we have learned is no matter how much training is conducted on a topic things still will happen that could cause injury or death.

The operational guide that discusses road closures will be reviewed and we will evaluate the need to increase the distance vehicles are in relation to the barricade.

Report Number: 12-0000091

Synopsis: Porch collapse traps FFs during rescue.

Event Description: On [date and time omitted], [department name omitted] was alerted to respond to a structure fire with a possible entrapment. Engine [1] was responding within four minutes with a crew of four, followed by Engine [2]. Engine [1] arrived on scene to find a one-story residential structure with one room and contents involved in fire with extension to the front porch. Engine [1] deployed a 1 ¾" attack line into service and advised Engine [2] to put a supply line on the ground from a nearby hydrant. Firefighters were confronted by law enforcement who stated that one occupant was still in the structure. Units advised the responding chief that they were going interior for a search and fire suppression.

As Captain [A] and Firefighter [B] were going across the front porch to make entry, the porch roof collapsed on them, knocking both unconscious. Lieutenant [A] and two police officers were able to reach the downed firefighters and remove them from under the roof and drag them to a safe area. Lieutenant [A] issued a MAYDAY and requested three ambulances and three other fire departments to respond.

The two firefighters were taken to local hospitals and treated for injuries. Both firefighters were out of work for two weeks for treatment. Both units returned back to active duty. The occupant did not survive.

Lessons Learned: Both firefighters did not have full PPE. WE need to enforce on every incident that full PPE is to be worn by everyone. Also, this incident is an example of the emotional effect firefighter injuries can have on other firefighters

Report Number: 12-0000092

Synopsis: High CO levels found following incident.

Event Description: This was a carbon monoxide incident. Another shift had the call. The call was for a welfare check with the police department. Crews found a deceased occupant on the third floor of a townhome. Police reported that an odor of exhaust fumes was prevalent, but this was not relayed to the

fire department. After several calls and days later carbon monoxide readings were found in the initial home and auto exceeding 200 PPM.

Lessons Learned: Be sure and monitor for carbon monoxide thoroughly and in adjacent apartments when there is a suspicious death.

Report Number: 12-0000094

Synopsis: Passing truck hits low hanging cable endangering on scene personnel.

Event Description: Our engine company was dispatched to a motor vehicle accident involving an automobile and a utility pole on the interstate highway. Police officers on the scene had requested that the ambulance cancel their response but that the engine continue to respond due to pole damage.

The engine company arrived at the same time as the power company. The power company then stated that the power line over the interstate was too low for clearance of large tractor-trailer trucks. Within 30 seconds a large box tractor trailer truck came through and caught the low hanging wire which created a very loud zipping sound as cable was pulled from pole to pole.

This also caused wires to shake and arc together on a three phase electrical distribution system causing a power outage. A residential electrical service was also located under the three phase lines.

The wire that was caught by the truck was a fiber-optic line with a steel guy wire for support over the large span over the interstate. At the time of the event, there was no time to divert or stop traffic once the hazard was observed.

When the truck caught the wire, the fire crews jumped for shelter near vehicles. There were multiple police officers, utility workers, the engine crew, as well as the civilians from the car in the danger area; however none were hit from the wire.

The cable was stretched by the tractor trailer truck until it broke. Pieces of the broken fiber-optic cable and support cleared the south bound travel lanes, but there remained a large tail of wire that went across the north bound lane and into the median. There were also several large coils of cable found in the median.

The wire was lying flat on the north bound lane and was a large concern until we were able to shut traffic down on that lane. The utility workers then cut and removed the cable from the travel lanes. Further vertical clearance was checked and considered to be at a safe height. The interstate was then re-opened.

Lessons Learned: Situational awareness was a large factor in this incident. The decision to close an interstate is a tough one and when this decision was made, there was no time for implementation. The police officers on scene who called for the engine response probably should have closed it though several smaller style trucks had successfully gone under the wire. They may not have perceived the problem.

Report Number: 12-0000096

Synopsis: Building integrity compromised during training fire.

Event Description: Along with several mutual aid departments, our department conducted a NFPA 1403 compliant controlled burn of an acquired structure. All pre-planning, pre-construction, pre-inspections, and pre-briefings were conducted. The command structure was in place, all safety positions were filled, along with an ignition officer. Several training fires were conducted on the second floor of this dwelling with great success. As the training moved to the ground floor rooms it was noted that water was draining through the ceiling from the previous evolutions. As the suppression team finished their extinguishment of an evolution and exited the structure, a three foot by four foot section of the ceiling came crashing down exactly in the spot where the crew had been perched. There were no injuries or problems. However, it was decided by the safety officers, operations section chief, and incident commander not to utilize this room for any further evolutions.

Lessons Learned: There were two other rooms utilized as burn rooms on that day. Prior to any ignition or entry by personnel, an inspection hole was initiated without any indication of further water. These inspection holes were also covered with small pieces of drywall prior to continuing.

As the safety officer, it became a major area of concern for the duration of the evolutions. This was a definite item of discussion during the after action instructor's briefing. This item was also recorded for future reference.

Report Number: 12-0000097

Synopsis: Deck gun swings loose during pump operation.

Event Description: The crew was in an area that was under development and was conducting some flow testing of hydrants using the engine. Traditional flow tested had indicated low fire flow. The engine is a top mounted pump with a deck mount within reach of the pump panel on top of the engine. Water supply lines were attached to a five inch Siamese which was connected to the five inch intake on the driver's side. Another piece of five inch hose was hooked to the hydrant adapter and that was placed under the engine and into the five inch intake on the officer side. The fog tip and stream straightener was removed from the deck gun and a diffuser with an internal pivot tube and a water flow gauge externally. The hydrant was opened and the intake on the driver's side was opened. With the pump at idle, the driver who was standing just to the left of the center of the pump panel facing the rear of the unit. He reached up and positioned the deck gun perpendicular with the engine off of the officer's side. I observed him tighten the handle to secure it and keep it from moving. He then slightly elevated the nozzle. He reached up and slowly opened the discharge valve for the deck gun (at idle) and when water started coming out of the diffuser, the gun immediately swung to the left causing the alert operator to

duck to keep it from hitting him in the head. We shut down and checked the locking mechanism to confirm that it was indeed as tight as possible and it was.

Lessons Learned: It is critical to pay close attention to what you are doing and always be observant of the situations around you. The pump operator was an experienced, seasoned firefighter. I feel the outcome may have been significantly different if the operator had been young and been inexperienced.