June 2021

# Mayday Confusion

## BACKGROUND

Two firefighters were injured and briefly trapped in a structure fire after operating in a dangerous area. The two firefighters called a Mayday and RIC (Rapid Intervention Crew) operations became hampered by other company actions and communication failure at the command level.

## INCIDENT DETAILS

An engine company was assigned RIC after arriving at an attic fire in a wood-frame two and a half-story home. It was providing mutual aid to a neighboring fire department.

The neighboring department had only recently started to request services to respond as mutual aid under a newly formed agreement and it was noted that the department was unfamiliar with the other department's operations. RIC protocol requires personnel to maintain accountability by tracking apparatus, number of operating firefighters and stability of the scene. Apparatus arrived and the RIC assembled equipment, proceeded to the command post and attempted a face-to-face with the IC (Incident Command) or ISO (Incident Safety Officer), which is normal protocol. Unable to attain crucial information from the IC and that there was no ISO, RIC placed its equipment and proceeded to do a 360° and evaluate the current conditions by place ground ladders to soften the structure. While doing so, an interior crew called a Mayday; the RIC was unsure of how many people were inside or what their location were. The operating department did not have the same method of assigning tasks that the responding RIC department had, so it created confusion as to who and where the trapped firefighters were located inside the structure.

It did not seem like the IC heard the Mayday announced on the radio. Because the only transmission was *"Mayday, Mayay"*, the IC may have been unaware until the apparatus on scene began sounding air horns (a common technique used to evacuate a structure). The radio announcement was heard by the RIC, who immediately started to react by returning to the IC for equipment and orders, but there was some confusion for a short time. There was no formal announcement by the IC to repeat the Mayday and make everyone on scene aware of the situation. The truck company operating a heavy stream near the interior crew (apparently not close enough to endangering them) did not understand why they were being told to shut down their stream as they were making good headway. This also delayed the RIC's entry into the structure. Eventually the crew entered (under the discretion of the RIC officer) and met with a second interior crew and assisted with the removal. It was determined that a member(s) of the interior crew were briefly trapped by a partial interior collapse on the second floor while opening up ceilings and walls checking for extension. Firefighter #1 needed assistance along with firefighter #2, who became briefly pinned by the falling debris.

The RIC was finally initiated by the IC. Once the truck company's master stream was shut down, the RIC was met by that second interior crew on the second floor who had already started assisting with the removal. The Mayday was quickly cleared when the crew(s) exited the building, and the injured firefighters were assisted out of the building and transported with neck and back injuries.

## INVESTIGATION AND LIABILITY ASSESSMENT

Firefighter #1 was admitted to the hospital with severe cervical and lumbar pain and required a 10-day stay having several needed surgical procedures. Firefighter #2 was treated and released with superficial injuries and minor bruising from his entrapment injuries.

In the investigation report, it was noted that members believe, in this case, that the crew was operating in an unsafe position on the second floor as the large caliber line was in operation. Because firefighter #2 was in a kneeling position in a protected doorway standing ready with a hose line, his injuries were less significant than that of firefighter #1. Firefighter #1 was in a standing position pulling ceilings and walls with a pike pole and was struck by a collapsing wall and ceiling causing him to fall to the floor.

During the interview process with the IC, it was clearly stated that there was "some confusion on the scene" and, after reviewing the radio log, it was noted that he did miss the original Mayday transmission and clarification was difficult. The RIC was unfamiliar

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with the home department's operating procedure and was clearly working autonomously with no oversight or direction.

CIRMA is 100% responsible for this work-related incident. The total direct cost of these two claims, including medical expenses, equaled $85,000.

## KEY RECOMMENDATIONS / ACTION ITEMS

To help reduce liability, the CIRMA Fire Services Task Force has recommended the following:

- Consider including a provision in the Memo of Understanding (MOU) to review any standing Standard Operating Procedures/Standard Operating Guideline (SOP/SOG) regarding the responsibility for a RIC and their activities on scene.
- Ensure clear communications between the arriving senior department officer providing the RIC coverage and the IC.
- Consider having a communications officer assigned to the command post to ensure that no transmissions go unheard.
- Incoming RIC companies should have a face-to-face with command and a full rundown of the scene, including the number of personnel on site, location of personnel, assignments of personnel and a complete 360° of the fire scene, to ensure that safety concerns are addressed.
- Consider not allowing crews to operate in the building while master streams are in operations.

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



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