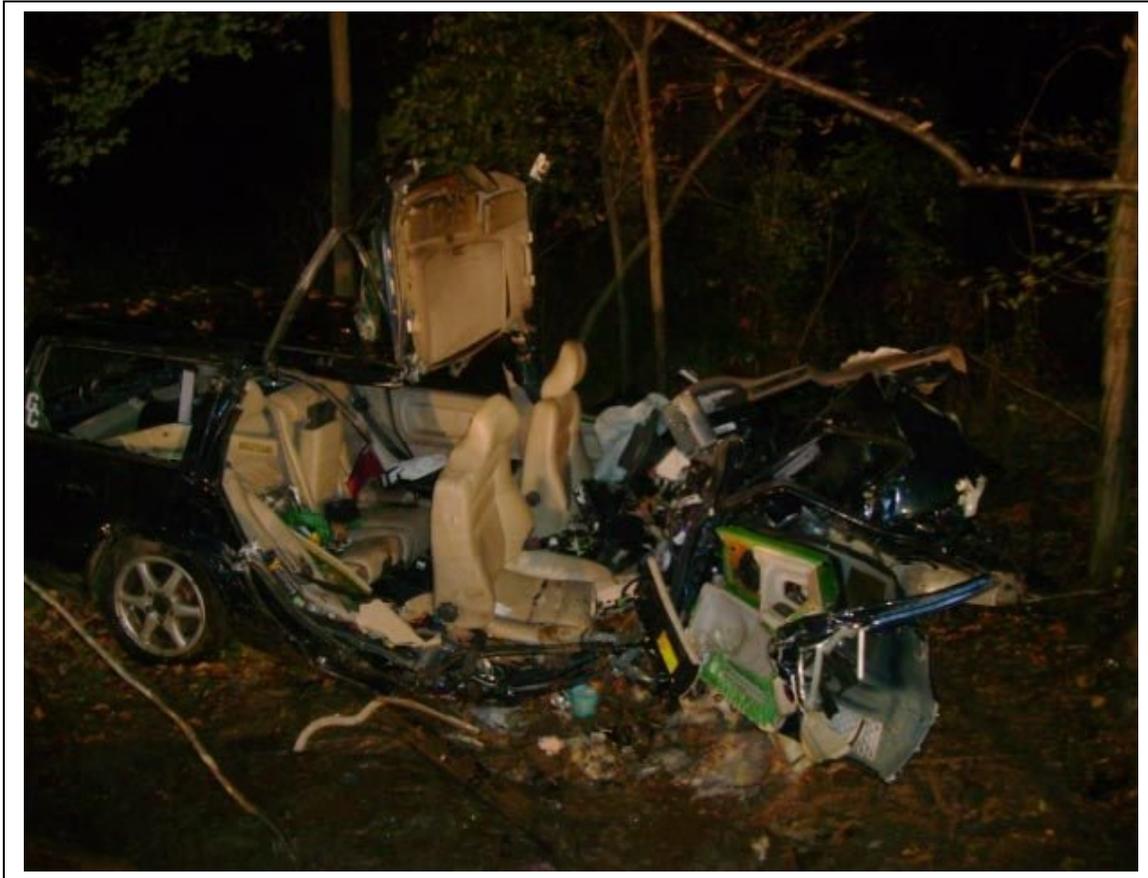


**Significant Multi-Casualty Collision with Fatality  
Hawkins Creamery Road & Johnson Farm Drive  
October 20, 2008 21:06 Hours  
Box Area 13-14  
Incident #F080108450**



**POST INCIDENT ANALYSIS**



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Cover photo taken by Buddy Sutton



## Introduction

On the evening of Monday October 20, 2008, five Damascus teenagers depart a church youth group meeting in a Volvo station wagon and begin the traditional drive to Burger King. There were a number of other vehicles leaving the meeting and making the same trek to the restaurant. As the Volvo traveled west on Hawkins Creamery Road, it left the roadway, struck a tree and caught fire.

Other teenagers and adults following the Volvo stopped to lend assistance. The male driver had self-extricated; the right-front male passenger was pinned; and the three unbelted rear passengers, two female and one male, were removed from the car by bystanders.

An off duty Montgomery County Detective arrived as one of the rear passengers was being removed and gave a report of a car on fire with two trapped. The detective along with bystanders continued to knock down the fire with a dry chemical extinguisher and triage the wounded children. Other bystanders – mainly teenagers – provided comfort and aide to their injured friends who were scattered over a wide area.

Hawkins Creamery Road is a winding two-lane road with no shoulder that runs East & West between Maryland Route 108 (Laytonsville Rd) and Maryland Route 124 (Woodfield Rd). The event occurred in a wooded valley between Woodfield School Road and Johnson Farm Drive. First responders encountered a number of challenges including a vehicle on fire, multiple high-priority casualties, entrapment, rough terrain, darkness and numerous bystanders which added to a highly-emotional event.

The roadway was dry and the weather was fair at the time of the collision.

Of the five teenagers in the car, four of them were initially triaged as Priority 1 Category A or B traumas; one was a Priority 2 Category C; and one bystander was a Priority 3 with contact burns. During the incident the Incident Management Team (IMT) was advised that one of the teenagers was the son of a Montgomery County Police Commander. This added to an already emotional scene. Unfortunately, the Commanders son died shortly after reaching Shock Trauma.

All personnel are commended for their actions that night; they were faced with a number of challenges. A number of issues were discovered; however improvements have been identified. This incident did not meet the threshold of eight patients which would automatically require a post incident analysis. However, because of the magnitude of issues and challenges, Battalion 705 believed an after action review was warranted.



## Montgomery County Fire and Rescue Service *Post Incident Analysis*

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The incident was reviewed by the incident commander, Deputy Chief Browning, and by Battalion Chief Barry Reid who was assisting the IC with Resource Status and Situation Status on the event.

Two primary witnesses were interviewed on October 29, 2008 – both arrived to lend assistance within a minute after the crash. One was Montgomery County Police Detective and the other was a civilian (part of the overall group) who was traveling a couple of cars behind the Volvo.

This document was written by Battalion Chief Barry C. Reid and approved by the Incident Commander.



## Dispatch and Initial Response

The initial dispatch from Fire/Rescue ECC at 21:08 was for a personal injury collision with one trapped and car on fire. Initial units dispatched included A713, M713, RS717 and E713. E713B was also added. Police had received the call at 21:06; dispatched the call at 21:07 and were on the scene at the same time (off-duty detective).

E713 arrived six minutes after the police at 21:13, gave an updated on-scene report, established command and requested two additional ALS units and one helicopter. An additional helicopter was requested after a third update from E713.

Additional units provided command and ground support.

EMS	ENGINES	RESCUE/ EXTRICATION	COMMAND/OTHER	MEDEVAC
M713	E713	RS717	C713B	HT8
A713	E717	E713B	C717	HT3
CCM18			EMS703	
M735			BC705	
FCA259			U100	



## Situation on Arrival

First arriving units found a car off the roadway in the woods on fire with one pinned (front passenger). The driver had self extricated and had less serious injuries. The three in the back seat had been removed and placed in various locations. One was found in the woods, the other two on the roadway. There was also a bystander who received contact burns attempting extinguishment and rescue.

It was drill night at Station 13 and Damascus volunteers were staffing an additional engine (E713B) and A713. Additional equipment and manpower on the front-end of this incident made a significant difference with early incident management. E713B is also equipped with an Amkus Rescue System. The additional resources on the initial response allowed the crews to simultaneously address multiple objectives.

The pinned passenger was feeling radiant or conducted heat from fire. Crews flooded the pinned area below the waist with foam which cooled his legs and relieved anxiety.

Operations were also hampered by darkness and there were a number of adults and teenagers congregating at the incident and walking between apparatus. This became an extremely emotional event and the bystanders were beginning to hinder operations.

## Obstacles Encountered

Obstacles encounters on this incident include:

- Apparatus Positioning
- Inadequate Resources (ALS)
- Resource Allocation (assignment of on-scene personnel)
- Overall Incident Management
- Situational Awareness
- Time Management (SA)
- Crowd Control
- Crew Integrity
- Fixations (SA)
- Documentation

(SA) Situational Awareness Concerns



## ***Apparatus Positioning***

The initial response of 1 ALS Unit, 1 BLS Unit, 2 Engine Companies and a Rescue Squad all arrived on the same side of the incident which was the Route 124 side. All subsequent units took the same route. The first two EMS units arriving pulled up as close as possible next to the scene. The Rescue Squad pulled up as far as possible but was unable to get close enough to use the on-board tool system. They had to go “portable” which created additional challenges.

Apparatus configuration created a log-jam which did not allow either of the first-arriving EMS units the capability to depart the scene early. This “olive bottle syndrome” plays out every day. By Policy, the EMS unit must position itself for efficient access and egress, leaving room for the Rescue Squad.<sup>1</sup> Personnel must be cognizant of this and position their unit accordingly. Crews should place all potentially needed equipment on the cot and roll it to the scene.

Consideration should be given on expanding mass casualty incidents to load additional supplies, backboards, reeves stretchers, and other patient moving devices on a cot and move supplies forward. First arriving units can easily create an EMS cache near the scene which can be used to move and treat multiple patients.

Other arriving units would be simple transport units. They should position themselves for rapid egress (facing out) from a pre-determined staging area.

The Rescue Squad should have also considered coming in from the opposite direction to obtain premium access and avoid blocking in other units.

Coordination on limited access roadways is essential. Key units should anticipate travel routes and ensure the best access for the assigned task. Similar to coordinating water supply/access on structure fires – consider announcing route of travel so that appropriate changes can be made if necessary.

All apparatus was on one side of the incident. Poor coordination allowed the first Landing Zone (LZ) to be set-up east of the incident near Woodfield School Road. It was impossible for units to get through the scene to reach that LZ. The LZ had to be reestablished on the West end at Clearspring Elementary.

Police and civilian vehicles also created problems.

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<sup>1</sup> Fire and Rescue Commission Policy 24-04, Vehicle Accident Response Sec 3.a.f.1.A



### ***Inadequate Resources (ALS)***

Initial reports from E713 revealed multiple traumas of High Priority. Additional medic units were requested but only yielded 2 additional ALS providers (with two 1+1 ALS units). **With a “Delta” call type, ECC should automatically dispatch additional AFRA’s to add ALS providers.** Two off-duty medics had to be utilized at the Helicopter LZ/Secondary Treatment Area due to ALS deficiencies. One of those medics was required to assist during transport.

**This would also be a good time to review the “EMS Task Force.”** The number of ALS providers yielded on such a dispatch is no longer sufficient. Additionally experience has shown that a second rescue squad is seldom needed. A good model to consider would be the Northern Virginia Model. The Northern Virginia EMS Task Force includes five 1+1 ALS transport units, two-4 person suppression units (AFRAs), two EMS duty officers, and air transport units (upon request).<sup>2</sup>

### ***Resource Allocation***

(Assignment of On-Scene Personnel)

Over 25 personnel were on this incident that arrived on apparatus and their POV's. It appeared that many lost focus or free-lanced with their own agendas (lack of incident management). There were multiple over-arching objectives initially to stabilize the incident. Once those objectives were controlled with appropriate resources personnel must tend to the wounded.

For example, there were a significant number of fire/rescue personnel working to free the entrapped passenger when BC705 arrived while children on the street were being tended by bystanders and one or two first responders. It is extremely important for initial arriving company officers to look at the big picture and not to lose focus of priorities (life comes first). Unit officers need to momentarily step back, take a breath, and direct resources to treat the wounded and avoid a moth-candle situation.

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<sup>2</sup> Fire and Rescue Departments of Northern Virginia - Book 8: Multiple Casualty Incidents



## ***Overall Incident Management***

E713's Officer established initial command and gave good situation reports. He was also challenged with multiple high-priority patients, entrapment and a car on fire.

C713B arrived on the scene, assumed command and stayed in his vehicle. He did not announce the location of the Command Post. (SA) Pitfalls are discussed beginning on Page 9 of this document.

The incident was not initially broken down into manageable areas. When BC705 arrived (15 minutes after dispatch), he quickly assigned an Extrication Group Supervisor (C717) and an EMS Group Supervisor (EMS703) - notifying command.

Pre-printed ICS worksheets were not being utilized by the IC or the EMS Group Supervisor. (SA)

Despite organizing the incident, it remained chaotic with random unneeded radio traffic with key objectives going unchecked.



## ***Situational Awareness (SA)***

C713B remained in his vehicle on arrival. This facilitated a quiet environment but he may not have seen the big picture (location of patients, etc). The officer on E713 had done a very good job with initial triage and command; possessing a good picture of the situation.

A study by Chief Richard Gasaway, PhD<sup>3</sup> has revealed that commanders were spilt in the best place to run command. Some preferred to be close to the incident (outside of a vehicle) where all of their senses could capture cues and clues to develop their SA. Others said they maintained better SA when they were sitting in a vehicle or quiet location free from distractions.

Gasaway did mention that when commanders were faced with a complex or overwhelming incident, they preferred to be remotely located. However, all cautioned that regardless of where command decided to locate, it was essential to perform a thorough size up including a 360-degree walk around the dwelling (relating to dwelling fires).

A detailed face-to-face transfer of command with the officer on E713 may have increased the IC's SA even though he elected to stay in his buggy.

The command post location was not identified (geographically or by a green strobe). This caused a delay for BC705 and EMS703 when they arrived. C713B's buggy was tucked behind E713B in a grassy area. Commanders need to remember to state their physical location and illuminate a green strobe – especially if the CP is not obvious.

Preprinted ICS worksheets are available and should be utilized. The tactical worksheet is an All-Hazards NIMS Compliant worksheet that can be used to organize and track resources and help maintain SA.

The study by Gasaway indicated that commanders maintained SA and overcame stress from the complexity of an incident by using tactical worksheets or command boards. Commanders have also noted that the tactical worksheet allow them to get back on track when they were interrupted or distracted.

A preprinted Treatment Disposition Log is available for the EMS officer to track the priority, treatment and disposition of patients (maintain SA).

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<sup>3</sup> Fireground Command Decision Making:  
Understanding the Barriers Challenging Commander Situation Awareness, Richard Gasaway 2008



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## **Time Management (SA)**

Poor time management may become a factor on any incident. On fire incidents, we gauge our success on life or property saved. Although time is seldom a consideration over the overall measurable outcome, time management is critical during the incident. Time must be considered for firefighter safety with specific benchmarks on air supply/time in the building as well as overall progress. If we do not see conditions improve over time, we would consider switching our strategy.

On EMS incidents, we typically manage success on the time it takes for the patient to reach definitive care – using the R. Adams Cowley “Golden Hour” as a benchmark. In Appendix D you will see a chart of patients by priority and in Appendix E you will see the time (in hh:mm:ss) they reached definitive care. Be aware that the data in the chart comes directly from CAD. You will notice possible discrepancies in the “Time Transported” column that *may* be inaccurate. The Transport Arrival time (TARR) would appear to be accurate.

It should be noted that all four significant traumas were transported from the scene by 21:50. That is when the final BLS unit was requested to transport the driver of the Volvo.

**Someone needs to be assigned to watch the clock and keep things moving.** There may have also been some confusion as to who was being flown out since many of the traumas were taken to the landing zone without proper transport orders. The LZ ended up being a secondary treatment area as well.

Lacking scene clock management, Incident Duration Reminders (IDR) should be given to the IC regardless of the incident type so that safety and welfare can be monitored as well as to maintain a sense of Situational Awareness (SA). FRC Policy 22-03AM (Communications Manual) reads:

*To ensure the safety and welfare of personnel operating on the scene of an incident, the ECC will issue Incident Duration Reminders, or **IDRs**, consistent with the requirements established by the Fire Chief. These notifications are issued twenty minutes after the arrival of the first primary unit on events where three or more primary units have been dispatched. After the first unit has arrived, ECC will issue these reminders at fifteen minute intervals.*

Carroll County Medic 18’s driver had to physically go to the CP to obtain the Landing Zone (LZ) location as well as obtain driving directions. The driver then states they were one of three units transporting to the LZ and had to wait again once they reached that location for the flight medic.



### **Time Management (continued)**

On expanding incidents where resources are coming from other stations and other counties, you will find that people do not know the lay of the land. Remember this when you are considering an LZ. If you do not live or work in the area, you will not know where Clearspring Elementary School is located. Elementary Schools in Montgomery County are typically buried in some neighborhood and “off the beaten path” which make them difficult to find.

As technology advances, emergency vehicles may come standard with navigation systems. We are not there yet. Most units, however, including mutual aid assets, carry an ADC map. **Command could reference the physical location of the incident AND the LZ by referencing the Montgomery County ADC Map Page and Grid. This will help crews maintain situational awareness and save time when transporting to the LZ.**

Additionally, it has been reported that the trooper medics may have performed extended treatment on the scene.

A single root cause for the extended transport times could not be identified. However, it is suggested that any one of the items mentioned in this report could be a causal factor. Multiple factors would have compounded the problem.

### **Crowd Control**

A crowd quickly gathered around the scene – including the action circle (which encompassed 50’ in any direction in the writer’s opinion. This was a very emotional scene packed with teenagers and parents. It was hindering operations. **The fire/rescue officers on the scene must coordinate with law enforcement to move crowds back early.**

Bystanders will cause additional chaos especially during early triage. Removal of bystanders will give initial companies a better chance to see who is directly involved in the event.

### **Crew Integrity**

Overall crew integrity was challenged on this incident. Competing objectives early-on and multiple patients seemed to split some crews. This created a problem when it came down to find a particular driver for an EMS unit. If a treatment area had been established, later arriving EMS units could stay with their unit until a patient was ready for transport – similar to a true MCI.



### ***Fixations*** (SA)

Two fixations caused a loss situational awareness on the incident. One was the fixation by EMS703 on a potential burn patient. Repeated inquiries distracted command causing him to lose sight of other competing priorities. The second fixation was the extrication. There were numerous personnel engaged in this activity. The extrication could have been performed more efficiently with fewer personnel. Personnel should focus on the number one priority of life and patient care. Three Priority 1 patients were lying on the ground and providers needed additional assistance.

### ***Documentation***

Most electronic reports lack pertinent detail and fail to include significant benchmarks with times completed. They also lack incident organization such a division and group supervision. Additionally, when functional or geographical elements are assigned to a unit officer, that officer fails to record units under their command and significant activities. Appendix G should assist with this deficiency by offering a template for officers. This mainly applies to FireHouse incident and unit reports. EMS narratives need to comply with the appropriate policy.



## Considerations for Overall ICS Improvement

Many considerations for improvement (other than command) have been addressed in "Obstacles Encountered." Overall command and control issues are listed below.

**Command Officers need to recognize obstacles to situational awareness and enhance skills to overcome them.** This may include:

- Dividing an incident early to avoid being overwhelmed
- Obtaining the big picture by a good face-to-face transfer of command or conducting a thorough size up if things remain unclear
- Utilize pre-printed tactical worksheets to remain on track
- Watching the clock. This would include ECC providing IDRs by policy
- Referencing standard maps for points of interest when working with mutual aid assets.

C717 arrived and did not report to command but went to assist with extrication. A complex, emotional, and rapidly developing incident needs immediate command support. C717 should have reported to the Command Post and helped the IC get organized. **Regardless of C717's role at the scene, he is still the highest ranking officer and may be held accountable for any actions or fall out.**

BC705 was the only one from fire/rescue who arrived on the opposite side of the incident (Woodfield School Rd.). BC705 obtained a quick briefing from E713 and asked where the command post was located. **BC705 noticed several people working on extrication while children lay in the street being held by one provider and a bystander (SA).** C717 was queried regarding the number of people he actually needed for the extrication – all others were sent to help patients. BC705 advised C717 he would be the DIVS for Extrication.

**BC705 should have found the CP and spoke with C713B first.**

However, BC705 got drawn into the scenario and chaos. BC705 ran into EMS703 and assigned him EMS Group, then finally located the command post. BC705 briefed the IC on assignments made, the current situation and continued to assist the IC with Situation Status and Resource Status.



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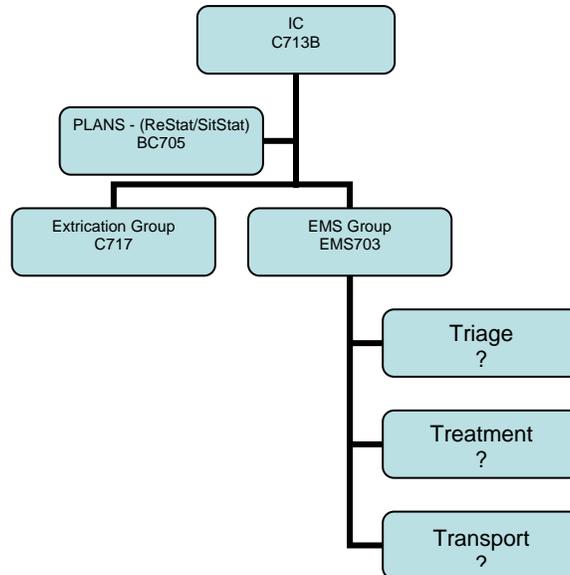
## Considerations for Overall ICS Improvement (continued)

The number one incident priority is life. Overall patient management could have been improved on this incident. **Early assignment of an EMS Group Supervisor to manage the triage and initial treatment of the injured is paramount.** An optimum action would have been to assign E713's officer as the initial EMS Group Supervisor role after the transfer of command. E713's officer (a medic) had already completed initial triage and had the best overall knowledge of patient location and condition.

**Once EMS703 was assigned the role of EMS Group Supervisor, the group failed to reach maturity.** Feedback from a number of personnel revealed extended times for a transport decision – even after a number of inquiries by the provider. Secondary triage was fragmented; there was no treatment area or officer, and no overall transport or disposition officer. EMS703 did make hospital contacts en route in an attempt to pre-load the overall patient disposition. Therefore he was attempting to reduce on-scene time.

If the unit leader positions are not filled, it is the responsibility of the EMS Group Supervisor to manage the function. If the EMS Group Supervisor is not filled, it becomes the responsibility of the incident commander.

EMS703 became fixated on a patient with burns who may or may not have existed while he was en route. **This fixation, and repeated calls to command before his arrival, distracted the IC away from more priority objectives (SA).**



### Considerations for Overall ICS Improvement (continued)

If E713's officer was initial EMS Group Supervisor, **a natural transition would have been to make E713's officer the treatment unit leader if EMS703 was assigned to the EMG Group Supervisor role.**

**When patients are scattered over a wide area, consideration needs to be given to move all wounded to a designated secondary triage area or Casualty Collection Point (CCP) (see Appendix C).** This will allow rapid identification of the most serious and appropriate action can be taken.

**Additional training may be needed for EMS Officers who assume the EMS Group Supervisor or Mass Casualty Branch Director roles.**

According to the EMS section, the officers complete a written exercise and partake in an interview which has few contact hours. The EMS Section should take full advantage of the Command Lab and engage in more hands-on exercises.

As credentialing progresses, the EMS Section should look for NIMS courses or equivalent courses that concentrate on those positions. I have recommended that the officer involved obtain a copy of the Firescope FOG or COG MAOP Pocket Guide and review it periodically.



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## Considerations for Overall ICS Improvement (continued)

**It has also been suggested that we develop guidelines for managing the “Mini-MCI.”** We run events that truly do not meet the classification of a “Mass Casualty Incident” because we are resource rich. We need to work on those marginal events that are on the cusp of a true MCI.

In 1983, the University of Delaware completed a study of 29 disasters and noted many common problems. The study’s findings are summarized in Appendix F and should be considered “Watch-Outs” for the daily multiple-casualty incident.

During the hot wash on the scene, it was identified that overall incident management could have been improved by having all command officers and the initial engine officer meet at the command post for an initial briefing. It was obvious that the incident was not running smoothly.

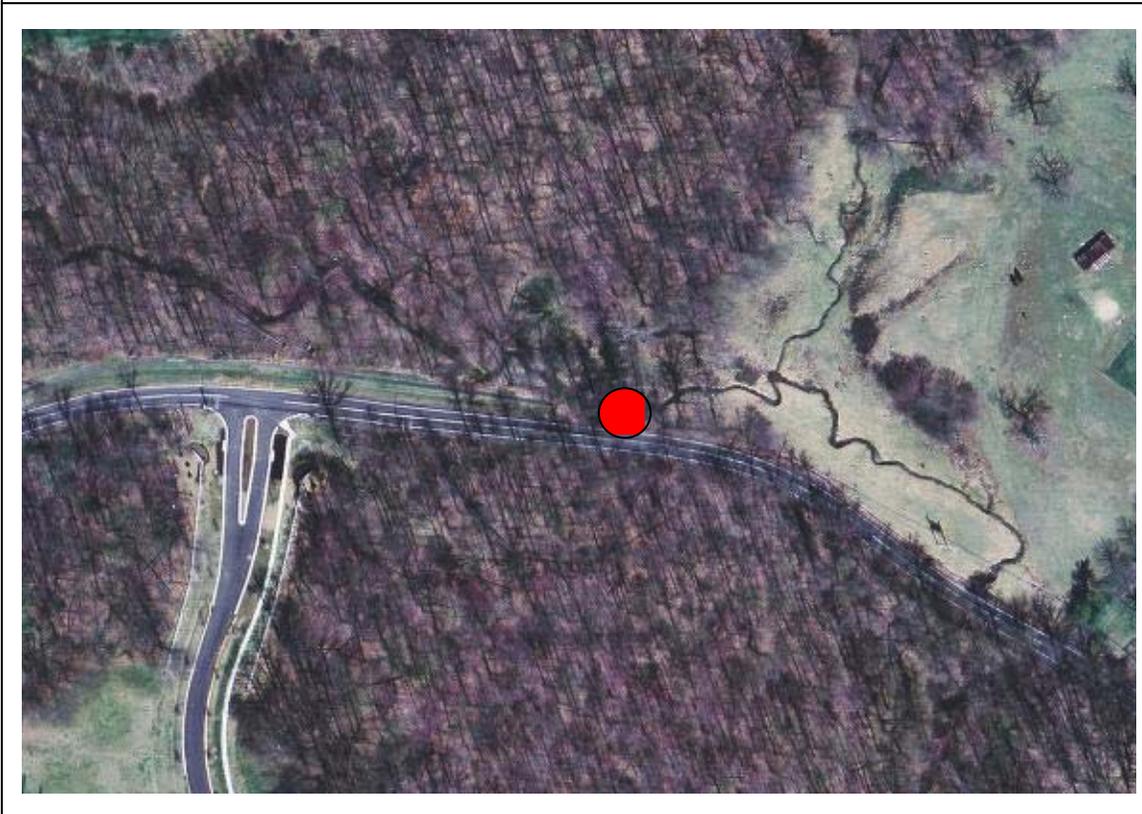
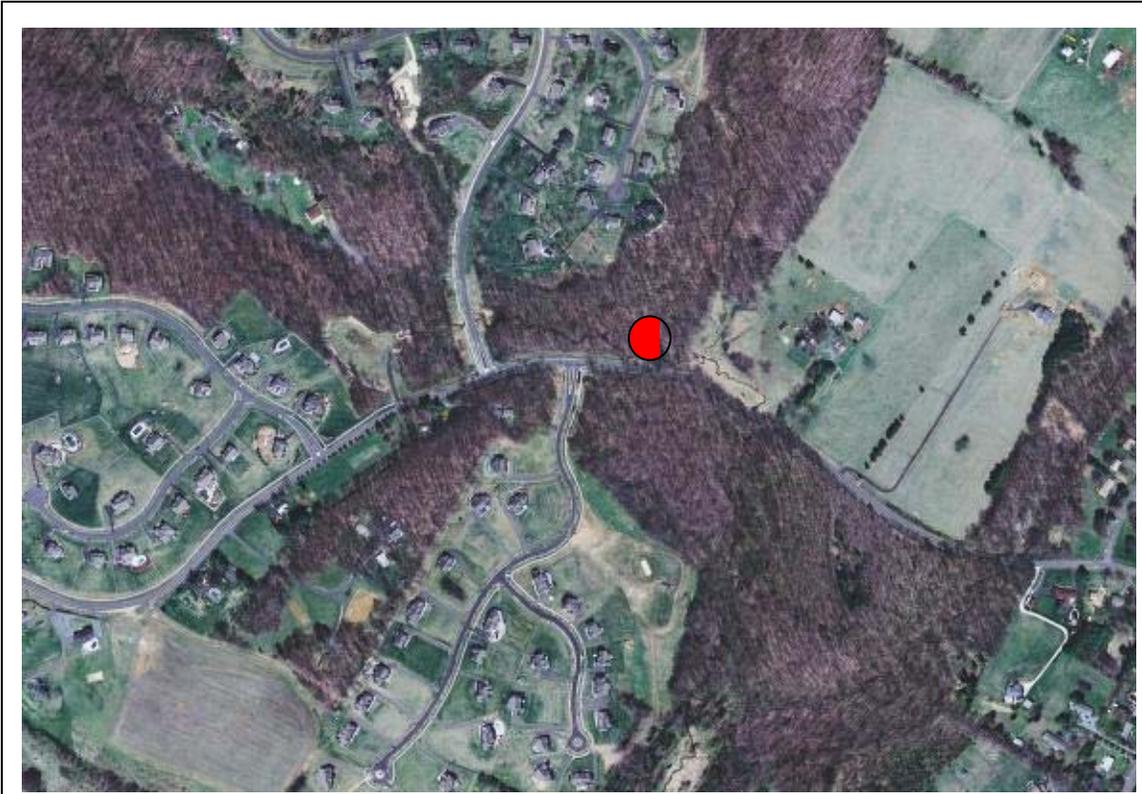
**Having primary command staff and the ranking police officer at the Command Post to provide Intel and a good situation report would have allowed the Incident Commander to re-evaluate the organization, update objectives, and make appropriate adjustments.**

There were coordination issues at the Landing Zone. U100 was managing the LZ and instructed E717 to funnel units to one area of the field but this did not occur. This may have caused an additional delay with total patient transport time. There were also additional safety issues at the LZ.

**It is important to develop an early strong command presence which would include maintaining radio discipline.** Once Level 2 command was implemented there were still a lot of random, unwarranted radio transmissions. Dividing an incident into manageable parts with Division and Group Supervisors will minimize this problem. Maintaining a strong command presence and maintaining radio discipline to avoid confusion on the scene.

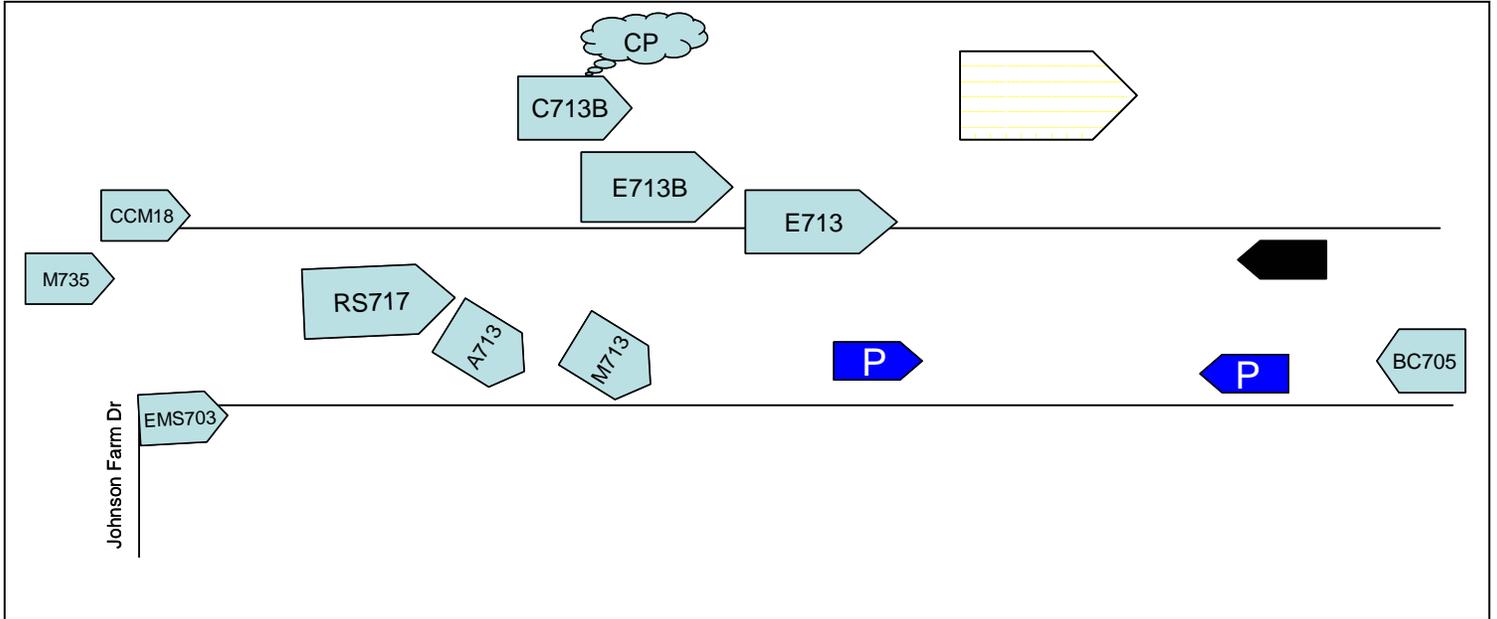


## Appendix A – Area Map





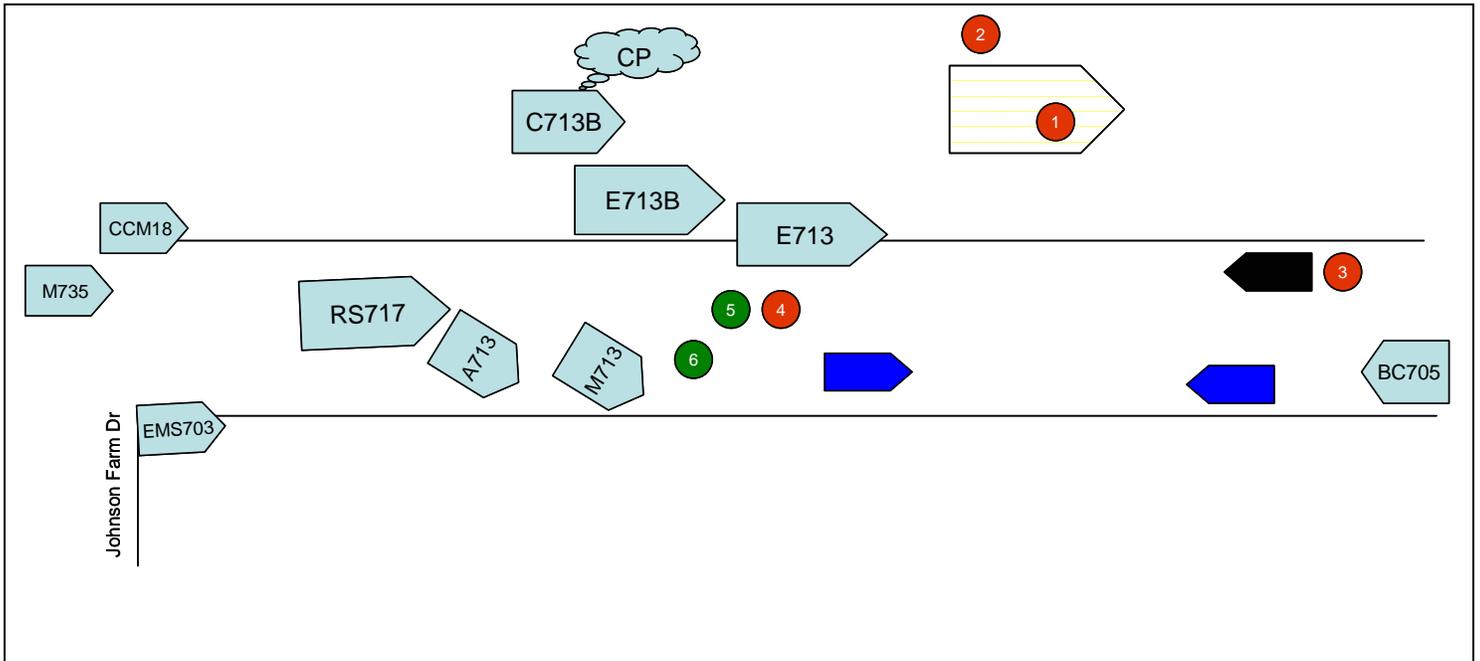
## Appendix B – Apparatus Positioning





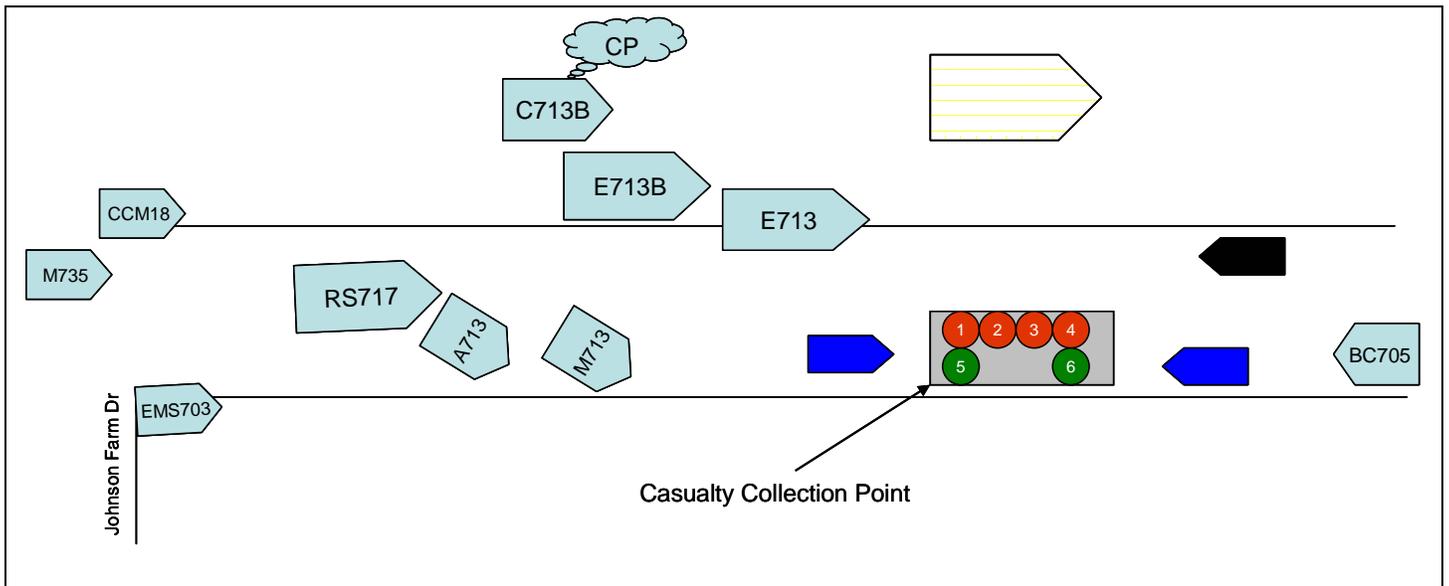
## Appendix C

### Approximate Patient Locations on Arrival



### Future Considerations – Casualty Collection Point

Future Consideration for Secondary Triage (Casualty Collection Point) which may prioritize treatment and transport needs





## Appendix D – Patient Information

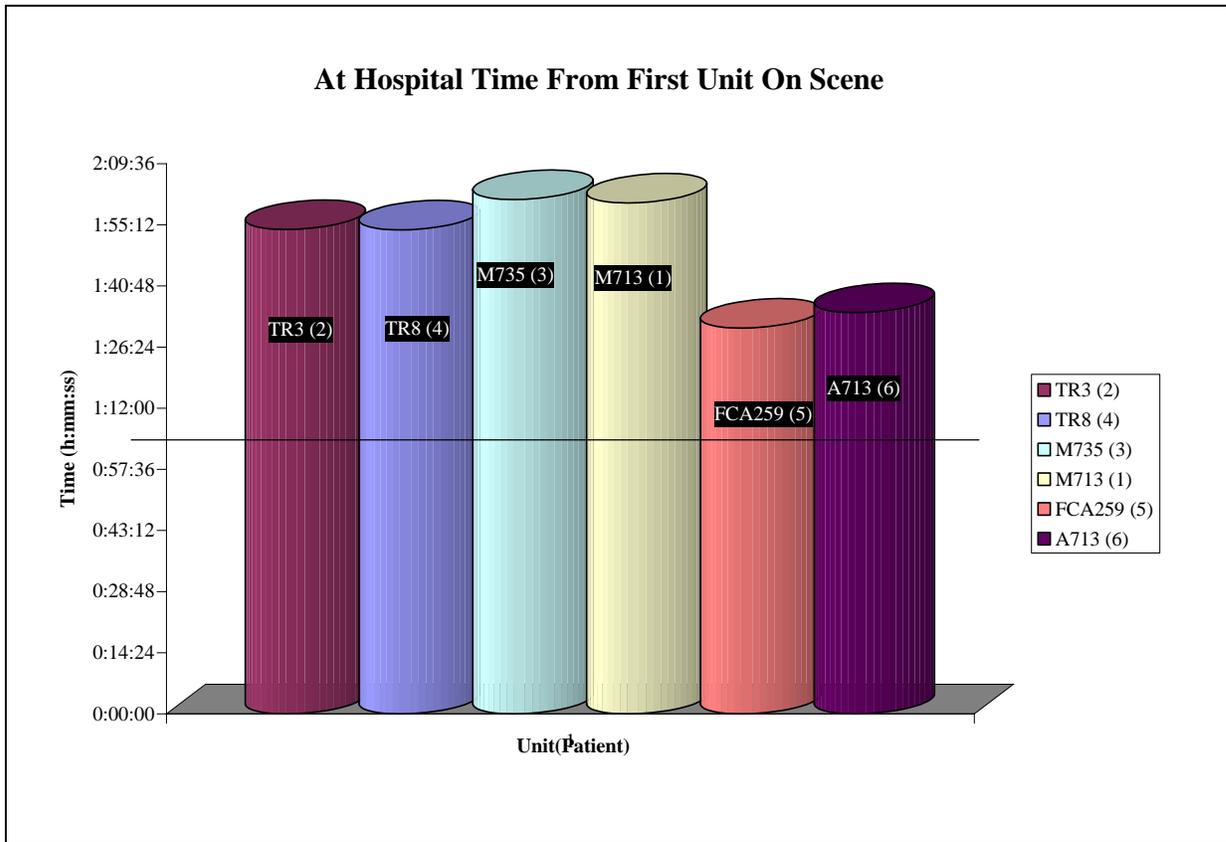
(Times taken from CAD Data)

Pt #	Gender	Initial Cat./Priority	In Vehicle	Found	Rx By	Transport By	Transport To	Time Trans	Time At Hosp
1	M	B/1	RF Passenger	Pinned – RF Passenger Seat	RS717M	M713	SUB	23:13:36	23:13:41
2	M	A/1	Rear Passenger	Outside of vehicle – removed by civilian	M713 M2	HT3	STC	22:35:51	23:07:26
3	F	B/1	Rear Passenger	Roadway behind van Woodfield School side – removed by civilian	M735	M735	SUB	23:14:11	23:14:40
4	F	B/1	Rear Passenger	Roadway – removed by civilian – up on Hawkins Creamery	M713 M1	HT8	STC	22:35:42	23:07:22
5	M	C/3	Driver	Self-extricated or assisted out before arrival – up on Hawkins Creamery	FC A259	FCA259	MGH	22:21:12	22:44:14
6	M	3	Bystander	Contact burns assisting at scene	A713	A713	SGAH	22:47:48	22:47:52



## Appendix E – Time to Hospital

(From CAD Data)





## Appendix F – 1983 University of Delaware Study

### Mass Casualty Incident Information

In 1983, the University of Delaware Disaster Research Center studied 29 disasters and found many common problems with Mass Casualty Incident Management.

- ❖ Inadequate notification of area agencies and hospitals that a mass casualty incident occurred.
- ❖ Lack of rapid primary stabilization of all patients.
- ❖ Failure to establish treatment area/sector and quickly move patients to this area.
- ❖ Poor triage.
- ❖ Delivery of inappropriate and overly time-consuming care.
- ❖ Transporting stable patients too early.
- ❖ Improper use of field personnel.
- ❖ Improper distribution of patients to medical facilities.
- ❖ Lack of recognizable EMS field command.
- ❖ Lack of proper pre-plans and lack of adequate training of all personnel.

Handling an MCI requires Planning, Preparation, and Practice

Planning for a Mass Casualty Incident  
JEMS Volume 18 Number 11



# Documentation Basics DOC A<sup>3</sup>PE

## Appendix G – Documentation Basics

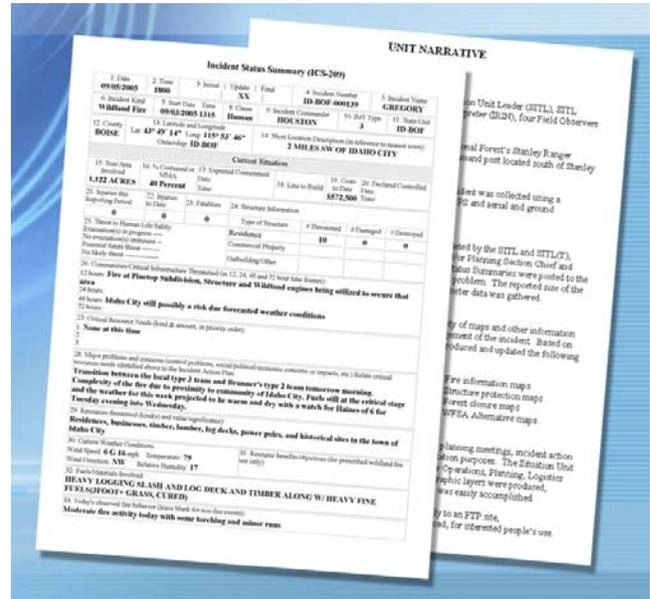
### Most Reports Suck!

There have been a number of significant events that lack good documentation. Unit officers and incident commanders must document their actions and incident management functions as if someone not on the event could understand it. The document could be called to court years after the incident and simple attention to detail could make a difference.

The writer should be able to transfer events in detail and paint a picture of the incident. The “auto-generate” function in the incident module is grossly inadequate. The software template should be able to prompt the writer with queues to avoid loss of pertinent details.

The unit report needs to give detailed information at the tactical and task level for an event. If the unit was assigned to a division or group it should be indicated. If the unit officer was a division or group supervisor, more detail is required which should include:

- The functional or geographical name of the division or group.
- What was the responsibility or objective of the division or group.
- Which units were operating in the division or group – including any changes in equipment or personnel under the command of the supervisor? For example, if additional resources were requested or if a unit went to REHAB.
- Documentation of injuries, accidents, or near-misses under the command of the supervisor.
- Specific actions taken and who was notified when objectives were complete.





# Documentation Basics

## DOC A<sup>3</sup>PE

The incident report and some unit reports should be more descriptive. They should contain the following:

<b>D</b>	<b>Dispatch</b> information. What were the units dispatched for?
<b>O</b>	<p><b>On Scene</b> information. This should be a brief description of findings upon arrival which may differ from the dispatch information.</p> <p>For a collision, you should indicate the number of vehicles, the impact type (e.g. side impact with significant intrusion, rear-end collision, etc.) and the total number of patients by priority and category. Provide additional information and be descriptive. You may document, for example, “the driver was pinned and the passenger was standing next to the vehicle upon arrival.”</p> <p>For a structure fire, you should include as much detail about the structure and conditions on arrival. It should include all points covered in the Safe Structural Firefighting Policy for the initial on scene report (IOSR).</p> <p>Weather conditions should be documented as well.</p>
<b>C</b>	<b>Command.</b> Who had initial command? What mode? Who established Level 2 command? (which is usually the writer of the IR) How was command transferred? What was the location of the Command Post?
<b>A<sup>3</sup></b>	<p><b>Actions, Assessments, and Accountability.</b> Document what initial control <u>actions</u> were put in place. This would include documentation of 2-out or the reason the two-out was waived. Did the follow up <u>assessment</u> glean any new information? Document the plan initiated by the initial IC (if applicable) and confirm/verify or indicate adjustments made including the request for additional resources. <u>Accountability</u> is documented by listing the initial and expanded incident organization with units assigned, for example:</p> <p>IC – BC705          Advisor – DC700          PLANS – C729B (Functions include Resource Status, Situation Status, and Demobilization Plan)          SOFR – Safety 700          IO – Not assigned          LOFR – EMS703</p> <p>RIG – C703B (DIVS) E703 T729 RS729 M708          RESCUE RS717 T703          DIV2 – E708 (DIVS) E728 AT708          DIV3 – E731 (DIVS) E729 T731</p> <p>For an EMS incident, an EMS Group (or Mass Casualty Branch) would be documented with specific Triage, Treatment, and Transport leaders.</p>



# Documentation Basics

## DOC A<sup>3</sup>PE

<p>P</p>	<p><b>Plan.</b> The overall <u>Incident Action Plan</u> should be documented which would include broad initial and updated objectives, contingencies, outcomes, and any recovery efforts. Specific tasks to accomplish the listed objectives should be documented on the unit report for the division/group supervisors or single resources responsible for the individual work assignments. Use Incident Priorities and RECEO-VS objectives to help you write the section. This will allow a logical flow of information.</p> <p>As you document your plan, you should record specific benchmarks (for example a completed primary search or an extrication) with times completed. This is where an aide who documents situation status and resource status (SitStat/ReStat) comes in handy. They can also watch the clock and record critical elements of the incident in chronological order. You then simply transpose that data to your report.</p>
<p>E</p>	<p><b>Event Statistics.</b> For a collision or MCI, this would include specific patient disposition information – who treated, transported, to what destination, and by what means. Names are omitted. Indicate by Patient Number or where they were in a vehicle. Accurate numbers are essential.</p> <p>For fires, include the number of fire/civilian injuries or deaths. This would include a firefighter that was injured on the scene or a civilian that was burned. You must also indicate this on the “response tab” on the report and complete the required supplements.</p> <p>Although auto-populated in the narrative, you should be specific about loss and value after discussing the event with FEI (if applicable). Questions always arise about value. You should think of it as “what was saved.” I would normally look up the tax records of a house and use the assessment as a value. (<a href="http://sdatcert3.resiusa.org/rp_rewrite/">http://sdatcert3.resiusa.org/rp_rewrite/</a>)</p> <p>If fire, indicate probable cause after consulting with FEI (if on scene).</p>

Regardless of what format you use, your report must contain sufficient details for someone who was not on scene to understand what occurred. You may be required to defend the report years from the incident.

I invite you to read “Grahams Rules for Improving Incident Documentation” at <http://www.gordongraham.com/rules.html>.