



**National Fire Fighter Near-Miss Reporting System
Reports Related to Incident Size-Ups**

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11-44

Event Description

Brackets [] denote reviewer de-identification.

On [date and time deleted], units were dispatched for a reported house fire. The address was in close proximity to the first due station. Chief officers and the first arriving engine arrived on scene within two minutes of the dispatch to find a 1.5 story single family dwelling with fire showing from the A/B corner of the first floor and a working fire in the basement. The engine took the hydrant a couple houses before the structure and pulled a 1 ¾" handline. The irons-firefighter on the engine forced entry through an iron security door and the residential door while the nozzle man completed his "minute-man" hoseline stretch. While the irons-firefighter was finishing forcing the doors, the nozzleman hit the fire extending from the first floor window. The line was quickly charged and the crew proceeded into the structure.

Upon entering we had visible fire in the living room towards the right. It appeared that the fire was coming up near the floor board area of the A/B corner. This fire was quickly knocked down. Conditions were zero visibility with light heat conditions at this time. The engine crew then advanced the line through the living room in an attempt to locate the basement stairs. Per our SOP, the first engine is to locate and hold the steps, the second engine provides a back-up line for the first engine on the fire floor, and the third due engine advances a line to the exterior access, if one exists (the fourth due standbys until directed, first truck to first floor, second truck to basement, third truck/squad is RIT). This SOP works well with our department since staffing is rarely an issue and units arrive within minutes of one another.

As the engine company made their way out of the living room, a stairwell leading to the attic was noticed on the right side. The engine company continued forward until we ended up towards the rear of the structure at the kitchen/bathroom area. We are familiar with our first due area and figured one possible location of the interior basement access would be just off of the kitchen; this was not the case in this structure. The engine crew noticed the temperature gradually increase, visibility was still zero. The engine officer attempted to notify command that we were towards the rear of the structure and still attempting to find the steps.

At this time it was noticed that the second engine was beginning to advance their line onto the first floor, along with several members of the first due truck company beginning their search. We began to move our line back towards the way we came in an attempt to find the stairwell (now thinking that we needed to get to the other side of the attic stairs). The engine crew ended up just barely entering the initial living room area again. At this point we heard a "crack", and the floor gave away in what felt like a two stage motion. First, the floor dropped an inch or two, followed a half a second later by a drop of about 8-12". It felt as if the floor had failed in the corner that we initially attacked the visible fire, and the rest of the floor subsequently leaned towards that end. This failure occurred roughly eight to ten minutes after the arrival of the first engine.

The engine officer was immediately to the left of a chief officer who had Division 1. Both fully understood what occurred and immediately notified command of a floor collapse and to evacuate the building. Command requested EVAC tones on all channels and for units to sound their horns/sirens. Inside the structure, the EVAC tones were clearly heard along with an abundance of apparatus sirens/horns. At this point, visible fire was beginning to lap out of the hole on the floor. Units were able to successfully get out of the living room and out of the front door they entered, immediately off of the living room. One member of the search crew was separated from his team and unaware of the conditions present. Although not in immediate danger in the A/D corner of the structure, this member bailed out of a window to get to safety. Upon exiting the structure, units operated from the exterior for approximately 15 minutes until the majority of the fire was knocked down. Upon starting an interior attack again, there was significant extension in all the walls and into the attic. Extensive overhaul began. Units returned to service in the early morning and all members went home safe with no reported injuries.

Lessons Learned

Although no one was injured at this structure fire, it was a very close call. After talking to the crew after the fire, they all agreed that they never want to feel the feeling of a floor giving away below them again. At our post incident discussion back at the station, several key items were brought up. Some of these items could have proved to add a great significance to the crew's safety.

- **Engine Placement:** Taking your own hydrant ensures an adequate water supply as quickly as possible. This fire occurred right at the end of a major snow storm so the roads were in poor condition and the 2nd due engine took longer than usual to arrive. However, the hydrant location left the engine a little bit farther away than desired and the 1 3/4" line pulled was not long enough to get into the attic or make the basement steps if we needed to. Towards the end of the incident, an additional 50' was added to make the steps into the attic (which subsequently led to its own problems such as the bale on the 1st floor accidentally being kicked closed). Laying out, even if it is only one length, is a much better option and gets the tail end of the engine just past the A/D corner of the structure. If need be, the engine driver could easily run the 100 or so feet down the street and charge his own line.
- **360 Walk-around:** While the irons-man was forcing entry into the structure, this was a great time for the engine company officer to do a complete 360 of the house. A chief officer did conduct this almost at the same time of the engine company's arrival, but conducting the 360 himself would have given the engine officer going into the house a better idea of the house layout and fire conditions prior to entry.
- **Using the TIC:** The engine company officer brought the thermal imager with him, but did not turn it on prior to entering the structure. Once he wanted to use it, he was unable to use it due to it being tangled in equipment and poor visibility. The TIC, although not the be all-end all, would have helped the crew in locating the basement stairs by showing where the thermal conditions were coming from. A

sweep of the floor also may have shown heated rafters, indicating a significant fire in the basement.

- **Tunnel Vision:** Crews also have to keep in mind all the information given to them while en route. It was stated that this was a reported basement fire. Upon arrival visible fire was seen from a 1st floor window. This indicated that there was a significant basement fire since there was already extension to the 1st floor. Don't get caught up by the fire venting out a window; think how advanced is this fire that I already have fire venting that window. Also, don't fall susceptible to the "be aggressive" attitude. A possible tactic for a well involved basement fire may have been to start knocking this fire from the exterior. You are not being a wimp by conducting an exterior attack. You are potentially saving your crews lives and still performing an aggressive, proactive attack.
- **Building Construction:** This house had 2X8 rafters in the basement and the floor failed within 10 minutes after arrival of the 1st engine. Building construction is important to keep in mind. Many basements are unfinished, with rafters and supports susceptible to the fire right off the bat. Know the various types of construction and the possibility that a poorly constructed or older chimney can deteriorate these supports slowly over years by "falldown" without igniting, leading to an earlier failure once an actual fire does occur. What if this house was lightweight construction? The engine company crew most likely would have fallen through the floor as soon as they entered the house.

10-760

Event Description

We responded to a single-family house fire around 2 o'clock in the afternoon. When I arrived, I was the first engine on scene. I gave my initial report and began my 360 while my crew deployed the attack lines. While I was doing my 360, I saw a pit bull on a chain on the C-side of the house. I told my crew about the dog on the fire ground radio channel, but forgot to tell the next arriving units. A person on another unit went to the back of the house to assist with ventilation, didn't see the dog, and was bit in the leg. The firefighter was not severely injured because he had his bunker gear on.

Lessons Learned

The lesson I learned was how important good communications are. If I had told the arriving units about the dog no one would have been bit. A good 360 around the house does not matter if you don't pass on that info to everyone.

09-1146

Event Description

While returning from a previous incident, the engine spotted light smoke in a residential area. At approximately the same time that they began to report the smoke, the county dispatch rang out a structure assignment to that area. As a result the engine arrived several minutes prior to the next due unit. The structure was a triplex with each unit being approximately 2,500 sq. ft. or 7,500 sq. ft in total. It was built into the side of a grade and entry from the front door placed you on the second floor, leaving you with one floor below and one floor above.

The captain gave a report on conditions that included smoke and fire coming from the roof and all occupants out of the building. The captain then made the decision to don SCBAs, pull an attack line, and make entry through the front door. A 360 degree survey had not been completed, nor was any other unit on scene. Upon making entry, the captain reported encountering light smoke at the ceiling level with clear visibility into the structure. He then made the decision to advance the line down a hallway where the captain and fire fighter encountered heavy smoke down to the floor; a second alarm was requested.

At this point, the captain requested ventilation, but no other units were on scene and the department's only truck company has an extended response time into the involved area. The captain and fire fighter continued to advance until they encountered active fire. After a quick knock down, they employed the use of a thermal imager and spotted an additional heat source to their right, down another hallway. They advanced to that position and began fighting fire in the kitchen area.

The second due engine arrived a full 5 minutes and 11 seconds after the initial unit went on scene. The driver of the first arriving engine had already established his own water supply. The second unit was assigned to back up the first due engine. After making an initial knock down of the fire in the kitchen, the captain realized he had fire below him and that there was an additional level to the building. However, he was not aware of how to access the lower level. The captain and fire fighter then began to fight the fire from above it.

It was at this point that the captain and fire fighter suffered burns. It is believed that as the crew was fighting the fire windows on the lower level blew out, creating horizontal ventilation contributing to the rapid acceleration of the fire. The crew, being positioned above the fire, resulted in them being exposed to an excessive amount of heat. This resulted in the captain and fire fighter backing out of the building.

The crew was treated at the hospital. The captain returned to duty and completed his shift. The fire fighter did not return that day. Both the captain and fire fighter were wearing all personal protective equipment including hoods. The fire eventually grew to five alarms.

Lessons Learned

In this case, the first arriving unit did not take the time to perform a 360 survey. This placed the crew in a position of making a blind attack. They did not have a clear understanding of the extent of the fire or the general configuration of the building. Had they known the extent of the fire and considered that all occupants were out of the building, they would have waited for an out team to be established and vertical ventilation efforts to be in progress before initiating the attack. This coupled with a lack of situational awareness regarding the extended response times of other units into their area resulted in the crew essentially fighting the fire alone.

To prevent this it is important that crews perform a 360 degree survey. They must be aware of the timing and actions of the other units within the response. This is imperative if we are to act as a team. Crews must be clearly versed on the OSHA two in, two out regulations. When encountering an IDLH environment, fire fighters are required to have an out team in place prior to entry. There are only two exceptions: life saving measures, and incipient fires. In the case of this incident, based on the initial report, it was clear that this fire was beyond incipient, and no rescue was required.

It is important to realize the effect that vertical ventilation has on operations. In this case, a delay in vertical ventilation allowed uncontrolled ventilation to occur, leading to the crew being burned. It is also important to recognize the hazards associated with fighting the fire from above the seat.

09-609

Event Description

We responded to a small, single story, commercial property that was operating as an American Legion Club. It had restaurant seating and separate rooms. We arrived to find smoke puffing through cracks in the cinderblock walls. We opened doors to find a fully involved structure fire. The business was locked and closed at the time of the fire. Remodels were done to the property with numerous overlaps of finish materials. The captain on the scene was convinced that he could make an offensive attack. Command gave him the latitude to attempt.

A three-man entry crew attempted to enter the "incinerator" and made it approximately twenty feet. Heat conditions were untenable and they withdrew reluctantly. After about thirty seconds, a two ton air conditioning unit fell through the roof to where the crew had withdrawn. Poor judgment created a potential for loss of life.

Lessons Learned

More emphasis should be placed on size-up and reading conditions during training. Command should take more responsibility for personnel safety and discourage freelancing.

What was at risk was not worth what was being risked.

09-329

Event Description

Brackets [] denote reviewer de-identification.

Three fire stations were dispatched to a house fire. Upon arrival in my POV, I found heavy smoke conditions from a one-story single family with a basement. Lines were deployed to the front door from Engine [1]. The captain and I were attempting an interior attack. Approximately 5 feet inside the door was thought to be a stairwell, actually a hole burned through the floor. After discovering it was not a stairwell, we backed out and within five minutes the entire floor burned through. This could have trapped my team in a fully involved basement.

Lessons Learned

Always do a 360 assessment to determine your risks vs. gains. No 360 was performed. No Incident Command was established and there was no accountability system used.

08-270

Event Description

I responded as the company officer on an engine company to a report of light smoke in the basement of a single family dwelling. This event occurred during a time when the city had suffered a major ice storm in the area. The storm had knocked power out to most of the citizens for a week. This event occurred during that week.

Upon arrival, I did a three side size up. I saw the B side driving down the road and saw the A side as I pulled up. I checked the D side after I got off the apparatus. There was nothing showing. The occupants met us outside and were not stressed about matters in the slightest. I immediately went into "nothing showing" mode and did not check the C side of the structure.

Investigating the area, we found a water line on the wall in the basement spraying water out of a joint. The line was covered by a towel and there was about an inch of water over the floor of the basement. There was also a slight haze of smoke visible. During the investigation, we asked about the resident's power status. They stated that they had not

had power for about 3 days now. No source of the smoke could be immediately found so I turned my attention into stopping the water flow. I asked that the street valve be shut down. Another officer stated that the line I saw inside the house should be the shutoff line for that structure. The resident confirmed this. I removed the waterlogged towel from the line and saw a scorch mark on the towel. I remember thinking it was odd that the towel was scorched but I didn't put 2 and 2 together immediately. I then reached up to the valve to shut it off and noticed that the water was flowing out of the supply side of the valve and that it was already shut off. I remember thinking that was odd as well but then my brain thought that maybe the valve was stuck so I grabbed the handle.

If I had checked the C side of the structure, I would have seen a neighborhood feeder transmission line lying over the metal roof of the back porch of the structure. Touching the handle gave me quite a shock knocking me backwards into the wall behind me. My shoulder, bicep, and wrist were all sore and cramped for about a week after the incident.

Afterwards, we found out that the electric company was turning lines back on without checking if they were down first. This line was re-energized and its power went through the plumbing. The energy had melted the solder on the joint to the valve. The owner had just placed the towel over the leak and had not received a shock at all.

Lessons Learned

A 360 degree size up is important even when there is nothing showing upon arrival. You may find other items that could endanger your life or the lives of your fellow firefighters. Even though the situation looks safe and easy, it might not be.

07-1152

Event Description

We were the first engine on arrival at a structure fire with heavy smoke showing from a large commercial ordinary construction (brick and stick) structure in downtown [location withheld]. The commercial structure was vacant and boarded up. We forced entry into the store front doors of the building and advanced a 1 3/4 handline into the structure. After advancing into the structure several feet with zero visibility another company on the scene pulled off the boards that sealed the front display windows of the vacant commercial occupancy. This provided the fire the oxygen it needed and fresh air to suddenly ignite the entire interior of the building with us inside. The rapid explosion of fire blew all three of us out of the structure and into the street. Only one of us received any injury (minor burns).

This near miss was clearly a result of a lack of situational awareness, proper size up or reading of the conditions thereby resulting in a poor decision. The decision to advance a single line into a heavily involved structure and zero visibility without ventilation was an act of automation and not judgment. We saw fire and we went after it. This event was

prior to the concept of risk management, reading the smoke, and a good working incident command system that exists today in our department. In the past, if it was on fire we went in even if bulldozers were parked outside the structure for a planned demolishing of the building the next day.

Lessons Learned

Risk management. Vacant structure not worth risking the lives of firefighters.

Situational awareness. A proper size up of the scene and greater experience by the initial attack crew would have told us that we had no business going into the structure with the fire conditions visible, much less with a single attack line.

Better coordination. Our attack team should have been called out of the building prior to the removal of the boards sealing the store front windows, which resulted in us being blown out of the building by the force of the fire.

Better command presence at the onset of the working incident.

07-864

Event Description

On 07/21/2003, 12 apparatus(s) and 22 personnel responded to a building fire. The first unit was on scene at 01:53:00. The last unit cleared scene at 05:07:00. Primary actions taken were extinguishment, salvage, & overhaul. There were 0 deaths and 3 injuries reported. Estimated value of property and contents was \$53,000.00.

Units from 2 stations were dispatched to a "residential structure fire" across from the address of the reporting party. A Public Safety Officer [PSO] in the area reported that she was in the area looking for the incident location. Within a short time, she located the incident and reported the incident was a working structure fire.

The engine [number deleted] arrived first on scene, followed by the squad, ladder company, and IC. Upon arrival, fire personnel noted heavy fire coming from the first floor B side of the structure. Heavy smoke was coming from the front porch. A 200 ft. - 2 1/2 in. smooth bore pre connect was pulled from the engine company to the front door of the structure. The engine and squad crews forced the door to the structure and made entry. One FF [name deleted] had the nozzle, another FF backed him up, and the lieutenant stood by at the front door while a third FF put his flash hood on correctly. A RIT made up of the second engine company's personnel and the PSO was in place. Once making entry, heavy heat and smoke emitted from the front door. The lieutenant told the interior crew to back out of the structure and started pulling the 2 1/2 inch line out of the structure. After exiting the structure, one of the FF's went to the apparatus and stated that she thought she had gotten burned on her ears. The sergeant and other

personnel noted that her ears were red and blistered. They poured water over her ears to help ease her pain.

RIT engine personnel laid 500 ft. of 5 in. hose from the hydrant to the first in engine.

IC asked communications to dispatch a third engine to the incident and have another engine standby for station coverage.

The fire attack moved from interior to exterior. The 2 1/2 in. smooth bore line was pulled to the B - C corner of the structure. Fire personnel knocked down the fire coming from the B side window, the C side porch, and the C side of the structure. During this time, fire personnel pulled the electrical meter and turned off the gas to the residence. Once the majority of the fire was put out, fire personnel advanced through the front door and used a 1 3/4" pre connect hose from the first in engine to put out interior fire. Interior crews reported that the B - C corner of the first floor had burned out the floor, ceiling, and roof. Another 1 3/4" pre connect hose was advanced into the basement area to put out interior fire. The sergeant was assisting with putting out the basement interior fire. After working for a few minutes, the sergeant went to the RIT engine and laid down on the pavement. After a few minutes, the assistant commander asked the EMS crew on scene to check the sergeant. The EMS crew took his vitals and suggested that he go to the hospital.

Fire personnel continued to use the 2 - 1 3/4" hose lines to extinguish hidden fires and hot spots. During this time, the public safety officer reported that she had tripped over some hose lines and hurt her arm. There was a deformity on her arm just below the elbow. She was taken to the emergency room by her sergeant.

All units cleared the scene. Fire personnel and apparatus reported to the station for cleanup. All units were put back in service.

Personal experience:

I was filling in for a firefighter from another shift. Consequently, I had not worked with these firefighters on a regular basis (which we all know can make a difference).

I was riding the squad truck when we pulled up on the working structure fire. The home was located at an intersection. The squad truck was approaching the home on the right and then turned left at the intersection to make way for responding engines. Because of this maneuver, I never saw the B and C sides of the structure, which became an important factor in the fire attack.

My initial size-up was of a one story house with a half basement (basement windows visible on the B side and half of the A side). I saw flames coming out the B side window of the first floor. To me, it looked like a room and contents fire getting ready to get into the roof.

I grabbed equipment from the squad truck and headed to the fire to assist in fire attack. I saw a firefighter from the engine pull the 2 1/2" smooth bore. I assisted in laying out the line to the front door of the structure. Heavy, dark smoke was pushing out of the front window and front door. No fire was visible from the front window. We forced the door open and were immediately hit with intense heat. By this time, both firefighters from the engine, a lieutenant, and myself were on the front porch ready for an interior attack. One of the firefighters, feeling the heat from the fire, realized that his flash hood was not properly donned. While that firefighter was fixing his flash hood, another FF took the nozzle and entered the structure approximately 10 feet. I followed behind her, assisting with the 2 1/2" charged line. Immediately after crawling into the house, I could feel heat around the seal of my facepiece and my knees and rubber boots were getting hot. I have never felt heat that quickly, and it made me wonder if the interior attack was a good idea. I made my way to the FF. She opened the nozzle and the hoseline went limp. She started yelling that she didn't have any water. I attempted to speak to her and tell her to keep the line open and wait for the pressure to boost, but she continued to yell that she didn't have any water. After a few seconds had passed, I felt the hoseline being pulled outside. Figuring there was a problem; I turned around and crawled outside. The FF turned around and exited the structure, witnesses saying that she came out of the structure standing. We were told by the lieutenant to move the hoseline around to the B-C side of the structure and start an exterior attack. As we maneuvered the hoseline, it was evident that this was more than a room and contents fire. There was heavy fire on the C side and B-C corner of the house, with fire on both floors and a small hole burned through the roof. We continued an exterior attack until the fire was extinguished. During salvage and overhaul, it was determined that the house was vacant. Half of the first floor had burned through and dropped to the basement. The PSO was walking around with a fogged facepiece on when she tripped over a hoseline and injured her forearm.

Lessons Learned

Many lessons can be learned from an incident that caused two injuries and could have caused more injuries or even deaths.

The first problem was scene size-up, which led to other problems. A walk-around by command would have ruled out an interior attack. Situational awareness was lacking by all.

Training on donning equipment properly is necessary. The firefighter who didn't have his flash hood on correctly could have been burned.

The nozzleman never bled the air out of the hoseline before entering the structure (a procedure written in our SOPs). The air pocket in the hoseline and a possible delay in the electronic pressure governor or pump operator caused the firefighter to believe that the hoseline was not charged. The nozzleman panicked.

Experience probably saved me from entering the structure further and falling through the floor. The lieutenant on the porch realized that the heat and smoke was too heavy for an interior attack. The lieutenant yelled and tugged on the hoseline to have us exit.

Panic can hurt you. The nozzleman stood up inside the structure to exit, burning her ears. I was in the same location she was, and I did not get burned.

Do not walk where you cannot see. The PSO was walking around with a fogged facepiece and tripped over a hoseline, injuring her arm.

06-214

Event Description

3 Engines and 2 Ladders were alerted to a structure fire at a commercial structure. The first engine, a volunteer piece with 4, arrived and found smoke coming from the D Side eaves of a single story wood frame commercial structure. They were met at the door by the property owners who stated that the fire was in the attic. They then proceeded to give directions to the access. The business was a vacation souvenir shop. The first line was then stretched inside and crew members climbed into the attic in search of the fire. The second engine arrived, the (deleted) engine with 4. The officer received the report from the driver of the first engine and assumed command. The first ladder was setting up to perform roof ops. The commander was receiving reports that the fire was in the attic but they were unable to locate. The utilities were secured by a cross-trained medic unit. They also pulled the next line from the engine. Still no progress was made. The second in engine was assigned water supply and then were given the assignment of the RIT crew. A crew from a mutual aid station arrived and was pulled from staging to perform some overhaul and salvage work in the area they thought to be on fire. While performing this duty they found the fire room. The back-up line was moved in to knock down the fire. The fire was held to the room and contents.

Lessons Learned

What was learned was the importance of a thorough size-up by the initial company and not placing ourselves in harm's way. The fire room was directly under where the interior crew was searching for the fire. It was already tight inside the business and if the fire had blown up, I'm almost certain we would have been working a firefighter fatality fire!

As the incident commander I have to rely on the information that is being given from the inside crews and the other officers on the scene. If a thorough size-up had been performed, then the fire would have been out with a water can. The crews admitted that once the owner showed them how to get into the attic, the adrenalin kicked in and the tunnel vision started. That crew could have fallen through the ceiling or the fire could have blown up and cut off their retreat. This situation could have turned bad quickly. We understand the first-in engine was staffed with (deleted). There were no senior people on the apparatus with them. They were all young firefighters trying to do their

best with just the little experience that they have. I hope that they will take this experience and learn a lot from it so they do not do it again. Luck may not be with them the next time.

In addition, an emergency to civilians is not an emergency for us. Take your time and establish command, perform a 360, secure utilities and do a thorough SIZE-UP!

When we allow the younger, less experienced firefighters to run the rigs alone, give them strict SOPs to follow. The department needs better, stronger SOPs. Set up training and Train, Train, Train!

06-111

Event Description

Our department was called out to a double wide mobile home fire. There were 3 of us that responded. I was Chief at the time. We found the structure involved in the front with flames coming out of the front windows. We charged a 1 3/4" line and began to knock down the fire. We had been in the defense attack mode about 15 minutes, when I decided to walk around to the rear while the two firefighters continued to battle the blaze in front.

At the rear of the structure about 6 ft. from the rear wall, was an 8 ft. propane tank. What we did not know was that the fire had burned through the rear wall and was rapidly heating up the propane tank to the point that the water that had fell into the valve containment bowl on top of the tank was boiling like a tea kettle. I had no idea why the pressure relief valve had not functioned, but I knew that we were very close to leaving this world. Needless to say we immediately began to forget about the structure and started to cool the tank. At that time I had attended two classes from the state fire academy that amounted to introduction to basic firefighting. However, my instructors had repeatedly stressed how important it was to do a walk around size-up. I had failed to do that and it almost cost our lives.

I am now a state Fire Academy certified Level 2 entry firefighter with 23yrs. experience. As Training Officer for our department, I tell our firefighters that unless they have the ability to see through structures, they had better be doing a walk around size-up. In my opinion, one of the most important aspects of any kind of emergency is situational awareness and in that incident I completely lost sight of that. Having looked at the results of the reports that were sent in by other departments' near-miss incidents, I was stunned to learn that the main contributing factor in the majority of those incidents was the same as our incident, situational awareness.

Lessons Learned

Never ever forget to do a walk around size-up and stress to every firefighter in your department that overall safety of the incident is everyone's responsibility. If someone forgets to do a size-up, bring it to the IC immediately and if that doesn't work, then do it yourself. After a tragedy happens it is too late to start pointing fingers at other firefighters for failing to properly secure the scene. After all, it may be the last time that you ever have a chance to do anything!!!
