

POST INCIDENT ANALYSIS

STRUCTURAL FIRE



INCIDENT # 08-0007874

**15 GIBSON PLACE
GAITHERSBURG, MD**

JANUARY 23, 2008

SUBMITTED BY:

BC Kent Mallalieu

I. Introduction

At 2336 hours on Wednesday January 23, 2008 units were dispatched for a report of a house fire at #15 Gibson Place. Battalion 703 arrived first to find a two story, wood frame, single family dwelling with heavy fire showing from the first and second floors in the alpha quadrant, a car burning in the driveway, and the siding melting off the bravo exposure. Command was established and an additional alarm was called for immediately.

A county police officer reported to command that neighbors stated that there might be as many as six people trapped. Command directed incoming units to make a quick search and to begin protection of the bravo exposure. After conducting a quick primary search, units were pulled from the building and the fire was attacked from side alpha using a blitz line.

After the fire was darkened the units were allowed back inside, although access was restricted to side alpha to help maintain accountability and control. The fire was extinguished and a secondary search confirmed that there were no victims. Overhaul was delayed until the Investigations Group could finish their work. The fire was officially declared out at approximately 0330 hours on the 24th and the remaining units were released.

One family of two (almost three – she was “expecting”) was displaced. There were no reports of firefighter or civilian injuries. The fire is estimated to have caused 500,000 dollars damage to the structure and another 200,000 to the contents.

II Building Structure/Site Layout

- a. Review type of structure: **Single family detached**
- b. Construction or design features contributing to fire spread or prevented fire spread, i.e. sprinklers, fire doors, etc.: **Wooden structural members contributed to the fire spread**
- c. Did the topography and/or type of fuel affect fire control efforts? **The fire involved two automobiles: one in the garage, and one just outside. This heavy fuel load contributed to the quick growth of the fire and the large volume of water needed to suppress it.**
- d. Did fire alarm and/or suppression devices work properly? **N/A**
- e. Did personnel or apparatus encounter any problems in gaining access? **The home sat at the end of a short narrow drive that**

limited close access to E731, T731 and BC703. Other apparatus had to position farther away. There was no vehicle access to sides Charlie or Delta.

- f. What is needed to correct these problems? **N/A**

III Fire Code History

- a. Review of Fire Code requirements and history. **N/A**

IV Communications

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

V Pre-emergency Planning

- a. Were the pre-fire or other plans needed on the scene?
1. Were they available? **No**
2. Should they be updated? **Not necessary**

VI On Scene Operations

- a. Structural integrity of building based on fire conditions on arrival, at 10 minutes, 20 minutes, 30 minutes, etc. ***Upon arrival there was a significant body of fire on the first and second floors with extension into the attic. At 10 minutes the master bedroom floor had collapsed into the garage and much of the roof over the***

alpha quadrant was gone. By 20 minutes the fire was knocked and the alpha/ bravo corner had been cordoned off for fear of a collapse. Operations in structurally questionable areas were limited to that which was absolutely necessary and all personnel were repeatedly reminded of the potential for collapse.

- b. Was Command identified and maintained throughout the incident? **Yes**
- c. Was a Command Post established and readily identifiable? Flag, Green Light, or other? **Yes. Command was established in the BC703 buggy off the alpha/bravo corner of the building. The BC703 buggy does not have a green strobe (lost, stolen...but gone)**
- d. Size up decisions by command **The size up by command resulted in a call for additional resources and direction to complete a quick search. I am not sure that all of the initial crews heard that we were only doing a quick search but all did hear me tell them to exit and all were accounted for before changing attack modes.**
- e. Was additional apparatus requested in a timely manner? **Yes, immediately**
- f. Strategy/action plan: **Rescue, exposure protection, fire containment, and property conservation**
- g. Did personnel, units, teams execute tactics effectively? **Very effectively, the crews on this fire did an excellent job mitigating a large fire on a cold night**
- h. What training needs were identified? Provide examples. **None were identified**
- i. Were Standard Operating Procedures used, were they adequate, need to be updated? If not used, why? **SOPs were adequate for this fire.**
- j. Offensive/defensive decisions by command? **This operation was initially offensive to protect search crews. This changed when it was apparent that any unfound victims would likely be dead and the risk to interior crews was getting too great. The mode was switched to defensive and, after confirming that everyone was out, a master stream attack was made. After the fire was darkened the mode was changed again so personnel could mop up the fire.**

- k. How was risk analysis applied to the incident ***The first thing the incident commander was told upon his arrival was that there might be six people inside. With two cars burning and no residents out front at 2330 hours on a week night I was confident we might have rescues/victims. I put crews inside, protected by two handlines, in the hope of completing a quick search. As mentioned above, when it became obvious that any trapped civilians would likely be dead, the risk I was willing to take was reduced and I pulled the crews out.***
- l. Were the divisions/groups used appropriate to the type and complexity of the incident. **Yes.**
- m. Was apparatus properly positioned? If not why? **Yes**
- n. Attack line selection and positioning ***The initial crews (E731 and E708) pulled attack lines and a blitz line. E703 established a second water supply and hand jacked a leader line to the side delta/alpha corner.***
- o. Ventilation operations ***External only***
- p. Salvage operations ***Salvage was conducted in the few areas where things were not destroyed. Unburned property was covered with covers or removed to the outside and given to the residents who showed up late in the fire.***
- q. Night time and interior lighting operations ***Lighting was provided by the truck companies and was sufficient.***
- r. Were Mutual Aid companies effective in operation? **N/A**
- s. Was water supply adequate? **Yes**

VII Staging

- a. Location adequacy ***The location was adequate.***
- b. Site Access ***There were no accessibility issues.***

VIII Support Functions

- a. Was a Rehab group established? **Yes**
- b. Were Fire/Rescue personnel provided with food and drinks? **Yes, by Canteen**

- c. Was adequate shelter provided for fire/rescue **Yes**
- d. Were crews relieved by fresh crews on a regular and frequent basis? **Yes**
- e. Were there any equipment or apparatus failures? **No**
- f. Did failures have a detrimental effect on incident outcome? **N/A**

- g. Were functions with outside agencies properly coordinated? (i.e. Red Cross, Power company, Gas Company) **Yes**

IX Safety Group

- a. Was a standby team established? if not why? **Yes, on side alpha**
- b. Were there any fire/rescue personnel injured? **No**
- c. Were all safety SOPs and regulations enforced? **Yes**
- d. If there was a Safety Dispatch were they used for Safety, Accountability or RIC? If not, why? **Used as the Rapid Intervention Group**
- e. What actions are necessary to change or update current safety and health programs to improve the welfare of members? **N/A**

X Accountability

- a. Were actions taken to ensure accurate personnel accountability? **Yes. After the initial search, all access to the building was limited to side alpha and that group officer was tasked with maintaining entry control. The accountability board was also maintained.**
- b. Was the status of units, Divisions/Groups/Branches and support personnel maintained? **Yes**
- c. Did personnel provide adequate feedback? **Yes**
- b. Was the incident continuously controlled and monitored? **Absolutely**

XI Investigations

- a. Was the Origin and Cause of fire determined? **Not precisely. The investigators determined that the fire was not suspicious and had likely begun on a work bench in the garage or in the garage door motor.**
- b. Factors contributing to fire spread? **A heavy fuel load in the garage (including a car) and wood frame construction.**

XII Lessons Learned

- a. Specific training needs identified? **None**
- c. Recommended improvements **None at this time**

XIII Overall Analysis of Incident

-Good? Bad? Why? **Excellent. This was a large fire on a cold night with lots of ice, lots of firefighters, and plenty of activity. We stopped the fire before it spread to exposure bravo and "saved" much of the Charlie and delta quadrants of the fire structure. No one got hurt. I could not ask for much better.**

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. **None needed.**

See post fire pictures on the following page.

