



National Fire Fighter Near-Miss Reporting System

These reports coincide with the new monthly podcast entitled *Communications* to be posted on Thursday, October 16, 2008.

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

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Report Number: 07-0000929

Report Date: 05/27/2007 1535

Synopsis

FF falls when staircase collapses.

Demographics

Department type: Combination, Mostly paid

Job or rank: Fire Fighter

Department shift: 10 hour days, 14 hour nights (2-2-4)

Age: 25 - 33

Years of fire service experience: 7 - 10

Region: FEMA Region I

Service Area: Suburban

Event Information

Event type: Fire emergency event: structure fire, vehicle fire, wildland fire, etc.

Event date and time: 05/21/2007 1830

Event participation: Involved in the event

Weather at time of event: Clear and Dry

What do you believe caused the event?

- Human Error
- Other
- Accountability

What do you believe is the loss potential?

- Lost time injury
- Life threatening injury
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Event Description

While climbing an exterior wooden stair case to check for fire and smoke extension in a room above the fire floor, the decking of the staircase gave way and firefighter fell through. Firefighter was fortunate that he fell over a joist. Joist prevented him from falling completely through and then 15 feet to the ground while holding tools and a water can. The firefighter was grabbed by two other firefighters before he tipped over and continued to fall. Firefighter was treated and released with a slight knee sprain and lower back sprain. Call was for a fire in the basement of a mill, small fire extinguished. Role was check for extension. Portable radios were on all persons, accountability system was being utilized. Team of 3 was involved in role of checking for extension. Firefighters made poor decision in not checking structural stability of staircase prior to climbing it. IC was set up down to operational level. No safety officer had been identified. One alarm assignment was on scene which consisted of 3 engines - 7 firefighters, 1 ladder - 2 firefighters, 1 rescue - 1 firefighter.

Lessons Learned

Checking the stability of all outdoor decking, staircases etc. should always be done, not taken for granted based on a mere visual inspection. Situation is preventable by sounding the stability of such structures and then minimizing amount of personnel on structures at any given time. Also important to keep in

mind the large increase in weight firefighters carry when wearing gear, SCBA and carrying tools.

Report Number: 07-0000748

Report Date: 02/26/2007 1845

Synopsis

High angle rescue performed by untrained personnel

Demographics

Department type: Combination, Mostly volunteer

Job or rank: ALS Provider

Department shift: 24 hours on - 72 hours off

Age: 25 - 33

Years of fire service experience: 14 - 16

Region: FEMA Region X

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: 08/02/2006 1551

Hours into the shift: 9 - 12

Event participation: Involved in the event

Weather at time of event: Clear and Dry

Do you think this will happen again? Yes

What do you believe caused the event?

- Equipment
- Human Error
- Training Issue
- Decision Making
- Command

What do you believe is the loss potential?

- Life threatening injury
- Minor injury
- Lost time injury

Event Description

We responded to a male adolescent who had fallen approximately 25 feet down the face of a 75+ degree waterfall. Witnesses stated the patient had possible seizure activity. Our personnel made access to the patient by using a rope and climbing down a well worn trail that was approx 45 degrees. The decision was made by the senior person on the shift to place the patient on a backboard and place him into a Stokes Basket. We decided the face of the waterfall was the best way to bring the patient up. It should be noted that water levels were low at the waterfall and the other access to the patient was over a narrow path above deep water. Ropes were sent down to the patient location and a good area was available for the rescuers. The senior person was with the patient and I advised him I would send down two ropes for the Stokes Basket and a third rope for the rescuer. I was told not too. The third rope was sent down but was not used. The team below proceeded to tie one rope to the Stokes Basket and then four firefighters held onto the Stokes Basket while the people above started to pull

the patient up. This caused quite a bit of confusion and multiple bystanders had to help out due to the extra weight. Two other firefighters then climbed up the face of the waterfall hand over hand using the rope that was sent down to be used as a second safety for the patient. We had one patient and four firefighters on one rope. None of the firefighters had safety gear on and none were tied in. We also had two firefighters on another rope, three firefighters above, five or six bystanders assisting in pulling the patient, and four firefighters up on the waterfall. While ascending the waterfall, two firefighters slipped on the wet rocks, but were luckily able to hold on with their hands. We were very fortunate that no one fell. Our department has no formal training in high angle rescue and we have no life safety rope that is available for service

Lessons Learned

1. A command structure must be in place so there is no question who will be making operational decisions.
2. A Safety Officer should be in place on all rescues.
3. Identify where training is needed. This should be based on the geography of the response area.
4. There should be adequate equipment available for the safety of firefighters and patients.

Report Number: 07-0001187

Report Date: 12/31/2007 1335

Synopsis

Near-Miss averted due to quick reaction from FRD driver

Demographics

Department type: Combination, Mostly paid

Job or rank: Fire Fighter

Department shift: 24 hours on - 48 hours off

Age: 34 - 42

Years of fire service experience: 24 - 26

Region: FEMA Region III

Service Area: Urban

Event Information

Event type: Vehicle event: responding to, returning from, routine driving, etc.

Event date and time: 12/31/2007 0930

Event participation: Involved in the event

Weather at time of event: Clear with Frozen Surfaces

What do you believe caused the event?

- Weather
- Decision Making
- Individual Action
- Situational Awareness
- Equipment

What do you believe is the loss potential?

- Life threatening injury
- Lost time injury

Event Description

The weather made this morning very eventful. Roadway surfaces were slick, bridges and over passes were icy. I passed six accidents on the way to work. One accident involved a county police officer who was trying to avoid a crash and totaled his vehicle. My event happened while returning from an investigation of a property damage collision which involved a vehicle that slid off the roadway and struck a tree. After clearing the call, we traveled westbound on [name deleted]. Reaching the bridge, we noticed a vehicle in some sort of collision at the far west end of the bridge. It was to the far right hand side that was facing us. The collision was half on the roadway and half on the sidewalk. Approaching the vehicle, assuming it spun out as a result of the icy conditions, I was traveling 30 to 40 mph and was operating a [name deleted]100' aerial. It has the [name deleted]independent front suspension and is also equipped with ABS. I had the engine retarder in the off position. As I approached the vehicle at the end of the bridge, I applied the brakes and felt the ABS activate. The truck lost traction. I was able to control my vehicle and get it to a stop with out any incident. We positioned the tractor drawn aerial to protect the scene and angled across the center right lane. As my officer exited the vehicle to evaluate an occupant whom appeared uninjured, I told him to make sure he shut his door. The tillerman and

I stayed in place. I left the vehicle in DRIVE and I did not apply the parking brake. I continued to hold the service brake with my foot while paying close attention to traffic in my left hand driver's mirror. I also continued to communicate with my tillerman via headsets. There were about a dozen cars approaching us coming onto the bridge from the eastbound side. We noticed they were traveling towards us at a higher rate of speed than what was appropriate for the morning's road conditions. Because of my positioning, traffic was funneled from the center and right hand lanes to the single left hand lane. Traffic was trying to "beat one another" for what they felt was optimal lane positioning. Meanwhile, my officer escorted the uninjured occupants down the road away from the scene leaving only the damaged car and the [name deleted]. What appeared to be a small dark green foreign sedan, lost traction and began to spin completely around (360 degrees). The driver had no control as the vehicle spun in our direction. The precise moment I saw this, I took my foot off the service brake, applied my foot gently to the accelerator and pulled forward. My tillerman started yelling that we were about to be hit. I pulled my vehicle forward approximately one length at about 57 feet. The vehicle, without colliding with anything, came to rest where we were sitting. The driver of the vehicle gathered himself, turned his car around, slowly got back into traffic and proceeded on. Over the next 15 minutes, a state road truck started applying salt and a Nissan pickup spun out losing control in the east bound lane. The tow truck that was responding for the car that we originally stopped for also slid on the bridge. We stayed on scene approximately 30 minutes. We left without incident after the bridge was salted and returned to quarters. I would also like to add that I had an arrow stick on the rear of my apparatus. The light was flashing from right to left in order to move traffic to the left. I feel that if it was not for my years of experience as an emergency vehicle operator and a professional truck driver, that this near-miss could have been considerably worse. The brackets [] in this report denote identifying remarks removed by reviewer.

Lessons Learned

Good situational awareness, decision making, communication, and training came into play.

Report Number: 05-0000321

Report Date: 06/26/2005 0851

Synopsis

Pager called for Kitchen fire. I responded from home to house across the street. Fire through the roof 30 seconds after

Demographics

Department type: Volunteer

Job or rank: Fire Fighter

Department shift: Respond from home

Age: 52 - 60

Years of fire service experience: 7 - 10

Region: FEMA Region IV

Service Area: Rural

Event Information

Event type: Fire emergency event: structure fire, vehicle fire, wildland fire, etc.

Event date and time: 06/09/2005 0930

Hours into the shift: 0 - 4

Event participation: Involved in the event

Do you think this will happen again? Yes

What do you believe caused the event?

- Situational Awareness

What do you believe is the loss potential?

- Property damage

Event Description

Pager called for a kitchen fire. I responded from home to house across the street. Fire through the roof 30 seconds after notification. Problem - Residential home used for construction debris removal business and tire truck repair business. House was loaded with ammunition - even one lamp that had a very large diameter "live" shell as it's center post. It did blow. It was a surround and drown from the get go - with live ammunition continually exploding. At the back of the house was a large storage barn filled with 20 lb. propane cylinders and a 200 gallon gasoline tank, used to fill trucks.

Lessons Learned

The safety issue - even residential structures need preplanning. Thankfully, the ammunition started going off earlier as the first engines were arriving. Taking initial command, I recommended to the first due lieutenant, who took over command, that I felt an exterior attack was safest. Turned out to be a good decision. Residents need to understand our need for residential preplans and should share things like ammunition, propane tank locations, children's bedrooms, handicap bedrooms, oxygen in use data, invalid, etc. We all focus too much attention to commercial preplans. Residents should also be educated on the dangers to rescue personnel and the possibility of manslaughter charges if rescue personnel are killed in something they had no idea they were getting into. Rescue personnel need to know that the residential house fire may actually be an

industrial situation. Fire Departments should consider residential preplanning. Towns need to enforce code violations and act on them.