National Fire Fighter Near-Miss Reporting System

These reports coincide with the new monthly podcast entitled *Task Allocation: The Final Step in CRM* to be posted on Friday, February 13, 2009.

For more information about other Near-Miss Reports, please visit the official National Fire Fighter Near-Miss Reporting System at www.firefighternearmiss.com

Report #	Pages
05-0000525	2-3
05-0000421	4-5
09-0000058	6-7
08-0000436	8-9

Report Number: 05-0000525
Report Date: 09/18/2005 0936

Synopsis
Unauthorized driver rolls brush truck during normal driving.

Demographics
Department type: Combination, Mostly paid
Job or rank: Captain
Department shift: 24 hours on - 48 hours off
Age: 43 - 51
Years of fire service experience: 24 - 26
Region: FEMA Region IV
Service Area: Rural

Event Information
Event type: Vehicle event: responding to, returning from, routine driving, etc.
Event date and time: 08/15/2005 1500
Hours into the shift: 5 - 8
Event participation: Told of event, but neither involved nor witnessed event
Weather at time of event:
Do you think this will happen again? Uncertain
What do you believe caused the event?

- Procedure
- Human Error
- SOP / SOG

What do you believe is the loss potential?

- Property damage
- Minor injury

Event Description
A veteran Lieutenant, serving an overtime shift at a station he never worked before, needed someone to take paperwork from the current station to a station located 15 miles away. A volunteer asked permission to make the trip in a brush truck. The Lt. asked if he was cleared to drive and the volunteer acknowledged he was. In fact, he was not. The Lt. gave the paperwork to the volunteer and sent him on his way. The untrained volunteer, on a road full of curves, lost control of the brush truck, rolled it at least once, and fortunately landed upright in a ditch with water up to the middle of the doors.

Lessons Learned
One lesson learned, unfortunately, is that no matter how well someone is liked, respected or otherwise deserving of praise, not all people are truthful. We try to consider each member of this department honest and when words are spoken, we assume the truth comes out. However, when the excitement of the mere thought of getting to drive a "fire truck" is offered to a young volunteer, you can almost see the glaze in his eyes; almost an over riding factor in itself. We have issued a new version of ID cards that now clearly states "Authorized Driver" or

"No Driving Allowed". Above and beyond the normal EVOC and follow up driver training, a new series of driving tests and operating procedures is now in place to ensure each and every driver is, without question, qualified to drive.

Report Number: 05-0000421
Report Date: 08/09/2005 1942

Synopsis
Swift water mishap in full turn-out gear.

Demographics
Department type: Paid Municipal
Job or rank: Lieutenant
Department shift: 24 hours on - 48 hours off
Age: 34 - 42
Years of fire service experience: 7 - 10
Region: FEMA Region IV
Service Area: Urban

Event Information
Event type: Non-fire emergency event: auto extrication, technical rescue, emergency medical call, service calls, etc
Event date and time: 07/11/2005 0930
Hours into the shift: 24+
Event participation: Involved in the event
Weather at time of event:
Do you think this will happen again? Yes
What do you believe caused the event?

- Training Issue
- Decision Making
- Weather
- Situational Awareness

What do you believe is the loss potential?

- Life threatening injury
- Minor injury
- Lost time injury

Event Description
Due to the aftermath weather of Hurricane Dennis, our community received major flood damage. Our specialty rescue squad answered several water related calls in the surrounding area in agreement to our auto-aid dispatch. On one incident, a dead-end road development was flooded under the cover of morning darkness. About six homes were eventually consumed from a nearby river's overflow. Nine residents had to be rescued from the homes. Water five feet deep rapidly flowed down the street between these houses. Our Swift Water Technicians assisted the local jurisdictions rescue teams that were already in operation. The initial responding Engine Company made a decision to attempt water entry to evacuate nearby houses. This crew's level of training is unknown, but it was apparent they were not trained in swift water rescue. The crew had entered the water wearing a Type V Rescue PFDs over full turnout gear. One of the personnel soon became trapped inside a house by rapidly rising water. This firefighter was eventually rescued by boat after the residents were taken to

higher ground. Self-rescue would have had little to no risk in the chest deep water without the turnout gear. Wearing full turnout gear near the water's edge with no fire hazard, I feel, warrants a near-miss.

Lessons Learned

Every swift water training class and experience I have had expresses and justifies the dangers of wearing turnout gear near the water's edge. If equipment is placed on the apparatus with untrained personnel, safety may become secondary to the feeling of helplessness. To prevent this, proper full training is recommended. If it is unavailable, awareness of the hazards must be a training priority.

Report Number: 09-0000058
Report Date: 01/19/2009 1737

Synopsis
Engine crew question risk vs benefit.

Demographics
Department type: Paid Municipal
Job or rank: Fire Fighter
Department shift: 48 hours on - 96 hours off
Age: 34 - 42
Years of fire service experience: 7 - 10
Region: FEMA Region VIII
Service Area: Suburban

Event Information
Event type: Fire emergency event: structure fire, vehicle fire, wildland fire, etc.
Event date and time: 01/19/2009 0200
Hours into the shift:
Event participation: Told of event, but neither involved nor witnessed event
Weather at time of event: Clear with Frozen Surfaces
Do you think this will happen again?
What do you believe caused the event?

- Communication
- Decision Making
- Task Allocation
- Situational Awareness
- Individual Action

What do you believe is the loss potential?

- Life threatening injury
- Lost time injury

Event Description
We responded on a second alarm for a single-family structure fire with crews on scene. There were heavy fire conditions and slight wind driven fire spread. Upon arrival it was not stated, but visually obvious, that the on scene crews had gone into a combination attack. They were using a 100' aerial device flowing water into rear of structure. An engine company of 4 was told to make entry on the ground level through front door to continue fire attack, by a district chief. Fire conditions-the rear half all levels were fully involved, the roof was missing on the rear two thirds (two-story with finished walk- out basement). The front door/porch, as well as the three-car drywall garage with two bedrooms over garage, appeared to be intact. The fire attack was made through the front door by two fire fighters (other two fed hose into structure); visibility was poor due to smoke and steam conversion. The nozzle team advanced approximately 30 feet into structure, when the nozzleman's foot stepped through the floor up to his groin. The back- up to nozzleman helped free him and the two quickly retreated to the front doorway.

Lessons Learned

Lessons learned-when arriving on scene, have at least one of the crew do a 360 walk-around. Do not blindly follow directions without questioning orders. When working above the fire, have a strong suspicion of overall task benefit. When arriving later into an incident, make sure all crew members are aware of current operational tactics. All crew members should have an evolving situational awareness of fire/operational changes.

Report Number: 08-0000436
Report Date: 09/14/2008 1209

Synopsis
Fallen tree causes hazardous condition.

Demographics
Department type: Combination, Mostly volunteer
Job or rank: Fire Chief
Department shift: Duty night (in-station)
Age: 34 - 42
Years of fire service experience: 24 - 26
Region: FEMA Region IV
Service Area: Rural

Event Information
Event type: Non-fire emergency event: auto extrication, technical rescue, emergency medical call, service calls, etc
Event date and time: 09/14/2008 0915
Hours into the shift: 0 - 4
Event participation: Involved in the event
Weather at time of event: Cloudy and Rain
Do you think this will happen again? Yes
What do you believe caused the event?

- Task Allocation

What do you believe is the loss potential?

- Lost time injury
- Life threatening injury
- Minor injury

Event Description
Brackets [] denotes reviewer de-identification. Dispatched to a reported tree down, blocking the entire roadway. There was a wind advisory issued the night before, in effect from 07:00 until 16:00 with wind speeds at 25 - 35 mph and gusts up to 45 mph. I was the Command Duty Officer and was out in the district in a staff vehicle. Two personnel were at the station as the available duty crew. When I checked responding, I advised Central Dispatch to notify the county and state highway department of this incident and to dispatch them to the scene; this was the first tree down of the day but certainly would not be the last. I responded in the staff unit and our rescue truck responded, both units non-emergent, from station [1] with two personnel on-board. This incident was approximately 8 miles from station [1] and only 3 miles from station [2], however, no personnel were available to respond a unit from station [2]. Upon arrival, we found a large tree, approximately 18 inch around at the trunk with a lot of branches and limbs and another smaller tree with vines that was pulled down with the larger tree. The tree was resting on the guardrail and the base of the tree was below the grade of the road. This left the tree suspended in the air as if it were a standing tree. Central Dispatch advised me back that they could not make contact with the county road department

or the state highway department and that other fire departments in the county were out clearing trees. Therefore, here we are with a major road in our area blocked completely. Travel around using other streets and roads would average 30 minutes. The county sheriff unit isn't willing to remain with the tree to control traffic, plus the location would probably be more of a hazard to citizens if we just opened the road to one lane for emergency vehicle access. Just opening one lane of the road would require an emergency worker to be placed in harms way for a longer period of time directing traffic. The decision was made to use our resources to clear the roadway. We had a county sheriff unit on scene with traffic blocked from the North and we used our rescue unit to block traffic from the South. There were no power lines in the area and traffic was blocked by parked units. We had helmets (with eye wear), gloves, and bunker pants with bunker boots. We began to clear the smaller branches and limbs from the tree. Once the tree was clear to the trunk and good access was made to make the cut on the tree at the guardrail, it was time to fell the tree. I used the chainsaw to begin the cut. The chainsaw couldn't have been more than three inches into the tree when the trunk splintered and sprang up violently. The main part of the tree went straight down onto the roadway and the splintered part of the trunk sprang directly up, still remaining attached to the base of the tree trunk. There were no injuries that occurred and no equipment was damaged. The other two personnel on the scene were clear of the tree and watching the cut be made. I then made the cut up from the bottom side of the tree and completed the cut. We completed our assignment and returned to service and quarters. Thanks to training on how to use the new chainsaw and how to fell a tree, injury was avoided. The safest was to avoid injury to us is not to be placed in these situations and allow other departments with the responsibility to perform such tasks.

Lessons Learned

Lessons learned are: Training on new equipment is essential, no matter how simple you think the piece of equipment is. Training on the tasks assigned to your organization. Situational Awareness for all personnel on-scene Policy decisions on what is our responsibility The best way to prevent a similar situation is to develop policy that says our department does not respond to trees in the roadway. Agencies with the proper equipment and personnel should be utilized to perform tasks associated with these hazards. However, in rural settings the road could be blocked for hours. That is the argument used to keep us responding. I would argue that if the street and road departments were prepared to respond to such events, the road could be cleared quickly, the scene mitigated and the debris cleaned up when they were there. In the current system, the call goes to the fire department and police department or sheriff's department unit. We simply open the road and throw all the debris into the ditch. Then when normal work hours roll around the street and road department respond back to the same site and clear up the debris. I argue this places more public workers in harms way for an extended period of time when it could have been taken care of with fewer personnel and less exposure the first time. Policy decisions and departmental cooperation is the key. These issues can be resolved as long as focus on service to the citizens remains the priority. Too often the policy decisions aren't that way, and department heads get into turf battles over whose job something is.