November 2019

Acting Officer in Charge

BACKGROUND AND DAMAGES

A 24-year-old male firefighter received first and second-degree burn injuries sustained at an apartment house fire. The firefighter was part of a four man crew responding on a mutual aid request to a neighboring town. The crew was composed of a 58 year old driver, a 24 year old Acting Officer in Charge (AOIC), a 32-year-old (FF #2) and 47 year old (FF #3). The four-person crew arrived on scene and reported to command where the three (3) fire personnel were instructed to clear all first floor apartments (per protocol, the driver stays with apparatus) and where then instructed to engage in fire suppression and overhaul efforts.

The crew received a mutual-aid call for a working apartment fire in a neighboring town. Upon arrival at the scene, firefighters were initially assigned to clear the first floor. After a quick primary search, all apartments were found to be clear and the fire was still doubtful on the second floor and advancing through the third. The three firefighters returned to command and were reassigned to operating a line on the third floor as a relief crew. They were asked to pull the ceilings and begin searching for extension into the attic of the third-floor apartments. Upon their arrival on the third floor, it was evident that the need for more hose and more personnel would be needed. This request was relayed and the crew was advised that it would be a few minutes until additional arriving crews would be available. The crew of three evaluated the situation and decided they would continue their efforts until lines could be added. Sending one (FF #2) firefighter to grab a 'high-rise' pack from the pumping engine. Upon his return, the other (FF #3) firefighter assisted with breaking and adding additional lines.

As the two crew members, (FF #2) and (FF #3) went to the landing to add and advance more hose, the AOIC stayed within the room to monitor the conditions. While this was occurring, the AOIC attempted to establish the extent of fire in the attic and began to investigate by pulling small areas of the ceiling down. At some point, while navigating through the moderate smoke condition and attempting to open up areas in the ceiling, the door to the unit closed with the uncharged hose under it. The AOIC noted that conditions were changing rapidly as fire was showing from the rafter area, the AOIC requested to have the team "step-up" the procedure.

Once the added lines were in place, the pump operator charged the hose-line on the orders of the AOIC in the room and it was at this time that the charged hose-line forced the door into the door frame, jamming it shut. The AOIC began to panic as there was no water available and conditions were worsening.

The two firefighters that had been in charge of adding lengths hastily returned to the third-floor apartment door that was closed. Hot gases and flames were present two feet down from the ceiling and items were beginning to off-gas at the floor level One of the firefighters who was assisting in the addition of the line began to radio a mayday as it became evident that the fire-fighter in the room had become trapped because of the door being jammed closed. The trapped firefighter started to panic and began yelling and kicking the door. The AOIC attempted to locate another means of egress but lacking a ground ladder or other method, no way was found to evacuate the apartment safely.

The two firefighters outside the apartment worked together to gain entry through the jammed door. The door was forced open, and the trapped crew member was able to escape to the landing where the Mayday was then canceled. The AOIC was assisted to the ground level and evaluated by EMS, transported to a local medical facility where it was noted he received first and second-degree burns on his neck and wrist areas. He was sent by ground transport to the Burn hospital for treatments where he remained for five days. The firefighter was unable to return to work for 90 days due to his injuries.

INVESTIGATION

The supervisor's accident review identified the below-contributing factors:

- Turnout gear revealed the following:
  - The neck collar on the gear was not up or fastened under the chin as required
  - Helmet ear-flaps were not in the down position
  - Firefighting gloves were worn, however, cuffs were turned down
  - Wristlets on the coat were worn
  - A Nomex® hood was worn

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- The entire crew should have vacated the area, once the safety feature (hose line) was no longer in place
- The AOIC should have been assigned to a senior member of the crew as opposed to the first person in the seat
- Proper personal protective equipment (PPE), although worn, was not worn completely

CIRMA LIABILITY ASSESSMENT

CIRMA is 100% responsible for this work-related incident. The total direct cost of this claim, including medical expenses, totaled $150,000.

KEY RECOMMENDATIONS/ACTION ITEMS

CIRMA Risk Management is recommending the following best practices to reduce liability associated with this type of claim:

- On-scene, senior management follow-up on overall operation
- Elimination of freelance actions by incoming crews
- Proper accountability and deployment of resources through Incident Command System (ICS)
- Ensure proper span of control and back-up crew availability
- Based on the size of the incident, additional sector supervision with appropriate workgroups
- On-going knowledge by incident commander of tasks in operation at all times
- Ensure proper personal protective equipment (PPE) is worn properly
- Yearly inspection for gear failure
- Ensure that a mentor program is in place to help direct younger, less-experienced officers
- 'Practice like you play' fire-ground training should be identical to fire-ground operations
- Instill and reinforce a culture of vigilance to eradicate complacency

Questions on this topic? Ask your Supervisor or contact your CIRMA Risk Management Consultant at (203) 946-3700.

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