National Fire Fighter Near-Miss Reporting System
Reports Related to Rapid Intervention

07-890

Event Description
We were dispatched to assist at a structure fire with a mutual aid department. Our department was sent for RIT & tender operations. The RIT team arrived and staged at the A/D corner of the structure.

Our RIT did a 360* of the building, set ladders checked conditions, number and locations of crews working and stood ready. About 20 minutes into the response, crews lost water for a short time and were forced to retreat. After water supply was re-established the crews made a second aggressive attack.

After about 10 minutes into the 2nd attack, the conditions rapidly deteriorated. After a quick consult (less than 20 seconds) with command the evacuation order was given and air horns sounded. Crews were attempting to retreat when there was a flash over. The RIT was activated due to lack of accountability of 2 crew members.

The RIT made their way into the 1st floor, did a quick search, found 1 FF wandering in the first floor hallway dazed and confused. He was assisted to the front door and handed to waiting FF's from the RIT support. The crew then made their way to the second floor landing which was the other FF's last known location. Following the hose line, there were no other FF's located. The RIT was cut off by fire that was coming now from a first floor room across a ceiling and then across the stairway.

The fire was hit from a hose line manned by additional RIT members and allowed other RIT members to egress to the front door. At this point it was determined that all FF's were accounted for and out of the structure.

Lessons Learned
The function of a command staff was needed. The IC attempted to do too much and the span of control was too great. Other department chiefs assisted with getting this under control.

There was a need for a committed accountability officer. The accountability officer was not keeping accurate records of crew locations or job tasks. There was only an attendance system initially, until a new accountability officer was assigned. If the accountability would have been in place, we would have known there was only 1 FF missing. Make sure that all firefighters are trained with the knowledge of an accountability system.

Have all FF's understand the RIT function and what the need of every FF is if the RIT is deployed.

There is no real way to change the fast changing fire conditions except to never do an interior attack with the risk of potential injuries of FFs.

10-277

Event Description

Fire department units responded to a reported residential fire [just after midnight]. Size up indicated heavy smoke showing with confirmation of the residents being out of the structure. The residents also reported that the fire appeared to be in the basement laundry area, around the dryer. Entry was made into the structure simultaneously with some ventilation underway. Further ventilation operations were ordered following reports from inside.

The basement stairway was located next to the main floor kitchen, with the seat of the fire located directly below the kitchen in the basement. The incident progressed as expected through the first twenty-minute PAR. Water supply was established, utilities were ordered for disconnect, RIT team was established, and ventilation was well underway.

About thirty minutes into the incident, a request was made from interior crews to have someone bring another 1 ¾" line in through the garage to access the basement. The RIT team was assigned to perform this task and then stopped, as the garage was too packed full of stuff to even make their way inside. That crew was then outside the structure, but had not reassembled for RIT assignment (IC's call).

The IC was making another 360 to check on a utility worker when dispatch notified IC of the forty-minute operational mark. During this PAR, command heard a PASS device activate and yelled in the direction of the activation, thinking that someone might have been standing still and it activate. The PPV fan was still operating so the noise level was elevated. Soon after hearing the PASS device, dispatch also reported the radio emergency alarm activation of a radio. IC was on Side "A" looking in the open front door of the structure and could see the faint blinking of the PASS strobe in the direction of the sounding PASS device.

Immediately, one of the personnel originally assigned to RIT was told face- to-face to get that person out of the building. At the time, IC was extremely unhappy, thinking that somebody had just let their PASS device activate and didn't bother to stop it. The RIT member followed the hose line in a short distance, approximately thirty feet, toward the strobe and dragged the downed firefighter out. Upon exiting the structure, he was helped to his feet, immediately assessed for injury, and then relocated to the ambulance for further evaluation. Subsequently, he was transported to the hospital, as a precaution, for further testing.

In interviewing the [downed firefighter], he stated that he was with his crew member in the basement on fire attack, along with another two-person crew. His low-air alarm had activated and he continued to work, thinking he had plenty of time. After a time, he told

his partner that he was going to run outside and get another bottle. He then left his partner and headed out of the laundry area in the basement, following the hoseline around the corner and up the stairs. Part way up the stairs, he completely ran out of air. In a condition of "high motivation," he started to hurry. Staying low and following the hoseline, he became disoriented and ended up reversing his direction. He then fell back down the stairs, knocking his face piece off.

The conditions were still untenable. He repositioned his face piece so his Nomex hood would give him some filtering action. He then activated his PASS device and activated the emergency button on his radio. He stated that he was unable to speak due to the heavy smoke conditions.

As a side note, his partner thought he heard a PASS device activate, but he stopped hearing it (the captain went back up the stairs to attempt exit) so he assumed that it was an accidental activation. As the captain cleared the top of the stairs, he had to keep his face close to the floor. It was at this point that the RIT person located him and pulled him to the exit.

Lessons Learned

One important lesson learned that must be addressed is that the SCBA Lost and Disoriented Firefighter Training conducted by this department worked in its most basic form. When the situation became less than ideal, the captain controlled his emotions, remained calm, activated his PASS device and his radio emergency button, took steps to get the best quality air he could find, and was actively involved in rescuing himself. Remembering those important training points is very commendable. However, although the outcome of this "near miss" incident was positive, this particular incident itself was completely preventable.

Several opportunities for improvement have been identified in response to this incident:

1) Strict adherence to the "Two-In Two-Out" rule should be enforced.

2) Strict adherence to the department's air-management protocol (when the low air alarm activates, you call for relief and then immediately exit with your assigned partner or crew) should be required. Additionally this should be reinforced with a department SOP/SOG regarding SCBA Operational Procedures and Air Management.

3) A "ZERO TOLERANCE" departmental policy regarding PASS device activations should be implemented and enforced. When a device activates, it gets immediate attention. Anything less than this creates a potential environment of dangerous complacency when hearing them activate.

4) Incident Command should diligently track at any moment where their personnel are and maintain a good communication link with anyone on the fire ground.

5) Once a RIT team is assigned, they should not be reassigned unless activated or relieved by a replacement, until the incident de-escalates.

6) Regular training should be conducted on the Lost and Disoriented Firefighter Procedures, along with SCBA Air Management training.

7) Training should be regularly given to reinforce the importance of the SOP/SOG's that are in place to keep personnel safe on the fire ground.

06-083

Event Description
After arriving at a structure fire in a single family home, and having initiated the incident command system, I ordered two fire fighters that arrived on a call back apparatus to initiate a rapid intervention team. We had a well-involved structure with reports of a person trapped, and the fire was communicating to a second structure. After the initial attack team entered, I noticed the RIT team putting their masks on and preparing to enter the building. Apparently, a Captain had ordered them into the building. The RIT team leader was upset he was "just standing around" so he solicited the Captain to go to work. I questioned the Captain and had them withdrawn from the building. The RIT team leader did not take the job seriously, and did not communicate his assignment to the Captain, leaving us without a RIT team at a very dangerous fire.

Lessons Learned
Assignments are to be carried out without argument. RIT is vital to our safety. When making assignments, first consider if the crew was assigned and accounted for by command as they arrive at the incident scene.

07-628

Event Description
Due to a LODD suffered by a neighboring department earlier in the morning on this same day, the crew at Station A reviewed RIT and Mayday procedures. Later the same night, Engine A was dispatched to a working structure fire along with the standard one-alarm assignment of 4 Engines, 1 ladder, 1 heavy rescue, 1 ALS transport unit and 1 (Acting) Battalion Chief. On Engine A's arrival, heavy smoke and flames were reported inside a "routine" ranch residential dwelling with a basement and attached garage. Police officer on the scene relayed information of potential occupants still in the house due to car in driveway and neighbor reports of not seeing the homeowners. An LDH supply line was secured and a 1 3/4" handline stretched to the front door. Report was made to the IC concerning possible entrapment and fire involvement into the attic area with lightweight wood truss construction. Entry was made with Capt. A and firefighter A (probationary < 2 months) through the enclosed breezeway between the kitchen and the

garage. The fire appeared to be located only in the living areas of the home and had not extended into the garage. The primary attack/rescue crew also had a thermal imaging camera and hand tools along with their handline. Additional crew arrivals began other essential duties. The interior crew knocked down the fire in the kitchen and was preparing to move into the living room to determine conditions in the hallway near the bedrooms. At this time, the fire appeared to be on the main floor only. As the crew began their advancement, the Captain advised his partner that he had left his TIC by the kitchen door (approximately 3-4 feet away). Firefighter A then turned around to retrieve the TIC. As he was doing this, Captain A decided to "lean" into the living room to look down the hallway. (It should be noted that the crew did not separate, rather the firefighter simply had to turn around to retrieve the TIC). As the Captain "leaned", the floor in the living room collapsed and the Captain fell into the basement without the charged hoseline. Captain A immediately called for a Mayday in the basement and advised IC of the hole in the floor. After trying to pull himself back up through the hole, another crew had made entry and Firefighter B made contact with the Captain in the basement. Firefighter B laid down on the floor of the kitchen and held his hand down through the hole to hold the Captain's hand to keep the Captain oriented and note his location. Firefighter B then radioed command and notified of contact with Captain A and location. Captain B had located Firefighter A and they both utilized the handline to keep the fire off of Captain A and Firefighter B. The IC immediately advised all crews of the incident and notified the RIT crew to respond to the kitchen area. As is protocol, a second alarm was dispatched. Additional staff officers and units began arriving. After approximately 5-7 minutes, Captain A was able to self-extricate after locating the stairwell through the dense smoke and heat. As he was extricating himself, a third crew had set up operations at the front door to assist with Captain A's removal. As this third crew was setting up, Firefighter C crawled in to the living room approximately 2 feet; the floor immediately collapsed sending him to the basement. Firefighter C subsequently also called a Mayday. Captain A had already escaped the basement when Firefighter C fell in. The RIT crew had already begun working on getting a ladder to Captain A and quickly changed to use it for Firefighter C. Firefighter C climbed up the ladder and out the front door. The IC immediately called an end to RIT operations and changed incident strategies to making this a defensive fire.

Lessons Learned

1. Better recon on arrival to determine occupancy and fire involvement.
2. NEVER leave the side of a partner, even though Firefighter A simply had to turn around, his attention was diverted from the Captain and subsequently became disoriented when he turned back around and didn't see the Captain. Likewise, the Captain had a probationary firefighter inside on his very first fire. He needed to take things a little more methodically and assist Firefighter A with essential functions and procedures.
3. Be more aware of structural conditions. There were no primary indications of a basement fire since most of the fire observed was on the main floor. Had it been identified that there was fire in the basement, as well as also in the attic, tactics may have been different.

4. IC maintained his composure and followed procedures. He was able to keep the situation calm and did not allow emotions to escalate on the scene. He ensured firefighting activities continued during the RIT evolution.
5. Post-Incident critique and review is ESSENTIAL. Due to extraordinary events happening within the department and surrounding areas, this essential piece was omitted!
6. Teamwork. Having a concerned care and "bonding" within a crew can produce extraordinary results. Firefighters will always help other firefighters, but the crew cohesion and attachments provide an intangible asset that is sometimes overlooked.

08-362

Event Description
Brackets [ ] denote information extracted or inserted by the Near-Miss Reviewer. [Reviewer Notes: Due to the complexity of this report and the number of departments that responded, a legend is being provided to give the reader a sense of the various agencies and personnel involved.

All identifying apparatus numbers and department names have been changed. The first due engine is “Engine 1”; second due is “Engine 2”, and so on. Truck company numbers have been changed to Ladder “1” for first due, Ladder “2” for second due, etc. The first department mentioned is the “Alpha” fire department and is listed as the Alpha FD or simply “A”, second mentioned is “Bravo” and listed as the Bravo FD or simply “B”, and so on. Firefighters from the respective departments are listed as “A” firefighters (Alpha FD members), “B” firefighters (Bravo FD members), “C” firefighters (Charlie FD members) and so on, as appropriate.]

THE PEOPLE:

(D/O) = Driver/Operator for the purpose of this report.

Incident Command
Town of “B” Deputy Chief. Positioned on Side A.

Safety
(1) “A” Captain (Dedicated function). Side A. (D Side porch access.)
(1) “B” Captain (Assumed function). Various suppression activities.

RIT
A two person RIT was established: (1) “B” Firefighter, (1) “A” Firefighter. One member was inexperienced but competent. Both were familiar with RIT operations through various training events. However neither had attended specific RIT training. At the time of the MAYDAY they were in full PPE w/SCBA. They had a set of irons and a vent saw that was warmed-up and ready.

3rd Floor crew

FF#1 (the victim) “A” Firefighter. Operating the nozzle on the 3rd Floor.
FF#2 (company officer) “C” Volunteer Assistant Chief & “A” full-time Firefighter. Checking for extension with FF#3 in an area approximately 15’ from where FF#1 was operating at the apartment door.
FF#3 (firefighter)”C Firefighter”. Working with FF#2.

Rescuers
FF#4 (firefighter) “B” Lieutenant. Operating on B Side.
FF#5 (Bravo FD Ladder 2 D/O) “A” full-time Firefighter & “B” paid call Captain. On Bravo FD Ladder 2’s turntable operating the aerial.
FF#6 (firefighter) “A” full-time Deputy Chief & “B” paid call Firefighter. On Bravo FD Ladder 2’s aerial, operating the pipe by remote.
FF#7 (Alpha FD OIC) “A” full-time Lieutenant & “F” Volunteer Assistant Chief. Supervising B Side operations.
FF#8 (company officer) “B” Captain & “G” Volunteer Chief. Established the RIT. No assignment at the time of the Mayday.
FF#9 (firefighter) “B” Firefighter. On Bravo FD Ladder 2’s turntable as a backup for FF#6.
FF#10 &11 (firefighters) “B” Firefighters. No assignment at the time of the Mayday.

All “Alpha FD” personnel have annual firefighter self-rescue training, including calling a Mayday. FF#5 & FF#7 are RIT instructors. The “Bravo FD” IC, FF#6 and the Bravo FD Engine 2 D/O are RIT trained. No other personnel on scene have had structured RIT training.

On [deleted] at 01:01 hours the “Alpha” Fire Department [Alpha FD] was dispatched on automatic mutual aid to [deleted] Avenue in the town of “Bravo” [neighboring town] for a reported structure fire. Alpha FD responded with Alpha FD Engine 1 (D/O and officer) and Ladder 1 (D/O). “Bravo” Fire Department (Bravo FD) responded with Engine 2 (D/O), and [deleted] EMS provided ALS.

At 01:04 hours an Alpha FD firefighter arriving in his POV and radioed the first size-up. He described a three-story wood frame with fire showing from the third floor. Thirty-four seconds later Bravo FD Engine 2 (D/O) radioed that he would be out checking the building for occupants and to have Alpha FD come in on [deleted] Avenue. Alpha FD Engine 1 and Ladder 1 arrived on scene at 01:07 hours.

The Alpha FD Ladder 1 D/O dressed the hydrant. I exited Engine 1 as the Alpha FD OIC. I crossed over to meet with the Bravo FD IC at the front of the structure, while Bravo FD Engine 2 laid into the A-B corner of [address deleted] Avenue. I observed the C, B, and A sides of the structure. Lights on the 1st and 2nd floors were on and provided a clear view showing no intrusion of smoke. A significant “glow” was visible through the 3rd Floor window at the front of the building on the B Side and very heavy smoke and the appearance of heavy fire through the roof. Bravo FD Engine 2 was positioned on the A-D corner with (2) 1-1/2” pre-connects off (not operating). The IC stated that everyone was out. We quickly discussed tactics and strategy, to which we both agreed, was an outside-

defensive fire and we expected to burn the roof off. Initial task was to bring Bravo FD Ladder 2's pipe into operation and I confirmed fireground communication would be [Channel] 1.

Bravo FD Ladder 2 was placed outboard and forward of Bravo FD's Engine 2, putting the aerial itself off the A-D corner. Bravo FD Ladder 2 was supplied via 4" from Bravo FD Engine 2. Once a water supply was secured for the ladder, I moved to supervise B Side operations where a 2-1/2" pre-connect had been deployed to suppress fire through the right side 3rd Floor window by firefighters that arrived via POV.

As the incident progressed my observations indicated that we were chasing the fire through the cockloft. To help prevent downward extension I advised the IC that I wanted to deploy ground ladders to the B Side 3rd Floor windows and operate a 1-3/4" hand line off the ladders. The IC acknowledged the plan. The 2-1/2" was shut down and a 1-3/4" pre-connect was deployed off of Bravo FD Engine 2. Before personnel ascended the ground ladders I checked with the IC to ensure that personnel operating master stream devices knew we had people "at the windows". Location and position of B Side personnel were continuously updated.

After a call by the IC for additional resources; Bravo FD Ladder 3 (D/O) and Charlie FD Engine 3 (D/O, officer, and FF) both arrived on scene at approximately 01:50 hours. The Bravo FD Ladder 3 D/O advised command that if they shut down the Echo FD Engine 2 supply line, he could position his ladder to cover the C Side. The IC acknowledged and ordered all units affected to "make it happen". No fire was visible through any of the B Side windows but the fire was beginning to burn out a vent at the roof line. B Side operations shut down along with Bravo FD Ladder 2's pipe. During this time, SCBA members of my crew got fresh bottles while others re-positioned a ladder. Also at this time I heard radio traffic that a RIT had been established and a crew of three (3) was going to the 3rd Floor to operate off the D Side porch and that they would be operating from the outside only. At 1:56:40 water was re-supplied to Bravo FD Engine 2. Sometime between 1:56:40 and 2:04:27 I heard the IC radio to the crew operating on the 3rd Floor to "back out". This message was repeated followed by an order to "Get out!" and then the demand "I want you on the ground now!" Mayday! Mayday! Mayday! was then transmitted. At 2:04:27 the Charlie FD Fire Chief radioed the communications center that he had taken over command and wanted the Delta FD dispatched for manpower, followed by an additional request for the Echo FD at 2:05:23AM.

MAYDAY! MAYDAY! MAYDAY!
Radio traffic from the IC to the 3rd Floor crew to get out, alternated with Mayday [messages] at least twice. The IC was calling the Mayday in an attempt to get the 3rd Floor crew's attention. The third round of Mayday was very clearly followed by "Man down!" SCBA members of my crew started to drift away. I told them to stay put that Command had a RIT established and the RIT would handle it. FF#4 was adamant in believing that no one was taking any action. I moved to hold him back when the air horns sounded an evacuation. FF#2 repeated his Mayday, adding that FF#1 was

trapped in a collapse. With the report of entrapment and my own observation that chaos was unfolding I told FF#4 to "Go!"

I recall only snap shots of events at this point. A chief officer (FF#2) in a white helmet on the 2nd Floor porch was gesturing frantically to the IC on the ground (this image drove it home this was not a drill; not a stuck foot or exhausted firefighter). I remember telling my Echo FD, Engine 2 D/O, to get the saw. Somewhere along the way, I donned an SCBA and went to the IC with the intention of "managing" the Mayday. The IC had a complete look of despair on his face as I asked him what he wanted me to do. His hopeless reply was "Whatever you can do." I tried to partner with a firefighter just heading up the stairs but could only match his pace. Arriving on the 3rd Floor, I came face to face with FF#2 and asked "What have you got?" He replied, "What do you mean what have I got? I got nothing!" was the angry reply. "What is your situation?" I asked calmly. This time he gave a detailed account of what occurred, who was involved and what action was being taken.

A firefighter exclaimed he found the victim. They went through a window, a three count lift and drag with some good progress. They did it again, again, and again with no progress. We barrel rolled him right over backwards. We pushed, pulled and folded him and out the window he went. When I came out the window he was still on the porch. Everyone was screaming, "Go! Just go!" His arm got caught on the newel post and I reefed on his arm and he disappeared down the stairs feet first. My legs buckled. When he didn't wake up after we rolled him out the window, I thought, "This is really bad."

Stepping off the 1st Floor porch I was told "no pulse." I knelt down in front of Bravo FD Ladder 2 and took a moment to get my head screwed back on. The victim was a firefighter with the "Alpha FD". I now had additional duties to perform.

THE RESCUE:
FF#2 noticed FF#1 was not at the apartment door and the hoseline going was through the door into the structure. FF#2 positioned himself in the door and observed severe structural compromise of the roof/ceiling and the personal light of FF#1 within the room. The Bravo FD Ladder 2 pipe was flowing water and FF#2 began yelling for FF#1 to get out. The stream from the pipe knocked FF#1 down. FF#2 observed FF#1 as he began to get up. FF#2 heard a loud crack and the roof collapsed knocking FF#2 out the door onto the porch. Dazed and trying to recover from the blow, he attempted to ascertain FF#1's situation. The collapse completely covered all access points. Unable to determine the fate of FF#1, FF#2 declared a Mayday. RIT was activated and the Bravo FD Engine 2 D/O hearing the Mayday appropriately shut down the Bravo FD Ladder 2 pipe.

As the RIT approached the porch access the "A" Safety Officer told them to drop the saw because they would not need it. (He thought the downed firefighter had simply collapsed.) As they made the 3rd Floor FF#2 directed them to a window with about 6" of clear space at the top. Using the irons they began to clear the window.

With the Bravo FD Ladder 2 pipe shut down, FF#5 donned SCBA and joined FF#6 and FF#9 who were assembling at the porch entrance. FF#4 joined the group to form a crew of four (4) and took the saw left behind by the RIT. FF#7 became available, donned SCBA and retrieved a saw.

Just as the RIT cleared the window, FF#4, FF#5 and FF#6 made the 3rd Floor and went directly into the window. FF#9 posted at the window to keep an eye on the other three. FF#7 with a 2nd saw followed FF#8 up the stairs and was the last firefighter to make the 3rd Floor.

On the interior FF#4, FF#5 and FF#6 faced a pancake collapse with no part of FF#1 visible. Only the audible alert of FF#1's PASS gave any indication of his location. On their first attempt to remove the roof section, it did not budge. As FF#4 reached for the saw, FF#6 found a leverage point and lifted, causing the roof section to partially break. FF#4 and FF#5 shouldered the broken section and it was hinged over exposing the FF#1's lower extremities. FF#1 was face down in at least 8" of water. The remaining debris was cleared and he was pulled out from under the remaining roof section and rolled over. SCBA air was verified to be flowing.

FF#7 was getting a situation report from FF#2 when FF#9 exclaimed they found [the victim]. FF#7 immediately joined the other three on the interior and assisted with the egress of FF#1 out the window. FF#1 was received by firefighters [positioned] on the porch. FF#5 initiated removal of FF#1 by dragging him feet first to the 2nd Floor where FF#10 and FF#11 were waiting as directed by the Bravo FD Engine 2 D/O to continue the egress effort. FF#1 was handed off to EMS that was ready and waiting. FF#1 was initially assessed as not having a pulse. Once in the ambulance, he was reassessed as being in respiratory arrest and was revived en-route to the hospital.

Also of note during this event, was the prompting by the Bravo FD Engine 2 D/O for the IC to move fireground operations to [Channel 2] and the decision by the devastated Bravo FD IC to turn command over to another chief officer. Best guess from time of Mayday to receipt of patient by EMS is as quick as 8 minutes or as long as 16 minutes. Time is from a recorded garbled radio transmission. "Water" is the only identifiable word and coincides with events on the fireground.

Lessons Learned

LESSONS LEARNED:
I just finished reading near-miss report #08-234 - Lessons Learned: Always underestimate the abilities of personnel who are not fully trained and certified. A lesson learned from our incident- Do not over estimate the capabilities of "experienced" personnel.

NEGATIVES:
Crew integrity: FF#2 (the company officer) has stated that with FF#1's (victim) background and experience, he was comfortable with leaving FF#1 on the nozzle by himself at the door and in a static situation. The decision by FF#1 to enter the structure

altered his operational condition from static to dynamic. At a minimum, this should have been communicated to the company officer.

Always work in pairs. Always!

Decision making: FF#1 exceeded the operational plan by entering the structure. Also, the need to enter is highly questionable.

Situational awareness: FF#2 said he yelled to FF#1 from the doorway to "get out of there!" because he observed conditions of imminent collapse, and while wrestling with the decision not to enter the structure and physically remove FF#1, the collapse occurred.

SOP/SOG: Regarding fireground operations… none.

Staffing: RIT was established with only two (2) personnel.
Out of all SCBA qualified personnel on-scene, all were involved in the rescue except two.

Training: In this region only [a few] individuals are known to have formal RIT training.

POSITIVES:
Training, training, training! FF#1 had all PPE w/SCBA in place and operating properly.

Although not formerly trained in RIT operations, the personnel assigned to the RIT keep up with training and had picked up enough knowledge along the way to make them effective.

Mayday procedures and RIT drills are regularly incorporated in our structural fire attack and search & rescue drills… it showed!

Task allocation: All personnel properly re-evaluated the priority of their assigned task before involving themselves with the rescue effort.

SOP/SOG: [One week] after the incident, "Bravo FD" and "Alpha FD" signed an automatic mutual aid agreement that mandates bi-annual mutual training.

Situational awareness: SA was good because of training. FF#5, FF#6, and FF#7 had been doing continuous size-ups. They remarked it seemed to accelerate the decision making process when the Mayday was called.

Incident Command: Stationary dedicated IC. Great effort has been expended over the last couple years on the importance of a dedicated IC to coordinate the fireground. If not for the organization before the Mayday, how quickly could assets have been re-deployed?

By far, this was one of the best run fires the [region] has experienced but the Mayday call shook the IC badly. You could see it in his eyes, in his voice, and he knew it. He asked another Bravo FD Chief Officer if he should turn over command. He said he thought it was a good idea and together they asked the Charlie FD Chief to assume command. I strongly believe this decision allowed for the continuation of an otherwise safe operation.

The Charlie FD Chief basically wrote off the personnel involved in the Mayday and called in all fresh troops.

Communication: Bravo FD and Alpha FD have evolved over the last year to the point that maintaining radio communication discipline and "span-of-control" is a norm for most officers.

Discussion: How would this scenario have changed if uncontrolled fire were factors? Master streams and handlines; although interior operations were never part of the plan, with firefighter safety considered and a tactical need to strategically operate handlines from the exterior, can it ever be done safely?

Experience vs. time in service, know the difference!

A MESSAGE TO ALL PROFESSIONAL (PAID OR NOT) FIREFIGHTERS:
About two and a-half years ago, I reviewed all non-medical LODD reports at single family residential structures and compared how we at Alpha FD operated to those that had experienced a firefighter fatality. Communication, command presence, RIT, and a focus on the basics were areas identified as needing significant improvement.

Programs to address areas of concern were implemented. A lot of hate and discontent was generated and some were adamantly against the direction the department was now going. With the continuous support from then Chief [name deleted], most of the department and some of our mutual aid firefighters eventually bought in.

To all company officers and my fellow training officers; the grief has been worth it! I believe there is no such thing as the perfect fire. Something always goes wrong. By training and training, hopefully the bad stuff is minimized and more things go right than wrong. The morning [of the incident] we experienced the pitter-patter of small successes vs. small mistakes that lead to a LODD. The statement has been made a dozen times over since the incident; "If this had happened a year ago we would be looking for 'FF#1' in the basement."

06-572

Event Description
During "routine" single family frame structure fire (with known victims), the pumper took 4 attempts to engage causing a delay in water to the hose for approximately 5-6 minutes. During this delay the interior suffered a flashover (4 minutes after arrival)

forcing all interior crew members back down stairs. (The attack line was manned by one FF and one officer. The remaining FF from the engine was attached to the ladder crew for rescue due to four known victims.) One member of the ladder crew was unable to make it back to stairs and was forced to self rescue from second floor window to ground. He was operating in room next to fire room approximately 10'-15' from stairs. He had just vented the only window in the room and was starting to search when the flashover occurred. He went back to the window and waited for us to start knocking the fire down. He decided to bail when conditions weren't getting any better. He suffered 10% 2nd degree burns to his back, right arm, and face (hood was pulled from around his mask exposing a ring of skin). A radio report claiming a partial collapse of second floor ceiling with members still in area initiated a PAR and attempt to re-enter area to find missing member. A radio report from IC verified missing members self rescue. A second line was now in place, (first line had burnt through due to being hung up on railing upstairs), and entry was attempted again. This was delayed due to first line (burnt through) still flowing and causing a reduction in pressure. Radio communications where intermittent and the P.O. wasn't getting the message to shut down the first line. This was accomplished by sending a runner. Once proper pressure was established extinguishment was accomplished and the 4 victims were found (none survived).

Initial crews on scene: 1 Ladder company w/ one Officer and 3 FF's (3 entered structure while operator placed ground ladders to porch); 1 Engine company w/ one Officer and 3 FF's (3 entered with Officer and FF on line and remaining member w/ Ladder company to initiate rescue; and 1 ALS unit w 2 FF Medics (we are a fire based EMS system).

Conditions on arrival: Smoke showing from 2 windows (fire room and victims location) and no fire visible. Occupants on sidewalk claiming victims on second floor. Moderate to high heat encountered at top of stairs. Smoke down to approx. 8"-10" from floor.

Operator error ruled out and no problem could be found with pumper. Initial thoughts were the twist the chassis experienced turning corner at fire scene (recent storm drain work had left approx. 18" drop from pavement. Unable to replicate. Shop changed alternator, batteries and cables thinking a low voltage issue was responsible.

Problem experienced: Delay in water; flashover; burnt hose line; intermittent radio communications; low pressure due to open line.

It is my firm belief that the injured FF's training, experience, and level headedness prevented this from becoming a LODD.

Lessons Learned

The importance of self rescue training can't be overstated. The RIT companies had just arrived on scene and were unable to respond without some delay. Two-in-two-out wasn't an option here due to KNOWN multiple victims.

Be the eyes and ears of the IC when you are inside. The call of a partial collapse (it didn't register that we had just had a flash-over initially) and resulting PAR call reduced the discovery time of a missing member.

If there's any delay in getting water to the line let all companies know. This will let interior crews back out of the hazard area and will alert incoming companies that a shift in positioning may be warranted. Our SOP's have the 2nd arriving engine stop at the nearest hydrant and await further instructions. If they know coming in that the on scene engine is having difficulties they can respond directly to the scene and take over pump operations with a minimum of delay.

This was a "routine" fire on arrival but resulted in a cascade of problems that, I believe, were a direct result of the delay in water. If we had gotten water on the first attempt this situation would probably still have resulted in the civilian casualties but not the injuries suffered by a member of my station.