20720 Goshen Road
November 12, 2006

Dispatch 1953
06-0100855

On the evening of Sunday November 12, 2006, units were dispatched for a Greenhouse on fire attached to a house in a non-hydranted area. En route, ECC advised that they were received another call from the resident who advised their house was now on fire. ECC also stated that they show hydrants in the area, but C17 allowed tankers to continue (appropriately).

While units were still en route, ECC advised that a caller on Warfield Road states that fire was now extending to her home.

About twenty minutes into the incident a MAYDAY was declared. Units were still engaged in an active fire attack located in the exposure.

This document contains analysis from the Incident Commander as well as the input from company officers operating on the fireground. A PIA is required by FRC Policy 20-02. A firefighter was hospitalized from this incident prompting a formal review by policy.

This document is separate from the MAYDAY review required by the Fire Chief but includes information on the MAYDAY including events that led up to the event.

The incident began as a fairly complex event but turned out to be routine. The unforeseen can occur on simple incidents.

This document contains issues that may require policy review in order to improve operations. Many of the 10 issues noted occur daily. This incident gives me the opportunity to forward these concerns

House Fire Assignment (non-hydranted)
Water Supply Task Force
Conventional Task Force (staged)

Estimated Total Loss:	$95K
Estimated Total Saved:	$1.2M

No civilian casualties
2 family pets lost (dogs)
2 firefighters injured

POST INCIDENT ANALYSIS
STRUCTURAL FIRE

I. Introduction

a. Provide a general overview of the incident including an area diagram of the building, exposures, water supply, time of day, weather conditions, etc.
b. Indicate unique circumstances/problems, etc.

The fire occurred in an attached greenhouse on the edge of a municipal water system. A "non-hydrant" water supply was instituted. Water flow was maintained during the incident.

Updates from ECC advised that fire was spreading to the main structure. In addition, a caller at 9001 Warfield Road (Exposure B) called and advised that she thought her house was on fire as well.

Weather and tall vegetation hampered initial windshield size up. Several RECON teams were used to determine incident complexity and verification of exposures, etc.

Weather at time of incident (NWS)

- Temp 47 degrees
- Rain – heavy at times
- Winds from the North at 23 mph gusting to 30 mph

II. Building Structure/Site Layout

a. Review type of structure
b. What construction or design features contributed to the fire spread, or prevented fire spread, i.e. sprinklers, fire doors, etc.?
c. Did the topography and/or type of fuel affect fire control efforts?
d. Did fire alarm and/or suppression devices work properly?
e. Did personnel or apparatus encounter any problems in gaining access?
f. What is needed to correct these problems?

This was a series of structures. From the street, looking right-to-left, you had a large two-story wood frame colonial with brick veneer. An attached vestibule joined the kitchen area on Side B of the main house, followed by a garage/utility area. The doorway(s) from the garage to the vestibule normally remain closed. This proved to be effective by holding the fire to the garage (see Power Point Photo).

The large greenhouse was adjoined to the garage with the garage door typically left open. The structure contained plant life and small quantities of typical household herbicides and pesticides. It is also believed that the family's two dogs resided in the greenhouse. Both perished during the fire.

The occupant was altered by a smoke detector. He traveled through the vestibule, through the garage and into the greenhouse. He noted fire on the outside of the structure but was unable to open the side door due to heavy fire involvement. He came back through the vestibule to the outside and noticed the fire. He called 9-1-1.

III. Fire Code History

a. Review relevant Fire Code requirements and history.

No code issues/violations. This was a single family home.

IV. Communications

a. Did dispatcher verbally provide all information available at the time of dispatch?
b. Was the fire ground channel adequate?
c. Were proper communications procedures followed?
d. Were there problems communicating with Mutual Aid companies?
e. Was the communication network controlled to reduce confusion?
f. Did units, divisions/groups/branches and Montgomery communicate effectively?
g. Was radio discipline effective?
h. Did Incident Commander provide timely updates to Communications?

ECC did an exceptional job. They provided updated information en route and properly placed units on alternate talk groups as the incident escalated. There were pockets of chatter where the unit did not use the division/group supervisor but I believe there was adequate radio discipline.

The following talk groups were utilized
7C – Operations *(MAYDAY)*
7D – Water Supply
7E – Task Force/Staging *(Operations)*

At the time of the MAYDAY, operations were switched to 7E. 7E was the logical choice since it should have been void of "chatter" from the task force assignment. Spanning or joining another tactical cluster would have been a poor option.

One confusing item to the IC was the term "MAYDAY" task force. This configuration is not known or documented in any policy.

V. Pre-emergency Planning

a. Were pre-fire or other plans needed on the scene?
    i. Were they available?
    ii. Should they be updated?

Local and MDC Altaris maps used for water supply

VI. On Scene Operations

a. What was the structural integrity of the building based on fire conditions on arrival, at 10 minutes, 20 minutes, 30 minutes, etc.
b. Was Command identified and maintained throughout the incident?
c. Was a Command Post established and readily identifiable? Flag, Green Light, or other?
d. Size up decisions by command
e. Was additional apparatus requested in a timely manner?
f. Strategy/action plan
g. Did personnel, units, and teams execute tactics effectively?
h. Were any training needs identified? Provide examples.
i. Were Standard Operating Procedures used? Were they adequate? Do they need to be updated? If not used, why?
j. What offensive/defensive decisions were made by command?
k. How was risk analysis applied to the incident?
l. Were the divisions/groups used appropriate to the incident's type and complexity?
m. Was apparatus properly positioned? If not, why?
n. Attack line selection and positioning
o. Ventilation operations
p. Salvage operations
q. Night time and interior lighting operations
r. Were Mutual Aid companies effective in operation?
s. Was water supply adequate?

There was continuous monitoring of the structure during the incident. Division and Group supervisors kept COMMAND abreast of changing conditions.

Command was maintained throughout the incident however the COMMAND POST was not properly identified. The current need for implementing the very small "green light" requires the IC to plug it in, open the window and place it on the buggy. The light needs to be a larger size and permanently mounted so that it only takes a flick of a switch to activate. The present method is a distraction and takes a time. Also, the light is also not large enough.

Numerous reports to ECC, weather, darkness and obstructions made initial size up difficult. RECON teams were deployed to gather more information but some of it was not relayed to COMMAND in a timely manner. For example, ECC gave updates en route giving the impression that two homes were involved in addition to the greenhouse. Intel gathering soon ruled-out one exposure on the Bravo side (Warfield Road). In addition, the initial on scene report from EW17 gave a report of an out-building well involved. The IC could not see the attached garage, only the glow on the main house (Exposure D). Several minutes later command learned that crews were operating in an IDLH attached garage.

Strategy and Tactics were applied correctly. Deployment of hand lines and ground ladders were appropriate. Large exterior streams were used on the greenhouse while small hand lines were deployed to the exposure. Exterior and Interior crews coordinated their attacks to avoid opposing lines.

The narrow driveway and soft, rain-soaked ground hampered apparatus placement. I would have liked the truck company closer to the fire but it didn't occur.

There were a few mutual aid tankers responding. I do not know of any communication issues.

Water Supply

There were communications problems with Water Supply on 7D. Several calls to the Group Supervisor went unanswered and there was some confusion regarding the second fill site. Several units including ECC used the term Water Supply Command, which is inappropriate. When a PAR was requested by command staff after the MAYDAY there seemed to be some confusion. I am not sure if apparatus tracking by the WSG Supervisor was adequate. He stated he was walking around at some point.

Private hydrants were within 2000 feet of the fire. A RELAY would have been more appropriate than a water shuttle.

Policy considerations: Please focus on Issues 1, 2, 3 and 4 on the accompanying document for policy concerns.

VII. Staging

a. Location adequacy
b. Site Access

Staging was placed at a shopping center about 1 ½ miles away. Anything closer may have hampered water shuttle. They were released after the incident was stabilized.

VIII. Support Functions

a. Was a Rehab group established?
b. Were fire/rescue personnel provided with food and drinks?
c. Was adequate shelter provided for fire/rescue personnel?
d. Were crews relieved by fresh crews regularly and frequently?
e. Were there any equipment or apparatus failures? Did these failures have a detrimental effect on the incident outcome?
f. Were functions with outside agencies properly coordinated? (i.e. Red Cross, Power company, Gas Company)

REHAB was established at the end of the driveway. Water and food were provided by Canteen 8. Crews were cycled through REHAB based on Division/Group Supervisor recommendations; however the CP failed to keep adequate records on this function.

We should have provided shelter to get crews out of the rain. A bus could have been used for that purpose or crews could have been shuttled to a nearby church or school. The incident lasted longer than expected.

There were no equipment failures. PEPCO on scene confirmed power down. The displaced couple would stay with a neighbor – Red Cross not needed

IX. Safety Group

a. Was a standby team established? If not, why?
b. Were any fire/rescue personnel injured?
c. Were all safety SOPs and regulations enforced?
d. If there was a Safety Dispatch, were they used for Safety, Accountability or RIC? If not, why?
e. What actions are necessary to change or update current safety and health programs to improve the welfare of members?

I am hoping that Captain Trevey will supply a more compressive report. Here are my comments:

Neither a Stand-by team nor RIC was initially established. The strategy was a defensive operation. As soon as the IC determined an interior operation was in place with an IDLH, the RIC was deployed.

A RID was dispatched early – before arrival of any fire/rescue unit. However, the RID up-county is not rapid. The RID had just arrived when a MAYDAY was declared – nearly twenty minutes into the incident.

X. Accountability

a. Were actions taken to ensure accurate personnel accountability?
b. Was the status of units, Divisions/Groups/Branches and support personnel maintained? Did personnel provide adequate feedback?
c. Was the incident continuously controlled and monitored?

The IC was using a proactive accountability system by the tactical control sheet. However, during the change in strategy and competing priorities early the incident, the IC lost track of a couple of units. Division and Groups were in place to limit the span of control. There was a strong need for a PLANS/RESTAT officer at the command post. This became critical at the time of the MAYDAY. When the MAYDAY occurred, the tactical control sheet was turned over to C17x1 who seemed to struggle with the tactical sheet and subsequent PAR.

There was a loss of crew integrity on EW17. The officer (EW17B) and small lines man (EW17C) apparently did not effectively communicate. The officer proceeded to perform a circle check while EW17C flaked out the Blitz-Fire line. EW17C noticed someone struggling with water supply at the unit. He went to assist and when he returned, another company was operating the blitz fire. EW17C did not know the location of his Captain (EW17B); he thought he could be inside the exposure. EW17C went to the exposure and saw the Division Supervisor (E281B), but did not identify himself. EW17C stayed to help crews in EXPOSURE D.

When EW17B returned from his circle check he did not see EW17C at his assigned task. EW17B just assumed that EW17C was inside but did not make efforts to confirm it. Several minutes went by and no attempt was made to track down EW17C. It was only determined after the MAYDAY that EW17C was the victim.

XI. Investigations

a. Was the fire's origin and cause determined?
b. What factors contributed to the fire's spread?

Fire was caused by arcing overhead wires igniting debris – ultimately igniting the exterior of the greenhouse

XII. Lessons Learned

a. Were specific training needs identified?
b. Recommended improvements

See attachments

XIII. Overall Analysis of Incident

-Good? Bad? Why?

The incident was initially challenging since we had a report of multiple exposures. Overall, the fireground management went well other than a couple of accountability concerns. I think the MAYDAY was handled appropriately as well.

Critique

If post incident analysis indicates that a positive learning experience would result,
or where it may be necessary to complete the analysis of an incident, a critique may be held at the discretion of the Incident Commander or their superior.

Dispatch

Units were dispatched for a Greenhouse on fire attached to the house. En route, ECC advises C17 that they were receiving calls advising that the fire was extending to the house and they were dispatching the RID. ECC also states that they show hydrants in the area. C17 also requested the Water Supply Task Force.

While units are still en route, ECC advises that a caller on Warfield Road states that fire is now extending to her home. C17 reports he was approaching the scene with a column of smoke.

Arrival

EW17 gives on scene report and lay-out instructions. I arrived on scene as EW17 was laying out in the drive way with their clappered Siamese. EW17 calls an exterior attack as the primary tactic to control the fire.

I establish command, perform a windshield size-up and establish priorities. What I observed was a structure that sustained heavy fire damage and was nearly on the ground. I was not able to get a clear view of other structures due to darkness, trees and the placement of EW17. Wind was blowing (gusting at times) from right to left away from the large two-story colonial in view.

Fire was spreading to evergreens on Side B of the main body of fire. These tall evergreens were igniting like Roman candles. It was unclear if there was a building immediately on the other side of the evergreens, but I was making that assumption based on reports from ECC (caller from Warfield Road). Based on the information from ECC and observations, I request a conventional task force to stage at the shopping center – Goshen & Whightman.

Priorities established.

1. Life – account for endangered humans in or near the main body of fire.
2. Identify and protect exposures
3. Confine the fire to area of origin
4. Extinguish the fire and complete overhaul
5. Provide on-going customer service to the occupant

Since the initial strategy (mode) was a defensive posture, a two-out and subsequent RIC was not immediately established. I was not clear if the Green house was attached to the main dwelling. In addition EW17B was instructed to perform complete circle check.

Talk Group Assignments
7C – Operations *(MATDAY)*
7D – Water Supply
7E – Conventional Task force assignment *then OPERATIONS during MAYDAY*

Initial Command Development
BC5 – IC
C17 – WSG Supervisor

Fire Attack Group
Objective: Contain main body of fire
EW17 (Group Supervisor) – deploying blitz fire to rapidly control
E81
AT29

Exposure Delta
Perform Search and Check for Extension
E281 (Division Supervisor) with 3 personnel entering
RS17
T8

Exposure Bravo
Objective: Determine/verify exposure threat and protect same
E291 (Division Supervisor)

Water Supply Group
C17 – Group Supervisor
E351 (fill site)
E281* (dump site)
W17
W4
W31

BC3x1 aos – assigned to assume Fire Attack Group Supervisor role
BC3 aos – assigned to RECON and general assessment/safety

RS17 reported all clear – Exposure D; EW17 also identified the occupants (2 adults) and they were out.

E281 reported extension into garage. Command ascertained presence of IDLH. This was confirmed and command deployed components from Fire Attack Group to cover 2-out. I discovered post-incident that E81 was already assuming the role and coordinating with the crew in the garage (to avoid opposing lines).

E291 reported no exposure threat on the Bravo side – redeployed to RIC function on Side A of Exposure D. This would have been the original assignment if interior firefighting was present.

Balance of RID was arriving on scene.

E281B declared MAYDAY – firefighter being brought out to Side A.

Command took following actions:

Transmission made on 7C – all units advised to switch operations to 7E. I initially assigned C17 to manage Operations on 7E but quickly determined C17 was engaged in Water Supply on 7D. I noticed C17-1 next to my buggy and advised him to assume OPERATIONS. He was proceeding to the fire ground but I quickly instructed him back to the buggy – gave him the tactical worksheet and instructed him to conduct a PAR.

RID components deployed to Side A to assist – assigned BC117C to supervise

BC4 on scene – assisted with PAR

Firefighter was brought down in stretcher and I made brief contact with him – identified as MFF Berti from EW17.

Berti transported on A87 with EMS3 to Suburban Hospital – P2 trauma

Once PAR was complete – operation resumed on 7C

General Issues for Discussion

1) **Primary Driver Not Driving**
2) **The Need To Know The Location Of Responding Chief Officers**
3) **Riding Position of Certified Unit Officer**
4) **Apparatus Responding With Staffing Above The Minimum Level**
5) **General Accountability**
6) **Loss of Crew Integrity**
7) **Chief Officers and Command Staff must Report to the Command Post**
8) **ICS Terminology – Labeling of Exposures**
9) **MAYDAY Optimal Actions**
10) **General Command – SOP**

Issue 1

Primary Driver not Driving

Berti is the primary driver on EW17. On this particular incident, MF Mothershead was on OT driving the unit. He was not totally familiar with the unit's operation.

When we cross-staff apparatus, the station officer needs to deploy drivers based on resources going out the door. In this case, he had two heavy drivers at this disposal. Berti was the only Rescue Squad driver and Tanker driver. This required a shift in the line up – requiring Mothershead to drive the Engine Tanker on a multi-unit response out of the station. Berti stayed back to drive another special service. At the time of the alarm, Berti was en route to the tanker but found a volunteer driver for it. He went back to the Engine Tanker and hopped in the bucket.

As one can see, the drivers program does not always fit the station – this case in point. The officer had to fit drivers with resources going out the door on any given moment. See EW17's PIA fact sheet for more information. It would have been beneficial if volunteers in the station reported to the station officer and make their presence known/obtain riding assignment.

Issue 2

The need to know the location of responding Chief Officers

The following Chief Officers were dispatched from the incident:

Laytonsville Duty Officer
Gaithersburg Duty Officer
Battalion Chief 5
Battalion Chief 3

The following checked on the air: C17, C17x1, BC117C, BC5, C8x2, BC3, and BC3x1. The only ones that announced their "responding from" location was BC3, BC3x1 and BC5. En route, ECC gave all updates to C17 who made appropriate decisions. ECC also gave him units on the RID and WSTF. I am under the assumption that C17 was responding from 17's first due. This was not the case – he was coming from Damascus. I expected a Laytonsville Duty Officer to be on the scene when I arrived. I was the first arriving.

*It is appropriate for ECC to transmit updates to the highest ranking officer. However, command officers need to know where others are coming from. For example, if Company 8 was running a house fire in Washington Grove and I simply stated I was responding, the company officer may assume that I was near the area. If I said I was coming from Station 9, that company officer and other chief's responding would realize that the first arriving may be there without a certified chief officer for a while**. The requirement should be extended to announce the "responding from" location for all chief officers. Not just those listed in the policy.***

FRCOPS 16.05am 5-d.4

***Response of Certified Chief Officers**. Dispatched **Certified Chief Officers** must respond to any **incident,** subject to procedures developed by the **Fire Chief**. Additional **Certified Chief Officers** may respond, based on their proximity to the incident, and after notifying ECC of their current location. A **Certified Chief Officer** may serve as a unit officer, if qualified on that specific unit. That **Chief Officer** may not serve simultaneously as both a unit officer, and as a **LFRD** on-duty chief officer. The command structure response authority for **Certified Chief Officers** is illustrated below.*

Issue 3

Certified Unit Officer Concern

RS17 responded with a F2 riding the officer position (career employee). A Laytonsville chief officer was driving the piece.

I was concerned that RS17 did not respond understaffed per policy. However, after reviewing the IECS policy and the Apparatus Staffing Policy, it can be argued that the unit was not understaffed. Both policies simply state that a certified unit officer must be on the unit. No where does any policy specify that the driver can not serve as the officer.

Issue 4

Apparatus responding with staffing above the minimum level

From a tactical deployment stand point, additional staffing is good to know. "If more than three please tell me" is my philosophy. Knowledge of additional staffing with qualified personnel allows the unit to become more versatile. It allows one unit to complete a task where it would normally take two or three. I have requested that units in my battalion announce their staffing level if above minimum. We should implement a change so that units responding with extra personnel announce their staffing level

Issue 5

General Accountability

The IC needs improvement in this discipline. Since we thought there were multiple structures involved and the initial mode was "defensive," I elected to relocate apparatus to contain the fire and verify what was actually burning. I initially thought I had two significant exposure issues; this was compounded by high winds and limited visibility. I was still under the impression that the main body of fire was in a detached structured based on EW17's IOSR.

During the process of incident management and Intel gathering, I moved units to cover the objectives-some by radio and some face to face at the CP. For example, E281 did a face to face and advised that he would take the line into the exposure with AT8's crew.

It was soon confirmed that there was no exposure threat on Side B. At the same general time, it was discovered that personnel were operating in an IDLH. Resources were redeployed to the RIC function. Soon found that units were operating in an attached garage.

I began lose track of units and personnel. I was in the buggy by myself. There was a need for someone to assist with RESTAT and SITSAT.

An "accountability report" is expected by the "benchmarks document." This report is to include the following:

Unit
Number of personnel
Location of entry
Reason for entry (task)

<u>This information is not required by any policy</u>. The only thing I was really sure of was that E281 was in Exposure D with three personnel. No one else gave me a report.

The absence or presence of an IDLH must be transmitted ASAP. As mentioned above, I was under the impression that we had an outbuilding on fire (based on the IOSR).

Issue 6

Loss of Crew Integrity

There was a break-down in communications and crew integrity on EW17. The initial strategy was communicated. EW17B was following instructions from COMMAND by performing a quick RECON. The E3 firefighter (victim) was performing the assigned task but became distracted by a water supply problem. Upon his return, another company was operating the blitz-fire nozzle. EW17 E3 met up with units in Exposure D – he was not aware of his Captain's location.

EW17 E3 did not communicate his self-reassignment to his Captain. He also did not communicate his presence with the Division Officer in Exposure D.

As soon as the officer realized that his E3 crew member was missing an active search should have been commenced and/or a MAYDAY declared.

Issue 7

Chief Officers and Command Staff must Report to the Command Post

I think most did this; however, I never saw C17 and a few other officers were in and out of the area. I maintain a sterile cockpit and may not immediately notice chief officers near the buggy. During the first five minutes, Chief Officers may approach the window in an attempt to get my attention. In addition, the Safety Officer needs to report to COMMAND upon arrival. I didn't see him until several minutes after the MAYDAY.

Issue 8

ICS Terminology

Many declared the garage as EXPOSURE B – using the primary residence as the focal point. Command was calling the garage and residence EXPOSURE D based on the orientation to the main body of fire / what was burning.

It has been normal to label exposures based on the fire building. It was initially thought that the greenhouse was detached.

It may be beneficial to clarify EXPOSURES early. For example, command would announce "anything to the right of the greenhouse is Exposure D.

If you label the garage as Exposure B, what would you label the house to the left of the fire building?

It was also suggested that division be labeled by major structural features, e.g. GARAGE, GREENHOUSE, etc. This may have caused less confusion.

Issue 9

MAYDAY Optimal Action

A MAYDAY was not declared until the firefighter was disentangled and was assisted out of the hazardous environment. The crew from Truck 8 performed admirably in freeing the downed firefighter and removing him to safety.

The trapped firefighter could not access his PAS or his radio to signal for help. It may have been possible with an enhanced microphone but these are not readily available or issued.

Once the downed firefighter was discovered, the rescuer/one discovering the victim should initiate the MAYDAY and activate the EB if possible. This could allow proper deployment of resources earlier to assist. The IC missed the first transmission of the MAYDAY. In addition, if possible, the rescuer should turn off the victims PAS Alarm. The PAS Alarm will interfere with radio traffic if it is close proximity to the transmitting radio.

The Officer on the RIC is the RIG GROUP SUPERVISOR by default. They hold this title unless COMMAND assigns someone else.

MAYDAY Optimal Action

Personnel must review and preplan duties and responsibilities for the RIG. Medic crews are reminded that they are to treat and transport the injured firefighter once he/she has been removed from the HOT zone. Other companies operating must allow the ALS crew to take over and treat the PATIENT. Personnel must be aware of orthopedic injuries and cut away clothing (at the seam if possible) to avoid further injuries to the PATIENT.

Issue 10

General Command/SOP

I need to do a better job of assigning chief officers; I assigned only a few on this incident. I have been told it is not my place to evaluate performance using past incidents. The system still needs improvement. I know who get the job done and ensure safety of the personnel operating on the fireground.

I was weak at managing the initial stages of water supply simply because I was not sure what was burning. C17 stepped up to the plate and did that for me – I did not assign him to the task.

What I really needed was someone to sit in the passenger seat and manage either the radio or maintain the tactical control sheet and perform SITSTAT/RESTAT. On some occasions a Chief Officer or the EMS duty officer would open the door and sit there. What a relief! A much needed function.

Yes there are occasions when I have holes to fill, but you sometimes can't think of every little detail. Many things – including division and group supervisors – are easily managed by competent company officers.

It is also evident that some Chief Officers need experience with the tactical control sheet. The big event is not the time to first lay your hands on it.

Many unit officers made comments concerning deviation of the SOP. The SOP was developed for a simple structure fire to support a search. Sometimes on-scene conditions and Intel requires you to call an audible. The SOP does not always fit the situation.

POST INCIDENT ANALYSIS
UNIT FACT SHEET

Unit ID:	**EW17**	**Unit Officer:**	**Capt. D. Deibler**		
Incident Address:		**20720 Goshen Rd.**			
Nature of Incident:		**Building Fire**		**Time of Arrival**	**1957**

Describe the situation upon arrival:

The situation initially appeared to be an attached garage structure fully involved in fire. Also, initially appeared to have not extended into main structure of the house, but there were multiple smaller fires outside and around the main fire area.

Describe SOP used or assignments given and/or actions taken in chronological order:

- PSCC had made multiple radio announcements to C17 that I had monitored and processed while enroute:
    a. That PSCC felt it was a working fire
    b. That there was a report that another structure was on fire with a Warfield Rd. address
    c. They had identified and verified with C17 a nearby water source (hydrant)

- At the intersection of Warfield & Goshen, I had the driver pause for a moment so that I could try to visualize the situation. I could see the fire at the dispatched location on Goshen, but could not see any fire situation that would be accessed from Warfield. I also tried to visualize the distance from the intersection to the fire scene, as I considered laying out from that point. I felt it would be too long of a lay and told the driver to proceed on Goshen.

- Proceeded to the driveway of the address, gave an IOSR including layout instructions. While driver was preparing his layout, I left the apparatus and walked up driveway to further assess the scene. I told MFR Berti before leaving the apparatus to stay on and that we were going to deploy the Blitzfire master stream to knock down the fire when they pulled up to the scene.

- Once I had walked to the scene and observed the conditions, I announced to BC5, who had arrived and assumed command at this point, that my crew was going to perform an exterior attack with the Blitzfire.

- Once EW17 came up the driveway, I started to assist with the deployment of the master stream device with MFR Berti. I advanced the nozzle close to the fire while Berti was clearing the hosebed and deploying the hose.

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- At this point, command requested me to perform an immediate observation of side C to check for the possible second fire. Due to the large amount of fire, I could not access side C via side B. I feel that I told MFR Berti what I was going to do but I am not sure if he acknowledged me while he was engaged in deploying the hose. I then went to perform a circle check via side D.

- Upon reaching side C, tried multiple times to give command a report but was blocked by radio traffic. I finally got through to command and gave a report that there was no second structure fire.

- I returned to side A via side D and saw the occupants of the house outside on the driveway and confirmed with them that everyone was out. I relayed this information to command.

- As I was returning to the master stream operations, I came across the RS17 crew on Side A who advised they were ready to enter the house. I advised them that the occupants were out and I felt that a hand line needed to be put into place in the house before they entered.

- I then proceeded to return to the master stream device. About this time I was assigned by command to be the Fire Attack Leader. As I returned to the master stream device, I noticed that there were 3 personnel operating it and repositioning it. A majority of the fire had been knocked down by this time. I assisted with moving the 3" line around to a new position and moved to where the nozzle crew was. I then noticed that it was E81's crew manning the nozzle and MFR Berti was not there. I asked Capt, Poole about Berti but he was not sure where he was.

- About this time I was relieved as Fire Attack Leader by a Battalion Chief from RVFD. I advised him I was going to look around for MFR Berti. I checked at EW17 but he was not there and the driver was not sure about his whereabouts. I then proceeded to the crews that were standing outside of side A. He was not there, but after conversing with these personnel, I felt that he was inside of the garage area working with other crews. . As I was returning to the master stream device, I noticed that most of the exterior fire was out except for a few spot fires. I went to EW17 and pulled a 1-3/4 handline to the exterior operations. I gave the nozzle to E81's crew and assisted with moving the hose as needed. After a couple of minutes, it appeared that almost all of the fire that was visible from outside was out.

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Incident Address:		**20720 Goshen Rd.**			
Nature of Incident:		**Building Fire**		**Time of Arrival**	**1957**

- After a couple more minutes of cooling down the area, I heard a PASS device being sounded from the interior area of the house. After it had been sounding for a couple of minutes, I heard a Mayday announcement on the 7C channel. I switched my radio to 7E as instructed by command as the Mayday was handled.

- As I saw the Firefighter being removed from the house, I advised Capt. Poole that I was going over to the area to see if I could find MFR Berti. It was then that I saw that the injured firefighter was MFR Berti and he was being treated for his injuries. I gathered some of his gear that was removed and set it by EW17. After he was removed from the scene to an EMS unit, I returned to mop up operations with E81's crew.

- Once the FM's were done with the garage area, I assisted with overhaul operations, then equipment cleanup until we departed.

Obstacles Encountered: Provide explanation
1. Lost Team Integrity – I assumed that MFR Berti would be operating the master stream device when I returned from my circle check. Now I am not sure that he understood where I had gone and I was unaware of where he was.. 2. Inadequate Personnel – MFR Berti was left to finish setting up the master stream deployment by himself while I performed the circle check. Apparently E81's crew took over the master stream nozzle operations because they saw no one at the nozzle. This may have caused Berti to feel that he needed to perform another task such as assisting to advance a pre-connect line to the garage area.

Coordination		Communication		Ineffective Equip. Use	
Equipment Failure		Inadequate Personnel	X	Too Many Personnel	
Safety		Staff Support		Other (Please Specify)	X

20720 Goshen Road
November 12, 2006

POST INCIDENT ANALYSIS
UNIT FACT SHEET

Unit ID:	**EW17**	**Unit Officer:**	**Capt. D. Deibler**		
Incident Address:		**20720 Goshen Rd.**			
Nature of Incident:		**Building Fire**		**Time of Arrival**	**1957**

Personal Critique/Do Over List

1. Riding Assignments – I would have liked to have had MFR Berti ride E1 instead of E3 as he is the listed Primary driver. During the shift, I had assigned MFR Berti as E3/RS1/W1 and the overtime driver as E1 because of our staffing level, driver situation, and volunteer support. As usual, I was unsure and unaware of the volunteer staffing in the station as they do not report to me usually for riding assignments. When the call was dispatched, volunteer personnel immediately assumed the driver positions for the tanker and squad. In order to facilitate a quicker response, I left Berti in the E3 position and instructed the career personnel on the ambulance to staff RS17. Also, I would have moved one of those personnel to the E4 position had I known additional volunteer personnel were riding RS17.

2. Water Supply – I would have laid a supply line from the intersection of Warfield & Goshen to be supplied from the hydrant in that vicinity. This would have been about a 1000' lay and would have kept W17 out of the driveway allowing access for the truck company and/or special service units to the front of the structure.

3. Crew Communications – I should have made sure MFR Berti understood where I was going and doing and what I expected from him.

4. Crew Accountability – I should have tried to verify MFR Berti's location and remove him to where our crew operations were being conducted. Even though I considered doing this, I felt comfortable about where it seemed he was operating, and that there was other crews operating in that area, and the situation (fire) seemed under control. In addition, MFR Berti is an experienced firefighter and I felt he was in no danger because the incident appeared to moving towards checking for extension and overhaul at that point.

20720 Goshen Road
November 12, 2006

POST INCIDENT ANALYSIS
UNIT FACT SHEET

Unit ID:	**E-81**	**Unit Officer:**	**Capt. Poole**		
Incident Address:		**Goshen Road**			
Nature of Incident:		**Building Fire**		**Time of Arrival**	**See PSCC**

Describe the situation upon arrival:
Large single family home with large amount of fire in what appered to be single story attached work shop/garage. EW-17 started water supply with 4" line and clappered siemese at base of 300' driveway. W-17 arrived with our unit. Crew assisted with relocation of supply line so tanker could get into position behind EW-17. E-81 took position behind W-17 per SOP.

Describe SOP used or assignments given and/or actions taken in chronological order:
Crew advanced to EW-17 position and advised with face to face of defensive operation. Crew assisted with deployment of "blitz fire" and 250' of 3" line on side A/B of burning single family home. After line was in position and charged no crew was available to use devise. At this time devise opened up and fire extinquishment started to confine and control fire spread. Knock down and cut off fire spread and large line shut down. Crew pulled 1 ¾" 200' attack line and extinquished pockets of fire advancing to side C to continue fire attack. Proceeded thru rear door to find Mayday situation and downed fire fighter being pulled from building. Proceeded back to side A and completed task of fire extinquishment. Assisted FM's with investigation and overhaul.

Obstacles Encountered: Provide explanation					
Coordination	X	Communication	X	Ineffective Equip. Use	
Equipment Failure		Inadequate Personnel		Too Many Personnel	
Safety		Staff Support		Other (Please Specify)	

PSCC could not pin point address, how many buildings on fire etc. On arrival was under the impression of a defensive operation (from radio and face to face contact) after placing large line in operation found that operation had switched and crew was in wrong position per the SOP. First due unit crew was fragmented at this point and action was needed (extinguishment). Crew stayed with fire attack on outside and was given command OIC for direction of operations from that point.

POST INCIDENT ANALYSIS
UNIT FACT SHEET

Unit ID:	**E281**	**Unit Officer:**	**Captain Maurice Witt**		
Incident Address:		**20720 Goshen Road**			
Nature of Incident:		**House Fire**		**Time of Arrival**	

Describe the situation upon arrival: First and second due units were entering the driveway. Heavy fire was visible from the green house.

Describe SOP used or assignments given and/or actions taken in chronological order:
We arrived as the third due engine. My crew was assigned to take a line into the Delta exposure which is a single story family room, laundry and garage off of the Bravo side of the two story section of the house. We took the line through the Alpha side door and made our way to the garage door. The door was failing from fire impingement. T8's crew with MFF Mike Dudrow and FF Billy Schadle were with us. FF Jeff Kuhns was on the nozzle and FF Walker was feeding us line from the exterior door. Once the truck took the door we ran short of line. I returned to the family room section to pull more and returned to the garage door. Due to the limited space within the laundry area and the limited space in the garage due to storage, we were pretty much in a single file line. MFF Dudrow and FF Kuhns advanced the line into the garage followed by FF Schadle and myself. Once in the garage they advanced straight ahead for about 15 feet and then to the left to knock the rest of the fire. I heard a PASS device activating but assumed it was due to the crew's immobility while flowing water. I then heard that we had a firefighter down. MFF Dudrow and FF Schadle removed an object from on top of the firefighter and carried him to the laundry area just outside of the garage which was inside the house. They set him down for a second and I noticed that this unknown firefighter did not appear to be responding or able to assist in his removal so I declared a Mayday to command. T8's crew and possibly others helped to move him to the front door where we had entered. Near the front door we were met by the RIC. There is a short wall just outside the door, he was lifted over the wall and moved out to the front yard. This was communicated to command by radio. I was unaware of the firefighters identity until we were in the front yard. To this point I thought it was FF Kuhns because I did not realize anyone but crews from E281 and T8 were in the area ahead of me. Care was taken over by the RIC and we reentered the structure to finish extinguishment.

During most of the time up until the Mayday I was the division officer. I had a tremendously difficult time trying to determine who was with what crew due to smoke conditions. I could not use helmet identifiers, the only way to tell who was who was to ask the verbally who they were and what crew they were with. If I had to do a PAR of the division we would have had to remove everyone outside so we could tell who was who.

I do not believe tactics or actions directly contributed to the incident. I believe because of the amount of "stuff" in the garage made any movement difficult. I do not have first hand knowledge of what happened to cause the incident. I had called for lights and PPV to the Alpha side of the exposure to try and push the smoke out through the garage to help visibility but they were not available until after the incident occurred.

POST INCIDENT ANALYSIS
UNIT FACT SHEET

Unit ID:	**E281**	**Unit Officer:**	**Captain Maurice Witt**
Incident Address:		**20720 Goshen Road**	

Nature of Incident:	**House Fire**	**Time of Arrival**	

Obstacles Encountered: Provide explanation					
Coordination		Communication		Ineffective Equip. Use	
Equipment Failure		Inadequate Personnel		Too Many Personnel	
Safety		Staff Support		Other (Please Specify)	

POST INCIDENT ANALYSIS
UNIT FACT SHEET

Unit ID:	**Engine 219**	**Unit Officer:**	**Captain Evers Trice**		
Incident Address:		**20720 Goshen Road**			
Nature of Incident:		**Working Fire**		**Time of Arrival**	**20:01**

Describe the situation upon arrival:

A large volume of fire was showing from the "Bravo" side with possible extension to or threatening of exposure "B".

Describe SOP used or assignments given and/or actions taken in chronological order:

Engine 291 was dispatched as the 4th due engine, which was responsible for supporting the initial water supply operations at the clappered siamese and the initial build-out of the "RIT".

Upon arrival engine 291 was redirected from performing our "SOP" to assist with the protection of exposure "B"; by gaining access from Warfield Road. Arriving at the location on Warfield Road (#9001) the driver was directed to position at the entrance and stage until I did a recon of the exposure in question. Upon reaching that location and conversing with a command officer from station 17, it was decided that engine 291 would drive through the field to gain access to that location. Being unable to reach my driver on "Oscar", I returned to the unit to have it repositioned; during that process that request was rescinded by command.

Engine 291 was not given a new assignment so the crew (Officer and FF) proceeded to the incident scene in full PPE and SCBA with tools to the "Bravo" side; the driver was directed to dress as indicated above an connect up with us on the "Alpha" side.

Upon reaching the scene and staging on the "Bravo" side, command was requesting if there were any personnel in the operational area that could fill-out the initial "Two-Out" assignment; engine 291 advised they could fulfill that request. Making our way the 'Alpha" side to stage near the entry point a "Mayday" was transmitted upon our arrival; not knowing the initial location of the mayday our initial engagement was delayed. At the same time it was observed that the interior crews were bringing out an injured firefighter at our staging location. We assisted the interior crew with the injured firefighter upon reaching the doorway. The injured firefighter was taken approximately 15' from the structure and placed on the ground where his regulator and face piece were removed. An evaluation of his condition/injuries was conducted verbally at which time his turn-out coat was removed. He was placed on the stretcher and taken to the EMS unit.

After being relieved of our "Two-out" responsibilities we later assisted with overhaul operations of the interior garage area.

POST INCIDENT ANALYSIS
UNIT FACT SHEET

Unit ID:	**Engine 219**	**Unit Officer:**	**Captain Evers Trice**

Incident Address:	**20720 Goshen Road**		
Nature of Incident:	**Working Fire**	**Time of Arrival**	**20:01**

Obstacles Encountered: Provide explanation					
During the "Mayday" when the injured firefighter was removed to the exterior we (the two-out) were inundated with personnel around the injured firefighter to the point we were unable to conduct an appropriate evaluation for injures. Personnel were told to step back and clear the area if not involved in the "RIT" operations.					
Coordination		Communication		Ineffective Equip. Use	
Equipment Failure		Inadequate Personnel		Too Many Personnel	X
Safety	X	Staff Support		Other (Please Specify)	

POST INCIDENT ANALYSIS
UNIT FACT SHEET

Unit ID:	**E351**	**Unit Officer:**	**Lt. Richard Anthony**		
Incident Address:		**20720 Goshen Rd**			
Nature of Incident:		**Housefire w/ Mayday**		**Time of Arrival**	**2002:54**

Describe the situation upon arrival:

Dispatched 5th due on House fire.
Arrived via Warfield and turned right onto Goshen.
Noted an apparently fully involved structure on our left just prior to making our turn.

Describe SOP used or assignments given and/or actions taken in chronological order:

Took fill site as 5th due.
Notified Command of site; was switched to separate channel for water supply.
Set up at hydrant in parking lot of St. Johns at 9000 Warfield Rd.
Noted that we were in smoke and ash plume from fire but this quickly dissipated.
Controlled traffic, set cones and flares, eventually had to stop traffic on Goshen to maintain access.
Filled approx. 6 tankers during course of incident.
Released by Command; packed up; went home.

Obstacles Encountered: Provide explanation					
--Had to repeatedly call Water Supply command to get acknowledged. --Our hydrant had static pressure of 50 psi (this did not effect us much due to slow pace of shuttle) Was told later that fill site at 20501 Goshen across the street had static 90 psi.					
Coordination		Communication	X	Ineffective Equip. Use	
Equipment Failure		Inadequate Personnel		Too Many Personnel	
Safety		Staff Support		Other (Please Specify)	X

20720 Goshen Road
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POST INCIDENT ANALYSIS
UNIT FACT SHEET

Unit ID:	**T8**	**Unit Officer:**	**MFR Michael Dudrow**		
Incident Address:					
Nature of Incident:		**Greenhouse on Fire**		**Time of Arrival**	

Describe the situation upon arrival: Greenhouse attached to two story single family brick colonial fully involved. Fire extension into attached garage.

Describe SOP used or assignments given and/or actions taken in chronological order:

First due truck company. Positioned on side A in driveway. Unable to position directly in front of house due to rural water supply apparatus. Mfr Dudrow and FF Shadle entered house thru front door to check for extension from garage into living area. Door to garage compromised due to large volume of fire. E281 advanced one 1 ¾" handline into laundry room to extinguish fire in garage to stop any extension into living area of house. T8 crew proceeded with E281 to force entry if necessary and to check for extension and provide ventilation. T8 driver placed ladders and supplied lights as needed. As fire was being extinguished in garage Mfr Berti became trapped under a large object from which he was unable to self extricate himself. Due to noise of flowing water Mfr Berti's cries for help went unheard. PAS device alerted FFShadle to Mfr Berti's entrapment. FF Shadle removed object from Mfr Berti and with the help of Mfr Dudrow was able to removed an injured and very disoriented firefighter from the hostile enviroment to the exterior on side A. At this point Mfr Berti was turned over to RIC team and M89 fro treatment and transport to appropriate medical facility**.** T8 assisted with overhaul.

Obstacles Encountered: Provide explanation					
Coordination		Communication		Ineffective Equip. Use	
Equipment Failure		Inadequate Personnel		Too Many Personnel	
Safety		Staff Support		Other (Please Specify)	

I think the Department made a very good showing with amount of fire on arrival and a firefighter may-day situation of which he could not self-extricate himself and most likely would not have been able to exit on his own. The fire damage was held to area of origin due to an aggressive and coordinated defensive and offensive attack. I feel that we have gotten too complex as to sectors, divisions, exposures, etc. There was confusion as to exposure D which was in fact the garage which was attached to the greenhouse. The fire on Slidell Road a few years ago there was a miscommunication as to Division 1 and the basement Division which resulted in the evacuation of the structure at the moment

POST INCIDENT ANALYSIS
UNIT FACT SHEET

Unit ID:	**T8**	**Unit Officer:**	**MFR Michael Dudrow**		
Incident Address:					
Nature of Incident:		**Greenhouse on Fire**		**Time of Arrival**	

the second line was being placed in service in the basement. This occurred at a critical time of the fire. This may have resulted in the total destruction of the house.

20720 Goshen Road
November 12, 2006

POST INCIDENT ANALYSIS
UNIT FACT SHEET

Unit ID:	**AT29**	**Unit Officer:**	**Lt. Mike Lowry**		
Incident Address:		**20720 Goshen Road**			
Nature of Incident:		**Structure Fire**		**Time of Arrival**	**20:03:03**

Describe the situation upon arrival:
Dispatched as the 2nd. Due truck on the box assignment. On arrival we positioned on the edge of Goshen Rd. and observed a large volume of fire on Bravo side of the structure. Myself and crew gathered our equipment and proceeded to the fireground.

Describe SOP used or assignments given and/or actions taken in chronological order:
I conducting my size-up as we approached the structure on Side-Alfa, I could see the fire making it's way into the residence through the single story garage from the greenhouse structure. Since the garage was only one story I opted to enter the garage from Side-Alfa and assist Eng.281's crew with search and hooking ceilings. As we made our way into quad.-A, we heard the Mayday activated with a Firefighter down. As we continued further into the area we heard the activated pass device and multiple vibra-alerts coming toward us. Before we could ask to help they had passed by making their exit from the structure. We continued to search the area with all clear and then we ran into Batt.3 who advised that Eng.281 made it out safely. Some small spot fires broke out and we used Eng.281's line to extinguish them.
Exited the structure and sent my crew to Rehab.

Observation:
Mayday procedures in general are not followed consistently throughout the department.
On this incident it was unclear to some units who was designated to be the RIG and where they were suppose to stage.
Radio channel confusion after the Mayday activation.

Incident Commanders should let the first alarm units do their job unless there is a need to change it.

Obstacles Encountered: Provide explanation					
Coordination		Communication	X	Ineffective Equip. Use	
Equipment Failure		Inadequate Personnel		Too Many Personnel	
Safety		Staff Support		Other (Please Specify)	

POST INCIDENT ANALYSIS
UNIT FACT SHEET

Unit ID:	**RB6114**	**Unit Officer:**	**FII Bryan Riley / Dep Chief Curtis Jr C17-3**		
Incident Address:		**20720 Goshen Road**			
Nature of Incident:		**Greenhouse Fire**		**Time of Arrival**	**1957 hrs**

Describe the situation upon arrival:
Upon arrival we found a Greenhouse with 100% involvement attached to a 2 car garage that was attached to a 2 story Home. The Greenhouse was the only part of the structure that was on Fire. Engine/Tanker 17 was on the scene and the OIC was starting his 360 degree walk around.

Describe SOP used or assignments given and/or actions taken in chronological order:
Once the Rescue Squad crew made it up to Side "A" of the structure we advised the OIC of Engine/Tanker 17 verbally that we were going to conduct a search of the 2 story home. He then advised us to get a line and take with us. At that time FI Saunders went and got a 1 ¾ hand line from the Engine/Tanker. Engine 281 was also at the front door to the residence and I advised the OIC that we were getting ready to enter the structure to conduct a search. Once the line was brought to the front door the crew from Engine 281 advanced the line into a door to the left of the front door on side "A" to hold the fire to the Greenhouse. The crew from RS17 entered the structure and found little to no smoke inside the house. Once the search was completed, with negative results, we closed all the doors leading from the main part of the house to side "B" where the greenhouse (bulk of the fire) was located. Once that was completed I announced that a primary was conducted with negative results and that there was NO IDLH inside the two story home and that we had exited the structure. At that point Command advised us we would be working with Engine 281 inside the structure. We met with Engine 281 OIC who advised us to run lights and fans to the front door (the door they advanced the line through). RS17's crew advanced several cord reels and lights from the Engine/Tanker to side "A". At that time a single "Mayday" was announced by Engine 281, that they had a down firefighter and were on the way to the front door. Once this was announced we met up with Truck 8's crew, who was carrying the downed firefighter out, at the front door and assisted them to the front yard on side "A". We assisted with the removal of the downed firefighters gear until the ALS unit arrived and it was at that time we backed away so they could work. After the Mayday was cleared we brought a fan to side "A" to start clearing smoke. After that the crew of RS17 was placed in a standby position in the front yard while other 1st alarm units conducted overhaul. After about 30min we were utilized to relieve the crews operating in the greenhouse for overhaul. Once overhaul was completed we assisted with picking up hose from Engine/Tanker 17 and other tools from the fireground. Rescue Squad 17 cleared the scene at 0002 hours.

POST INCIDENT ANALYSIS
UNIT FACT SHEET

Unit ID:	**RB6114**	**Unit Officer:**	**FII Bryan Riley / Dep Chief Curtis Jr C17-3**
Incident Address:		**20720 Goshen Road**	

Nature of Incident:	**Greenhouse Fire**	**Time of Arrival**	**1957 hrs**

Obstacles Encountered: Provide explanation					
No Obstacles Encountered by Rescue Squad 17					
Coordination		Communication		Ineffective Equip. Use	
Equipment Failure		Inadequate Personnel		Too Many Personnel	
Safety		Staff Support		Other (Please Specify)	

POST INCIDENT ANALYSIS
UNIT FACT SHEET

Unit ID:	**W31**	**Unit Officer:**	**MFF Michael Berry**		
Incident Address:		**20720 Goshen Rd**			
Nature of Incident:		**House Fire**		**Time of Arrival**	

Describe the situation upon arrival:
Tanker 31 had two personnel staffing used from T-31. Dispatched as second due Tanker. There was still fire showing from side A of the house. First due Engine had dropped the clappered Siamese at the end of the driveway. Chief 17 was assigned Water Supply. Water supply Task Force already requested and unit assigned to 7 Hotel.

Describe SOP used or assignments given and/or actions taken in chronological order:

- Supplied clappered Siamese
- Set up folding tank site
- Dumped enough water into folding tank to cover E-281's low level strainer
- Third due Tanker arrived on scene; Water Supply advised to disconnect from Siamese and proceed to fill site at Goshen Rd. and Warfield Rd.
- Arrived at fill site with E-351 on a hydrant
- Continued with water shuttle for 3 round trips
- Picked up equipment, rehabbed Tanker back at Station 31

Obstacles Encountered: Provide explanation					
Folding tank area was uneven; to overcome we used the step chocks off of E-281 on the downhill side of the folding tank. Wanted to keep the road open to get the Tankers past the tank.					
Coordination		Communication		Ineffective Equip. Use	
Equipment Failure		Inadequate Personnel		Too Many Personnel	
Safety		Staff Support		Other (Please Specify)	

POST INCIDENT ANALYSIS
UNIT FACT SHEET

Unit ID:	**W4**	**Unit Officer:**	**Lt. Couse**		
Incident Address:		**20720 Goshen Rd**			
Nature of Incident:		**House Fire--**		**Time of Arrival**	**---**

Describe the situation upon arrival:

Filled folding tank at end of driveway.

Describe SOP used or assignments given and/or actions taken in chronological order:

Dumped water and filled tank twice. No other actions taken.

Obstacles Encountered: Provide explanation					
Water supply officer never took charge of water supply					
Coordination		Communication		Ineffective Equip. Use	
Equipment Failure		Inadequate Personnel		Too Many Personnel	
Safety		Staff Support		Other (Please Specify)	

POST INCIDENT ANALYSIS
UNIT FACT SHEET

Unit ID:	**C-17**	**Unit Officer:**	**Chief 17 Buddy Sutton**		
Incident Address:		**20720 Goshen Rd.**			
Nature of Incident:		**House Fire**		**Time of Arrival**	

Describe the situation upon arrival:

Fire showing. Units were in order EW17, W17, E81, T8, and E281 was picking up EW17 supply line.

Describe SOP used or assignments given and/or actions taken in chronological order:

Units on location, EW17 up driveway followed by W17, E81, and T8. E281 remained at the end of the driveway to pick up the supply line. Command was taken by B/C 5; I reported to command that I would take "Water Group". I then had all units switch to "7D" for water supply operations. E281's driver started to give this water to E81. W31 was the next tanker to arrive. I had him take his folding tank down and put it in front on E281 so we could have all tankers be in a loop. Tanker 31 dumped his water into the folding tank, E281 drafted from the folding tank and began the tanker supply operation. E351 (5 due) reported to the hydrant at the church entrance on Goshen Road to set up a fill site. Never once did a unit ask for water, we never ran low on water, all personnel did an outstanding job. I asked command for the fire flow, command reported to me it was 300 gpm. We had no problems maintaining that flow. A water supply task force was started, but the only units used from the task force where E131 and W9. Tankers had no problems utilizing their side dumps into the folding tank, and E281 had no problem keeping a draft and supplying the operation. Again all personnel did an outstanding job.

Obstacles Encountered: Provide explanation					
Coordination		Communication		Ineffective Equip. Use	
Equipment Failure		Inadequate Personnel		Too Many Personnel	
Safety		Staff Support		Other (Please Specify)	

20720 Goshen Road
November 12, 2006

POST INCIDENT ANALYSIS
UNIT FACT SHEET

Unit ID:	**BC3**	**Unit Officer:**	**BC Rich Holzman**		
Incident Address:		**20720 Goshen Rd**			
Nature of Incident:		**Bldg Fire**		**Time of Arrival**	**20:03**

Describe the situation upon arrival:
There was a visible working fire from the corner of Goshen Rd and Warfield at the dispatched address.

Describe SOP used or assignments given and/or actions taken in chronological order:

1. Positioned on the driveway off the road donned ppe and SCBA and reported to the IC
2. Assigned to do an updated circle check. I went to the side A of the Greenhouse, made sure Fire Attack knew of my presence. I started at the A/B corner to side A, D, C and B of the house, garage and green house. I reported my findings command – wood frame greenhouse attached to a garage, greenhouse fully involved, extension into the garage, nothing visible from the house.
3. Assigned to go to exposure D. I went into the house from side a traveling from unburned to the garage area. Smoke present in the kitchen area and towards the garage. I found Exposure D (E281 B) we did a face to face I reported this to command.
4. I was about to enter the garage when the Mayday was called and immediately personnel came through the door, carrying a downed firefighter. I notified command that they would be on side a of the house
5. I remained with AT29's personnel to maintain efforts for ruling out further extension. They extinguished several hot spots. RS17 came in for 1 member of their crew who was still in the garage and he left with a low air vibralert.
6. AT29 reported an injury to the T2 position. I sent them out for evaluation
7. Awaited FM's to complete their initial investigation
8. Reported to command - anticipation of needs for the event
9. I continued to have the garage as my primary responsibility. E281, E291 and AT29's crew assisted with efforts at Salvage and Overhaul.
10. Direct communication occurred multiple times with Fire Attack group leader throughout the incident
11. Completed all tasks per command with regular updates

POST INCIDENT ANALYSIS
UNIT FACT SHEET

Unit ID:	**BC3**	**Unit Officer:**	**BC Rich Holzman**		
Incident Address:		**20720 Goshen Rd**			
Nature of Incident:		**Bldg Fire**		**Time of Arrival**	**20:03**

Obstacles Encountered: Provide explanation
It is very challenging trying to verify 1 if not two separate working incidents and build out a rural water supply The mayday was switched by ECC without hearing from the IC. People were operating on multiple channels. The IC could not monitor that many channels effectively. Battalion drivers would have made a difference for the IC both for initial size up and managing communications. The driver of TW17 was unsure of the operation, limitations and coordination of the Class Foam System without seeking input. Consider using common names for operating areas as divisions – greenhouse, garage, etc

Coordination	X	Communication	X	Ineffective Equip. Use	
Equipment Failure		Inadequate Personnel		Too Many Personnel	
Safety		Staff Support	X	Other (Please Specify)	

POST INCIDENT ANALYSIS
UNIT FACT SHEET

Unit ID:	**BC4**	**Unit Officer:**	**John Gallo**		
Incident Address:		**20720 Goshen Road**			
Nature of Incident:		**Structure Fire**		**Time of Arrival**	**2024 hours**

Describe the situation upon arrival:

BC4 responded on the Task force for the house fire at 20720 Goshen Road. BC5 on the scene with command, C17 assigned as the Water Group Supervisor. AOS while E281 initiated a Mayday for a firefighter down on the Alpha side of the structure. Parked the BC4 buggy and immediately reported to command post to assist BC5. Assigned by BC5 to conduct a PAR on 7 Delta, with units assigned to the Water Supply Group per the Safe Structural Firefighting SOP's. The water Supply group consisted of C17 as the Supervisor and BC109 assisting him. E281 was operating as the Dumpsite engine, with TW17 nursing E281 in the driveway.

E351 and E131 operated two Fill-sites at 20501 Goshen Road at the church. TW 4, 31, and 9 shuttled water between the Fill-site and Dumpsite. Frederick County ET254 and Howard County Tanker 44 returned to service. The Water Supply Group with no water Interruptions maintained a 400-gpm fire flow.

The Water Supply Group responded to two PAR checks at 2012 and 2051 hours both accounting for all personnel assigned to the Group.

Continued coordinating the Water Supply Group with Command until the incident was downsized and BC4 released for service.

Describe SOP used or assignments given and/or actions taken in chronological order:

A PAR was conducted in accordance with the Safe Structural Firefighting SOP, after a Mayday is initiated.

Obstacles Encountered: Provide explanation					
Coordination		Communication		Ineffective Equip. Use	
Equipment Failure		Inadequate Personnel		Too Many Personnel	
Safety		Staff Support		Other (Please Specify)	

ECC

From a PSCC perspective:
At the time the fire was dispatched, we had gone down to our 5-person staffing. As the incident escalated to covering 3 channels, I had called up one person to handle 7D and 7E. As usual, we were busy with many other incidents on top of the fire and everyone was on a phone call. At the time of the mayday, we still had only 2 people working the fire channels. As soon as someone was free from the phones, I called up all personnel to the floor. This was roughly 10 minutes into the fire.

There was one issue with our CENTRACOM radios that didn't allow us to speak on 7F when we noticed units had switched to that channel. I BELIEVE the issue wasn't a malfunction but training-related. In an effort to recreate the situation, we found that one cannot select an announce channel when other channels in the same group are also selected. In hindsight, this makes sense because if you have 7C selected and you go to talk on 7F, you'll be trying to talk over 7C at the same time-from 2 different locations. It's the same function as when a mobile radio beeps at you because the channel is busy. Again, this information was not relayed to the fire operators during training but has been disseminated to attempt to eliminate any future occurence.

POST INCIDENT ANALYSIS
UNIT FACT SHEET
RAPID INTERVENTION

Unit ID:	**RS291**	**Unit Officer:**	**MFF Lancaster**		
Incident Address:		**20720 Goshen Road**			
Nature of Incident:		**House Fire**		**Time of Arrival**	

Describe the situation upon arrival: Radio reports had fully involved greenhouse on side B of the building with extension into the house. E281 reported that fire was burning thru interior door where they were holding it. Since we were dispatched as the RIG I advised my crew that we would set up the RID on side A near the closest entry to were the crews were working.

Describe SOP used or assignments given and/or actions taken in chronological order: Dispatched as the RIG. MDC went OOS prior to dispatch. Arrived on scene switched mobile to 7B and advised ECC we were on scene and that I would make a face to face with command to advise same. Command was busy running incident and I didn't want to disturb him at that time. We positioned in church driveway across the street to leave room for tankers. We began gathering equipment for RIG from the Rescue and proceeded to the command post. As we began crossing the street a mayday was sounded. I did not hear the original Mayday only command asking who had the mayday. Before we got to the command post E291 (RIC) advised mayday was out of the building on side A. Since mayday was declared all operating units where switched to 7E. My concern at this time was that there was no one operating as the RIC for these units and the original mayday had been handled. I approached the command post for a face to face with the I/C to advise we were on scene and assuming the RIC for the remaining units. I was advised by command that there was a mayday and that I need to report to side A and assist. At this point I figured it was best to coordinate with the other RIG companies. Reported to the downed firefighter on side A and made a face to face with Captain Trice (E291) and Captain Cochran (AT35). All agreed that RS291 would maintain RIC for remaining units operating. At this time I monitored 7E and had my RS3 monitor 7C. Remained on 7E until units switched back to 7C. Maintained RIG did several circle checks thru out until released by command.

Obstacles Encountered: Provide explanation					
Coordination		Communication		Ineffective Equip. Use	
Equipment Failure		Inadequate Personnel		Too Many Personnel	
Safety		Staff Support		Other (Please Specify)	

20720 Goshen Road
November 12, 2006

POST INCIDENT ANALYSIS
UNIT FACT SHEET
RAPID INTERVENTION

Unit ID:	**AT35**	**Unit Officer:**	**Tony Cochran**		
Incident Address:		**20720 Goshen Rd**			
Nature of Incident:		**House**		**Time of Arrival**	**2009 hrs**

Describe the situation upon arrival: Most of the visible fire was knocked.

Describe SOP used or assignments given and/or actions taken in chronological order:
RID Sop used.

Organized the RIG with the other crews from the RID (RS291, M89) and designated the RIG staging location, which was near the command post. Advised command of this location. As AT35 B & C were about to make a lap around the building a mayday was issued. Reported to the location that the injured firefighter was removed to which was side "A". The injured fire fighter was initially evaluated by E291, which was part of the RID and then by M89's crew. Encouraged others who were not assigned to the RIG, or giving aid to return to their assigned duties. After the injured fire fighter was removed from the scene reorganized the RIG to the original staging location. Advised command of the RIG's reorganization. Released by command with no other actions by the RIG.

Obstacles Encountered: Provide explanation					
Coordination		Communication	X	Ineffective Equip. Use	
Equipment Failure		Inadequate Personnel		Too Many Personnel	
Safety		Staff Support		Other (Please Specify)	

Communication:

- did not initially hear the mayday. I heard a lot of radio traffic but I did not pick up the mayday transmission.
- Listening to the radio I never had a clear indication as to what unit was the RIC. I knew from the dispatch order E291 was to be the RIC. From what I heard on the radio E291 was given other responsibilities. So I wasn't sure who the RIC unit was.

POST INCIDENT ANALYSIS
UNIT FACT SHEET
RAPID INTERVENTION

Unit ID:	**M89**	**Unit Officer:**	**Kaufman**		
Incident Address:		**20720 Goshen Road**			
Nature of Incident:		**Single family house fire**		**Time of Arrival**	**1957ish**

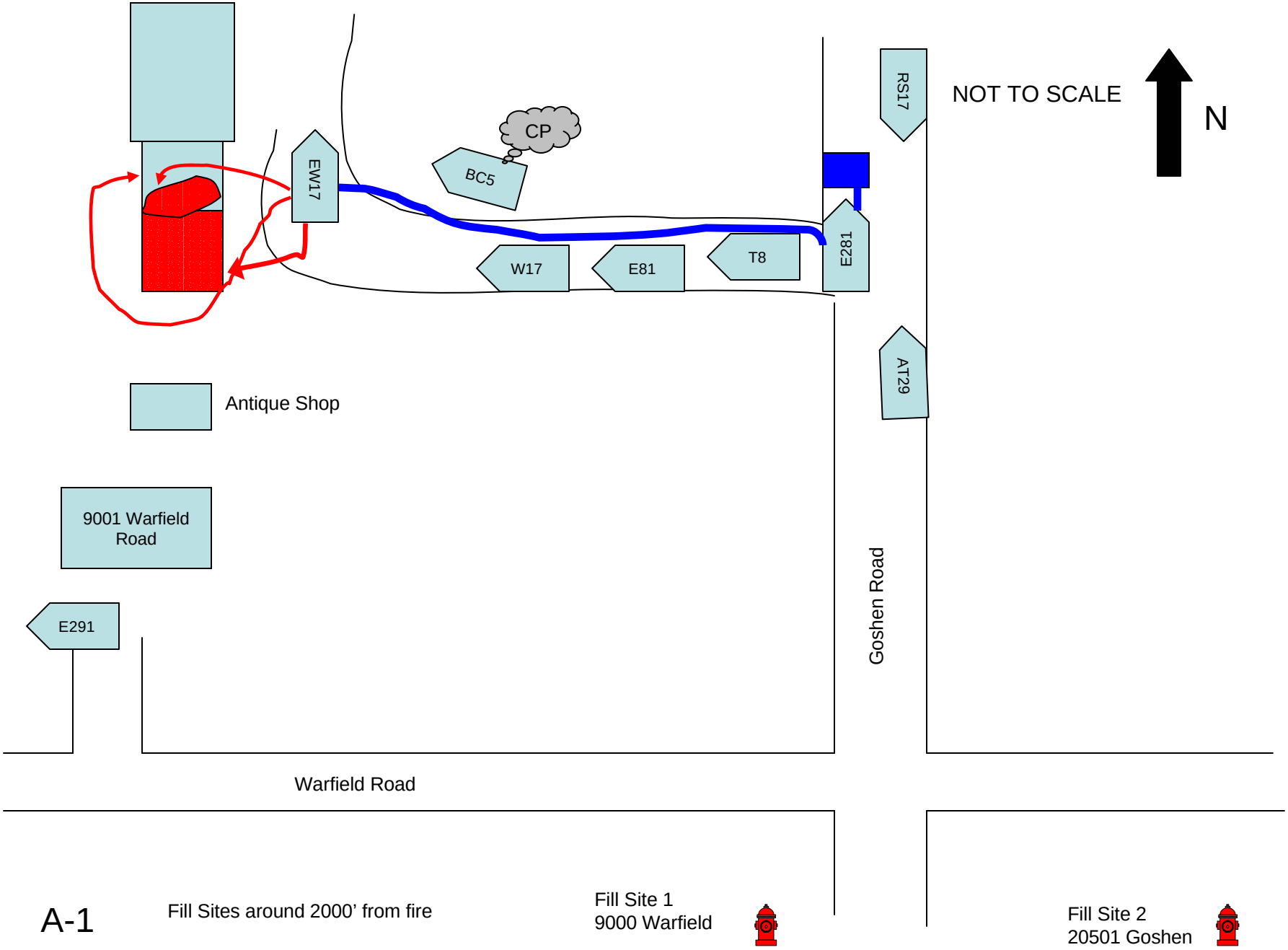
Describe the situation upon arrival:

There was heavy fire from the attached greenhouse, circle check just being completed. Command in place, water supply looking good, no RIG established yet.

Describe SOP used or assignments given and/or actions taken in chronological order:

We were dispatched on the RID. We arrived and geared up to join the RIG. We reported to the front yard and met up with Captain Cochran (not sure which unit he was from) who identified himself as a RIG member. Having heard the 4th due engine had been redeployed, we did not meet up with them. RIG seemed informal and it was unclear who was the RIG group leader, but we were only two units before the mayday was called. We followed command instructions to move to the front yard. (The mayday seemed to go well from an ICS perspective). We found T8 extricating Fred and we dropped some gear in order to attend to him. Everybody had crowded around him (a totally expected and understandable phenomenon) and it was difficult to gain access, but when we (the medic crew) were close to him, we were pushed aside by Captain Trice. On at least 3 occasions, we identified ourselves as the medic crew and were ignored and literally shoved aside. Furthermore, Captain Trice removed Fred's running coat which required Fred to move his injured shoulder, clearly aggravating his injuries. Trice would have continued to remove Fred's running pants, but the alert safety captain (Treavy?) told Trice that if any more gear needed to be removed, it should be cut. Captain Trice never identified himself as the RIG group leader nor did he verbalize responsibility for his actions. We were able to move Fred to A87 and care was transferred to Captain Landry for transport. The fire had been contained and we were redeployed from RIG to rehab. We treated one MFF with an injured ankle (and then I saw him on live TV the next morning in an operational capacity…. hmmm). Nobody else came through rehab, so our function was actually 'aide station'. We assessed the homeowner who refused transport. We provided no other functions before being clearing.

Obstacles Encountered: Provide explanation					
See above.					
Coordination	X	Communication	x	Ineffective Equip. Use	
Equipment Failure		Inadequate Personnel		Too Many Personnel	
Safety		Staff Support		Other (Please Specify)	



A-1

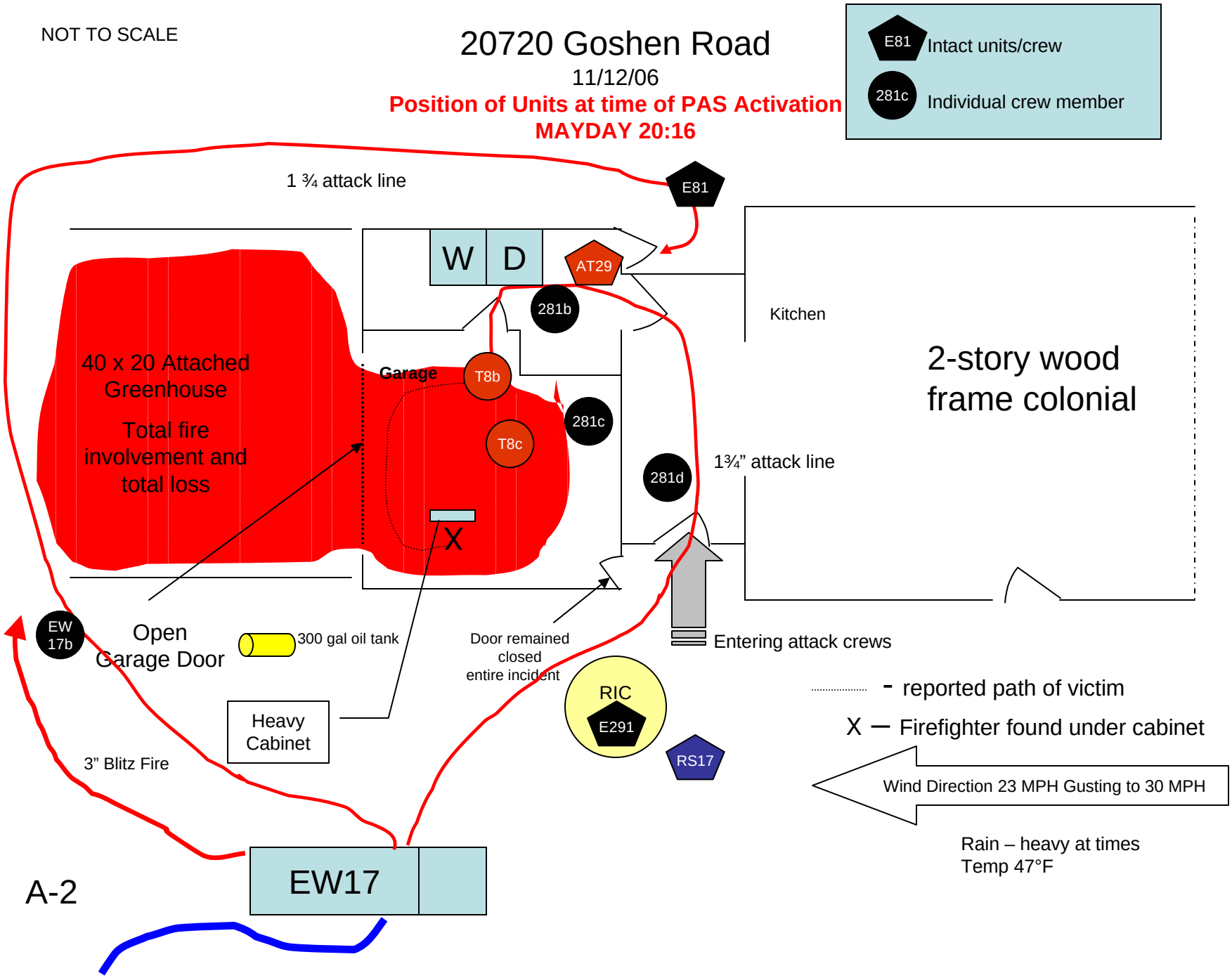
Fill Sites around 2000' from fire

NOT TO SCALE

20720 Goshen Road

11/12/06

Position of Units at time of PAS Activation
MAYDAY 20:16

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