

Building Fire 101 Odendhal Avenue August 16, 2008



Fire on the 9TH Floor at 00:24 Hours

Occupancy – HOC Residential High Rise Housing nearly
200 elderly and disabled residents.

Table of Contents

Introduction	3
Incident Action Plan	4
Phase 1 Life Safety	4
Incident Stabilization	5
Phase 2 – Complete Evacuation	6
Phase 3 - Reoccupation	7
Incident Organization	8
Challenges, Successes and Recommendations	9
The Fire Alarm System.....	9
Apartment Access	10
The Building Manager	10
Communications.....	11
Code Enforcement	13
EMG	14
PIO	15
Canteen.....	15
General Command and Control.....	15
Bring your Tennis Shoes	16
Ride On	17
Firehouse Reports.....	17
Fact Sheet Responses – Obstacles Encountered	18
Final Thoughts	21

Appendices

- A – Building Site Plan
- B – Building Floor Plan
- C – Ortho Photo Overhead
- D – Tax Records
- E – Report Completion Status Final

Introduction

On August 16, 2008 at 00:24 hours, E708 & RS717 responded for a fire alarm at the Forest Oak Towers, 101 Odendhal Avenue in Gaithersburg. Upon arrival, RS717 found the building being evacuated and nothing evident. ECC advised E708 that they had reports from the ninth floor – one reporting no smoke, and another reporting a haze.

E708 entered the first floor lobby and found water coming down the elevator shaft. E708's requested BC705 on the scene and began to ascend the stairs with RS717 to the ninth floor. En route, the crews encountered elderly residents with various medical or physical disabilities attempting to exit the building. Upon reaching the ninth floor, the crew encountered smoke and E708's officer requested the box alarm assignment.

Forest Oak Towers is a ten-story residential high rise built in 1981 and valued at \$17.4M as of July 1, 2008. It is Type I construction, fully sprinklered and equipped with a high rise fire control package. At the time of the fire, it was managed by the Housing Opportunities Commission and was occupied by approximately 175 elderly residents – many non-ambulatory. The building evacuation plan at the time of the incident recommended that disabled residents remain in their apartment in the event of fire

On the night of the incident, a plastic ornament was taken from the ninth floor elevator lobby, placed near apartment 909 and set fire. Apartment 909 was located near the elevator lobby. Smoke detectors in the elevator lobby activated and all elevators were recalled to the first floor lobby. In addition, smoke doors closed in the hallways and the stairwells were pressurized – limiting the travel of the products of combustion. The fire alarm evacuation system did activate and was sounding on all floors. A single sprinkler head near the apartment quickly extinguished the fire – however there were mild smoke conditions on the ninth floor and significant water damage – draining down the elevator shaft and other floors.

At the time of arrival, nearly one hundred residents were outside the building entrance. Others were encountered by fire/rescue personnel evacuating via stairwells and many others remained in their apartments.

There were no civilian or firefighter injuries. Loss was estimated at \$1,000 from the fire and over \$400,000 from collateral water damage due to the sprinkler.

Incident Action Plan

Command was established on Side A in BC705's buggy.

Immediate priorities were addressed followed by tertiary functions.

Phase 1 Life Safety

Tactical Talk Group 7C

1st Life Safety Priority: Fire Floor - Units on the 9th floor were assessing fire and smoke conditions – assisting residents in sheltering in place or moving to the stairwells. Stairwells had not been designated for fire or evacuation at that time.

Additional resources requested:

RID

TF (staged at Station 8)

Red Cross

EMG

3 busses from Ride-On

MAB726

2nd Life Safety Priority – Floors above the fire. An Upper Management Group was assigned to handle all objectives above the fire including, 1) assessment of occupants and their condition – shelter in place (fire out) if possible or move to safe zones, 2) confirm no vertical extension; 3) perform vertical ventilation if needed; and 4) report needs to command.

3rd Life Safety Priority – Floors below the fire. A Lower Management Group was assigned to assess all floors above the fire including but limited to 1) assessment of occupants and their condition – shelter in place (fire out) if possible or move to safe zones; 2) Assess and report water damage and any hazards caused by the sprinkler system, and 3) report resource needs to command.

Incident Stabilization

This building housed elderly residents in need of care – many were non-ambulatory. The incident would not be stable until the residents were completely cared for. A number of key personnel were assigned to customer service and liaison functions to deal with the resident's needs.

Lobby Control (E753) took over the PA announcement in the Fire Control Room – I asked them to make an announcement to shelter in place and not evacuate but I believe they simply turned off the alarm.

As soon as the immediate life safety issues inside the building were addressed, The Upper Management Group was demobilized and requested to report to 8th Floor Staging. A708 was already on the 8th floor.

When code enforcement arrived, the IC requested that they assess the building for hazards. I recommended that they call the City of Gaithersburg and obtain the appropriate inspectors. Their initial response was that they handle these issues after hours. The intent of the IC was to limit evacuation of the entire building – hoping to get the residents back in.

The weather was cool – upper 60's to low 70's and the occupants were tolerating the environment. Many chairs were placed outside for the residents. Two first floor bathrooms (located in the hallway common area) were made accessible for the residents and F/R personnel escorted them / monitored same.

The RID and TF were demobilized.

Code Enforcement assessed the building – reported water in the electrical systems and did not feel that the residents could safely occupy the building.

Phase 2 – Complete Evacuation

Talk Group – Tactical 7D
Command – 7C

Based on Code Enforcement's assessment, the plan was shifted to evacuate all residents. An EVAC Group was assigned and resources deployed to facilitate the safe removal of the residents. Keys were given to personnel for each floor in zip lock bags by the building engineer – there was no master key. Each room was checked and residents removed.

I had no response from EMG (per ECC) and Red Cross was still not on the scene. I requested Captain Dement (who had EMG contacts) – he was on T706 – so they were added to the call. Captain Dement acted as Liaison and worked with the cooperating/assisting agencies as well as the property manager.

Many residents reported the need for medication. At least three residents wanted their blood sugar checked. Based on the potential EMS need, command requested M708 (on the initial RID) back to the scene and also requested an additional ALS unit (M731).

Captain Dement had a plan to house residents in area hotels. Currently there were 80 on buses, many self extracted (in their cars) and possibly 100 more in the building. This was a 175 unit building housing about 220 residents. Additional plan was to shelter folks at Gaithersburg HS. School Security (Crowley) arrived on scene. It turned out that the Gaithersburg High School was under some form of renovation and could not be used. Many residents also had pets that could not be taken to shelters. Gaithersburg Animal Control was requested.

Captain Dement utilized a resident list from the property manager to maintain accountability.

When issues began to mount with housing the resident's, I once again insisted that Code Enforcement contact the City of Gaithersburg. I also made the request through ECC. The city of Gaithersburg responded with a building inspector and an electrical inspector – they arrived at 03:11. The PIO (requested by BC703 – Goldstein) was also contacted at my request. Captain Garcia arrived at 03:22.

After evaluation by the City of Gaithersburg, coordinating with MC Code Enforcement, occupants were allowed to reoccupy the building except the following units:

101 Odendhal Ave
Forest Oak Towers
August 16, 2008

Apartments

909, 908, 907, 906, 905
809, 808, 807, 806, 805
709, 708, 707, 706, 705
609, 608, 607, 606, 605

The Phase 2 evacuation was told to stand-by while the plan was clarified. Liaison (T706 Officer) briefed command and a plan was taking form. Residents who could make it back to their apartments without assistance would be allowed to return – all others would be taken to area hotels.

The elevator was still – and would remain – OOS until an inspector could clear it. The Fire Alarm System was placed back in service
The sprinkler system would remain OOS – the sprinkler company was en route.

Phase 2 groups were demobilized and Phase 3 groups mobilized.

Phase 3 - Reoccupation

Talk Group – Tactical 7D
Command 7C

The phase 3 group would coordinate the re-occupation of the building. Challenges occurred when some resident could not ascend the stairs. Stair chairs were requested to assist. Command requested Liaison (T706 Officer) to the Command Post to reemphasize the plan. Many residents awaiting “transport” back to their rooms were placed back on the bus for deployment to shelters.

A final sweep was done in the “no re-entry” apartments by E753 and Captain Dement. Many residents entered via an uncontrolled door and re-occupied some of those rooms. They were escorted back out.

A total of six residents were transported to the Holiday Inn on Montgomery Village Ave. Many residents had self-extricated on their own to find shelter. The remainder reoccupied their apartments. Management will place notices on the affected apartments to deny entry. Code Enforcement and the City of Gaithersburg will follow up at daybreak and as needed.

Incident Organization

Phase 1 (Fire – Life Safety)

Command and General Staff (various phases)

IC – BC705 (Reid)

Advisor – C708

SAFETY – None Assigned

PIO – Garcia (arrived Phase 3)

LOFR – Dement (arrived Phase 2)

DOCL/RESTAT – John Epling

Phase 1 Operation

RIG – RS729 DIVS (8th Floor) RS729, AT703, M708 (A708)

DIV9 – E708 Officer (DIVS) E708, RS717, AT708 – DIVS changed to BC703

Upper Group – E731 Officer (DIVS) E731, E728, T731

Lower Group – E729 Officer (DIVS) E729, AT729

Lobby Control – E753 Officer (DIVS) E753 – DIVS changed to C703D

Occupant Services – EMS703

Phase 2 (EVAC) Commenced at approximately 01:45

T731 Officer (DIVS) BC703 (coordinating) AT708, RS717, T731, E708, E753

Occupant Services – EMS703, E728

Liaison – T706 Officer

All others in REHAB

Phase 3 (Reoccupation) – Commenced at approximately 04:30

E729 Officer (DIVS) E729 E728 AT729 M708 A708 M731

Final Sweep – E753

Occupant Services – EMS703

Liaison – T706 Officer

Assisting and Cooperating Agencies

Montgomery County HOC

City of Gaithersburg (police, inspectors, animal control)

Red Cross

Montgomery County Schools

Ride-On (MC Transportation)

Montgomery County Police

101 Odendhal Ave
Forest Oak Towers
August 16, 2008

Fire intentionally set by Apartment 909 – plastic flower arrangement.
Approximate loss - \$1K from fire; \$400K from collateral water damage from
sprinkler system

Challenges, Successes and Recommendations

(Comments and recommendations from the author in blue)

The Fire Alarm System

Several months ago, serious issues plagued the buildings fire alarm system. This required a fire watch by the MCFRS for several days. Sometime after that period, the fire alarm system was upgraded. The building is equipped with a modern high rise package including PA systems, system controls and automatically pressurizing stairwells.

E708 obtained one set of Knox Box keys and entered the lobby to check the fire alarm panel but the panel had been removed. The officer then attempted to gain access to the Fire Alarm Control Room but the combination locked had also been changed - the access code that was supposed to work didn't.

Key personnel at Station 8 were not briefed or informed of the fire alarm system change and the removal for the fire alarm panel from the lobby. Additionally, the combination lock was changed. Historically, three buildings in Station 8's first due have combination locks for the Fire Alarm Control Room (FACR) equivalent to the door combinations at Station 8 and 28. Those buildings are: Londonderry Towers, The Hilton, and Forest Oak Towers. The Captain on E708 was surprised when he found that the combination did not work. Later in the incident the building engineer told E708's officer about the combination and explained the combination was on a piece of paper inside the Knox Box.

I recommend that the Station Commander at Station 8 appoint a liaison for HOC buildings in Gaithersburg. There are several such buildings listed on the Montgomery County HOC web site. Oddly enough, Forest Oak Towers was not listed.

Apartment Access

Personnel were asked to enter apartments to retrieve medications and to complete Phase 2 of the IAP (Evacuation). The building manager simply provided keys for the 6th through 10th floor. BC Goldstein assigned a FF from AT708 to the property manager to help obtain and organize the keys in zip lock bags. All of the keys were unmarked. RS717 was assigned as the key runners – from the lobby to the 6th floor where Mike Crawford (EVAC Group Sup) and BC Goldstein were based.

Personnel only did Floor 10 down to Floor 6 before the plan changed. The group did find people in apartments that were not on the “shelter in place” list.

Unfortunately one resident claimed that hundreds of dollars were removed from their purse – basically accusing fire/rescue personnel of stealing. Gaithersburg City Police were sent to the apartment to take a report and found the claim unfounded.

Some personnel believe that we should not re-enter the individual apartments to obtain personal belongings or verify occupancy. There is always a possibility where public servants will be accused of wrong doing. The purpose of the mission outweighs this possibility. It is best to provide the best customer service and to verify that all residents have exited the structure. This method – although cumbersome - accomplished a number of objectives with little damage. Needless to say it was rather challenging. There should have been a master key or at least have the keys numbered.

The Building Manager

The building manager was on the scene - she was helpful and responsive. She did not have a plan in case of catastrophic infrastructure failure and what to do with the residents. She did have a contact list for building services and was able to contact key representatives for the sprinkler system and elevators. She was genuinely concerned with the occupants and worked with Captain Dement to help resolve issues.

I would recommend that the Division of Community Risk Reduction contact the HOC Property Manager and help her develop a plan for total or limited evacuation – preplanning shelters – care of pets, etc.

Communications

During the fluid part of the incident (incident not stable) the 7C operator tells me, "You will have an intermittent operator." Before I could deny or question the statement, he was gone and a resource order was delayed. I then went to 7B and advised I needed an operator on Charlie. Once the Charlie operator got back on I stated I needed an operator to stay on 7C. The 7C operator's response was simply "9-1-1 calls come first." At that time, nearly 100 vulnerable elderly residents on the street and almost another 100 in the building at risk.

As an IC, I was curious about the business practice is at ECC. I understand they have work and rest periods. I do not know what triggers an "all-hands" event or what the "response time" is to get to full strength if they are in rest periods. We should not have to switch to another talk group and have the potential of losing critical on-scene communications to obtain resources or information. I did receive a response from Captain Bailey and it is summarized below.

The current set-up of our communications framework allows for the support of fire ground operations by an ECC based operator on an "as available basis." It is the intent of the system that the Incident Commander "owns" the primary talk-group and other portions of the Incident Block, independent of ECC intervention. Requests for additional resources are supposed to be addressed to one of the continuously manned talk groups. That an operator is ever provided is a luxury not a right. We experienced a mini-"event wave" with that call. An event wave is when multiple callers report the same incident. All those calls have to be answered and all of those callers queried for additional clarifying information. Event waves chew up resources but are typically short-lived so that a call back of personnel is unreasonable. [By the time they get back the wave is over] Obviously multiple complex incidents operating across multiple zones and incident blocks would create a similar situation equally prohibitive to the assignment of an operator for each.

As far as what our operational priorities are, certainly emergent situations such as a Signal 3 or a Mayday, once sounded, become the operational priority of the center. However, the duty of the center to process and dispatch calls for assistance from the general public is not diminished subsequent to an emergent event involving fire/rescue personnel.

101 Odendhal Ave
Forest Oak Towers
August 16, 2008

To frame the question as, "which is more important, a 911 call or a Mayday," denies the nuances of the situation. The 911 call could be reporting a child not breathing, or a plane that has crashed into a crowded mall, or the first wave in the next terrorist attack. The ECC exists to process 911 calls which includes answering them and is not relieved of that duty when critical events occur.

Whether or not, or even how, the ECC should prioritize the answering of 911 calls over the expressed operator needs of an incident commander is a policy matter beyond the scope of this office.

ECC is a dynamic environment, such that the need to call back personnel is based on the discretion of the floor supervisor. That supervisor must weigh the relative benefit of a call back against the nature, severity, and anticipated duration of a given event. No two situations are alike.

Of course a Mayday or a Signal 3 seem to be obvious situations where the call back should be required, however, each of those incidents have the possibility of speedy resolution. Sometimes affecting the call back reduces resources at the most critical times. While I will not venture to argue that the ECC does not play a role in the effective mitigation of a Mayday I will submit that the incident commander will play the larger role and based on the structure of our communications system should be prepared to manage the Mayday in the absence of an operator.

101 Odendhal Ave
Forest Oak Towers
August 16, 2008

Code Enforcement

Code enforcement was requested to evaluate the building and services. I did understand when I called that the building falls in the City of Gaithersburg and that our Code Enforcement personnel act as liaison for them.

Upon their arrival, I recommended that they contact the City of Gaithersburg. Past experience with the City of Gaithersburg has been very positive. They have come out after hours. Code Enforcements initial response to me was that “they handle City of Gaithersburg matters after hours.” I was already aware of this. However, the next business day was Monday – over 48 hours away. At that point I simply asked them to meet up with the building engineer and give a recommendation. My objectives were to shelter in place and do everything possible to get the folks back in the building. We were in the process of sheltering in place at the time.

Some time later, Code Enforcement returned and expressed reservations of the residents *safely* occupying the building. They were highly concerned about water in the elevator shafts, water coming through light fixtures, and water around electrical panels. Therefore their stance was total evacuation.

At that point and time, all power remained on in the building and no electrical shorts were noticed. I understand that water will seek out the low point through gravity, and it will tend to follow poke-throughs and the like seeking that point. I am not convinced, however, that the electrical system is always compromised.

Therefore – based on Code Enforcement’s assessment, we began Phase 2 of the Incident Action Plan (developed as a contingency) which was total evacuation.

During this process, we lost our prime shelter that was initially chosen (Gaithersburg HS). We also had issued with medications (again 175 disabled elderly residents) and many had pets (family) which they could not take with them to the shelter.

I once again called the Code Enforcement folks to the CP. I also called ECC and had them contact a City of Gaithersburg representative. I advised Code Enforcement to do what ever they had to do to get a City Representative on the scene. I have even used the Gaithersburg City Police to get a rep. Gaithersburg City Police were on the scene.

A short time later a Building Inspector and Electrical Inspector arrived from the City of Gaithersburg.

101 Odendhal Ave
Forest Oak Towers
August 16, 2008

With their assessment and working with Code Enforcement we were able to isolate 20 apartments over 4 floors and allow the remainder back in the building.

We should do everything possible to provide the right service to the customer. If we continued with the initial plan (Phase 2) we would have displaced these occupants the entire weekend. All agencies need to work together and do everything possible to minimize occupant impact. Total evacuation may have been avoided if early contact was made to the City of Gaithersburg.

EMG

Through ECC, I request an EMG representative to help coordinate the relocation of occupants and sheltering. There was no response according to ECC. At that point, I contacted Captain Dement at Station 6 based on BC Goldstein's recommendation. Captain Dement arrived on T706 and acted as liaison with assisting and cooperating agencies to arrange for shelter and services. In addition Captain Dement was very concerned with resident accountability. He obtained a resident list from the manager and used it extensively through Phase 2 and Phase 3 of the incident.

As a Chief Officer in this county this is alarming. What if this was a more serious incident requiring immediate mobilization of the Emergency Management Group? Based on ECC response – summarized below) - ECC had no contact information or EMG according to Captain Bailey. I did brief A/C Donahue on this issue and the Code Enforcement issue on Tuesday August 19, 2008.

Until recently, i.e., the past week or so, there was no codified method for making contact with any EMG personnel. A list has since been distributed that allows for quick contact of key EMG personnel. Any contact problems should resolve with the use of that list.

PIO

I had news stations calling me on the Battalion phone. I would have assumed that the PIO would have shown up. I had BC Goldstein contact ECC and request the PIO. BC Goldstein contacted ECC and the response was “they sent out a page.” BC Goldstein directed ECC to look up Captain Garcia’s phone number in Telestaff and call him. Captain Garcia did arrive on the scene during Phase 3 Operations.

The DOC/ECC should have an on-call list for the PIO with a contact number at all times.

Canteen

I had two canteens on the scene – CT733 and CT708. We actually used one for the residents for light snacks (many were diabetic). Near the termination of the event I retrieved a cup of coffee from CT733. As I was drinking it, Captain Trice said “you wouldn’t be drinking that if you knew where it came from.” When I asked him to elaborate, he said the operator of CT733 used the water out of the coolers housing the drinks to make the coffee. The same water everyone was putting their filthy hands in. Trice said that he said something to the operator and was basically blown off. I immediately discarded the coffee.

Basic food safety training as needed for these canteen operators. Personnel had been handling a number of humans, etc and then reaching for Gatorade. This is unacceptable and very dangerous. I briefed BC Tippett on this issue on Monday August 18th 2008.

General Command and Control

A Task Force was alerted and staged at Station 8 early in the incident but released. The majority of the personnel operating at the scene had no rest during the shift at the time of the alarm. Once I realized the fatigue during labor-intensive Phase 3 of the IAP (reoccupation of the building) it was too late. If I had to do it over again, I would not have released the Task Force. I would have rotated them through the incident.

The reoccupation of the building became an issue. The plan was to allow residents back in the building who could make it back without assistance. Naturally, all residents wanted to go home if they could. Once engaged, I heard units calling for assistance (manpower, stair chairs, etc). Once realized, I

101 Odendhal Ave
Forest Oak Towers
August 16, 2008

requested the LOFR to the command post and reiterated the plan. Those unable to make it own their own were returned to an awaiting bus.

When company officers are assigned the role of Division/Group Supervisor it is important that they keep command informed. If an issue arises and they find themselves in a position where they can not immediately manage their mission, command must be informed. It may be necessary to appoint an alternate until the issue is resolved.

Since the fire was under control quickly, I reassigned companies to geographical and functional areas inconsistent with the Safe Structural Firefighting Policy. This was primarily done to keep companies together (i.e. engine and truck out of the same house working together)

I was very fortunate to have John Epling (volunteer from Gaithersburg) with me in the buggy. He had just completed an ICS course and was able to take care of the tactical work sheet and document the incident chronologically like it was second nature.

Chief 708 acted as advisor on the scene. At some point in time he left without telling the IC. This is an accountability issue.

No two-out was assigned. Just like a fire in any residential high rise there are always life hazards. I did assign the RID to the 8th floor.

Bring your Tennis Shoes

I have always told my folks to bring their street shoes if they are dispatched on a greater alarm for a high rise fire because they would be running the stairs to help Logistics. In this case the first alarm could have used them. Once the fire threat was over, it became a humanitarian effort. The IC has the authority "dress down" or wear less PPE. In Phase 2 and Phase 3 of this incident, a Class C or Class E uniform (with comfortable shoes) was appropriate.

Conducting the labor intensive operations in Phase 2 and Phase 3 of the incident in partial PPE (trousers & boots) further increased firefighter fatigue.

Battalion Chiefs should encourage personnel to carry comfortable clothing with them on the apparatus. It may be as simple throwing your street shoes on the piece when you get dressed. You never know when you will be deployed to perform a task (e.g. wide area evacuation, humanitarian effort in a shelter, etc) that would simply require street clothing.

Ride On

Ride-on was contacted through ECC. They were very responsive and were able to provide three busses in short order. I personally thanked the supervisor on the scene during the demobilization phase.

Firehouse Reports

Many unit reports were inadequate, lacking information on actions taken and assignment in the incident organization. Out of 17 units that played critical roles, 9 of them contained only one or two short sentences. Two of those units were Division/Group Supervisors.

Division/Group Supervisors need list units in their respective division or group and specify actions. For this incident, it should be summary of findings in a geographic area and actions/general group accountability. The majority of units did an outstanding job documenting actions on the requested after action fact sheet. They should be putting that energy in their unit reports.

The report needs to be written so that someone who was not on the incident can understand what occurred.

The issue of effective report writing had been brought up to upper management in the past. While I have a certain standard or benchmark for documentation, it may vary from one officer to the next in our organization. A template or minimum expectations should be developed for fire incident reports. Similar skills are given to EMS providers using Denise Graham's book, "The Missing Protocol – A Legally Defensible Report.

Gordon Graham (no relation) discusses similar matters in a report given to Fire-Rescue West in 2002 (<http://www.gordongraham.com/rules.html>).

Fact Sheet Responses – Obstacles Encountered

(Random entries removing names and unit numbers)

- ❖ *Crowd control was inadequate. Residents of the apartment building were wondering around apparatus, not being monitored before and after being placed on the busses, walking in and out of the building when command ordered an evacuation making it difficult to safely evacuate other residents and confusing for units operating within the structure. In addition, the apartment keys given to divisions operating on different floors were not labeled making it difficult and time consuming to place residents*
- ❖ *The keys that were given to us by the Resident Manager did not unlock several of the apartments.*
- ❖ *Rudeness of Battalions Chiefs and other Command Staff on the radio to group leaders, i.e. the need for additional resources to assist occupants gain access to their apartments on upper levels and groups being on the wrong talk group when it was unclear as to the talk group being used throughout the incident for each group as the incident changed.*

Poor decision by Code Enforcement and EMG not to allow occupants to reoccupy their apartments based on the magnitude of the incident, time of day as it relates to when morning comes and being able to deal with safety deficiencies in the building and not allowing a fire watch to be conducted until safety deficiencies were dealt with.

Lack of resources once the decision was made to allow the occupants to reoccupy their apartments. Very taxing carrying occupants to the 10th floor; some in excess of 350lbs which required 4 personnel on each stair chair and switching crews every two floors.

Placing personnel in a vulnerable position by going through personal belongings and being accused of thief and the employee feeling as though they were not trustworthy until proven otherwise.

- ❖ *We should **not** have gone into apartments to get medications and personal belongings. As you know someone said that money came up missing from their purse and someone from my crew was in this apartment. He was **very** upset over this and should have never been put in this situation.*

- ❖ *FRS personnel did not understand that we had an obligation to maintain a presence on each "floor" since we instructed people to shelter in place*

Key management by management company

- ❖ *Elderly population needed to use restroom facilities. Fortunately, there was a restroom on the first floor, off the lobby, that could be accessed without interfering with fireground operations. If the rest room had not been accessible (e.g. fire in that area of the building), we would have had to bring portable toilets (which we were not prepared to do). Also, the weather was fair; if the weather had been extremely hot or cold, staging the occupants outside the building would have been a challenge, as the occupants of this particular building would have suffered waiting for the Ride-on buses. Furthermore, the elderly occupants needed assistance in going back to their apartments, since the elevators were out of service and they had to go up the stairs, posing a risk of medical incidents.*
- ❖ *Very labor intense operation. Large amount of time and resources needed to move building. Gaining entry to fire alarm room comb changed, was advised latter that new comb was in bottom of Knox box but unable to confirm.*
- ❖ *The high floors that people needed to be carried to.*
- ❖ *People were not properly screened upon returning to the building to determine what apartments they occupied. Also, the FD was taking non ambulatory occupants back into the building after being advised not to.*
- ❖ *Initially overall coordination of relocating residents. Assessment of the situation was hampered by gaining access to the fire apartment and surrounding areas that were affected. Code enforcement initially deemed the entire building uninhabitable. After efforts were made to provide housing for the affected residents, enforcement then allowed only the residents not affected by the fire, smoke and water were allowed back in the building.*

In my opinion, there was a lengthy delay in providing the ability to shelter the residents. Weather forecasting had possible thunderstorms in the area. Most of the residents were elderly with various medical conditions requiring supportive care. A point person should be appointed and given the responsibility to develop contingency plans and contacts lists should this type of event occur. Amer Red Cross was a great help. However, not sure what their extent of assistance is.

101 Odendhal Ave
Forest Oak Towers
August 16, 2008

- ❖ *The overall complications observed and expressed to me by the personnel were they were exhausted in this task and that stair chairs are normally designed to move patients from an elevated position to a lowering position.*

Ferno Stair Chairs weigh 33 pounds and are designed with an assistance guide track that allows the members to have weight disturbed in a central downward location. The hand grip locations on the stair chair are designed to provide a center of gravity position and keep the weight closer to the provider making the occurrence of injury minimal. Having the provider use the stair chair in a lifting position keeps the provider's body in an outreach position distributing the weight further away from their body. Without the use of the tracks the provider is forced to handle the full weight capacity.

Insufficient manpower for the assignment in returning citizens to their residency in upper divisions. This was noticed by our personnel and radioed to command that we had to use Medic 731 and Ambulance 708 personnel to return this patient. Later on I heard other companies expressing the same situation a similar plan had to be devised to accomplish the same task.

- ❖ *A multitude of non ambulatory patients. Wheel chair bound or could not walk long distances.*

The keys in the lock box not labeled with the apartment numbers.

Final Thoughts

With the resources this county has to offer it should not be this difficult to coordinate an incident of this magnitude. Contact lists need to be maintained and key personnel and stakeholders should be easy to contact at any given hour. Disasters sometimes do not occur Monday through Friday from 9 to 5. This was a county facility with nearly 200 vulnerable elderly residents. We may have family or friends in one of these facilities. I may even be in one of these facilities one day. Shouldn't we operate seamlessly?

This was a very challenging event. I have to attribute the success of the incident on talented, well-trained officers. I could not have requested a better team – experienced in Logistics, Planning and basic customer service. I was fortunate to have many folks from various US&R disciplines on the scene as well. They bring a wealth of knowledge to the incident. Former Council member Mike Subin was also on the scene (as a US&R member) and provided input to Command and Operations.

40

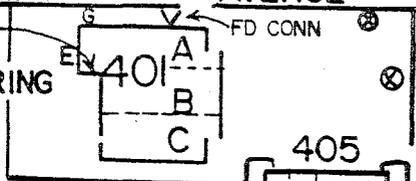
MONTGOMERY AVENUE

AVENUE

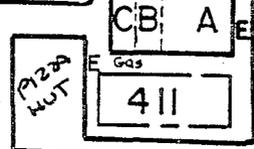
Ladder to Roof in 401 A

FD CONN

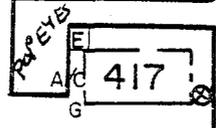
401 B-BOWSTRING TRUSS ROOF



405



411

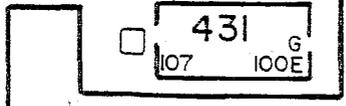


417



425

425 'A' UPSTAIRS G
425 BUS. ENTER SIDE 4

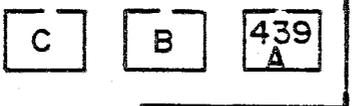


431

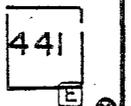
DALAMAR ST

NORTH FREDERICK AVENUE

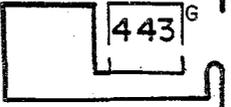
430



439



441



443

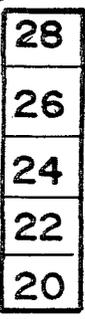
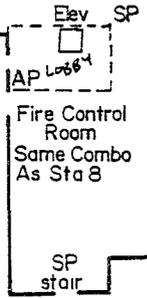
444

Appendix A

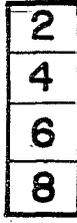
SEE MAP 40A

FD Conn

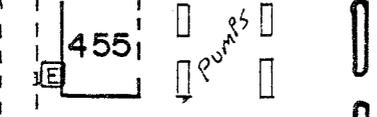
101 ODENHAL AVE



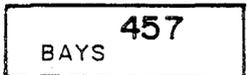
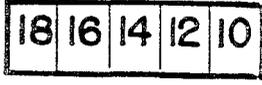
WHETSTONE DRIVE



451



455



457

ODENHAL AVENUE

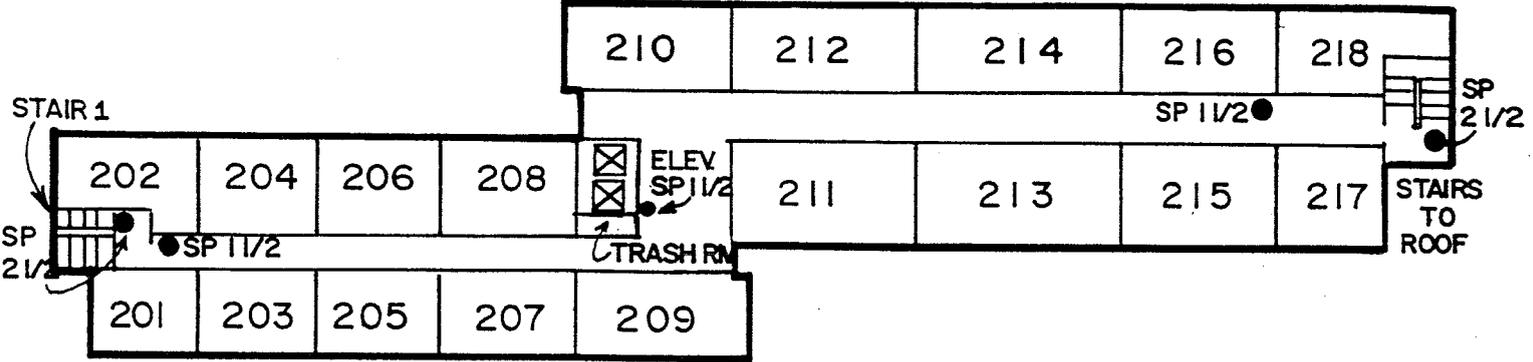
AVENUE

HANSON
REV 9/89

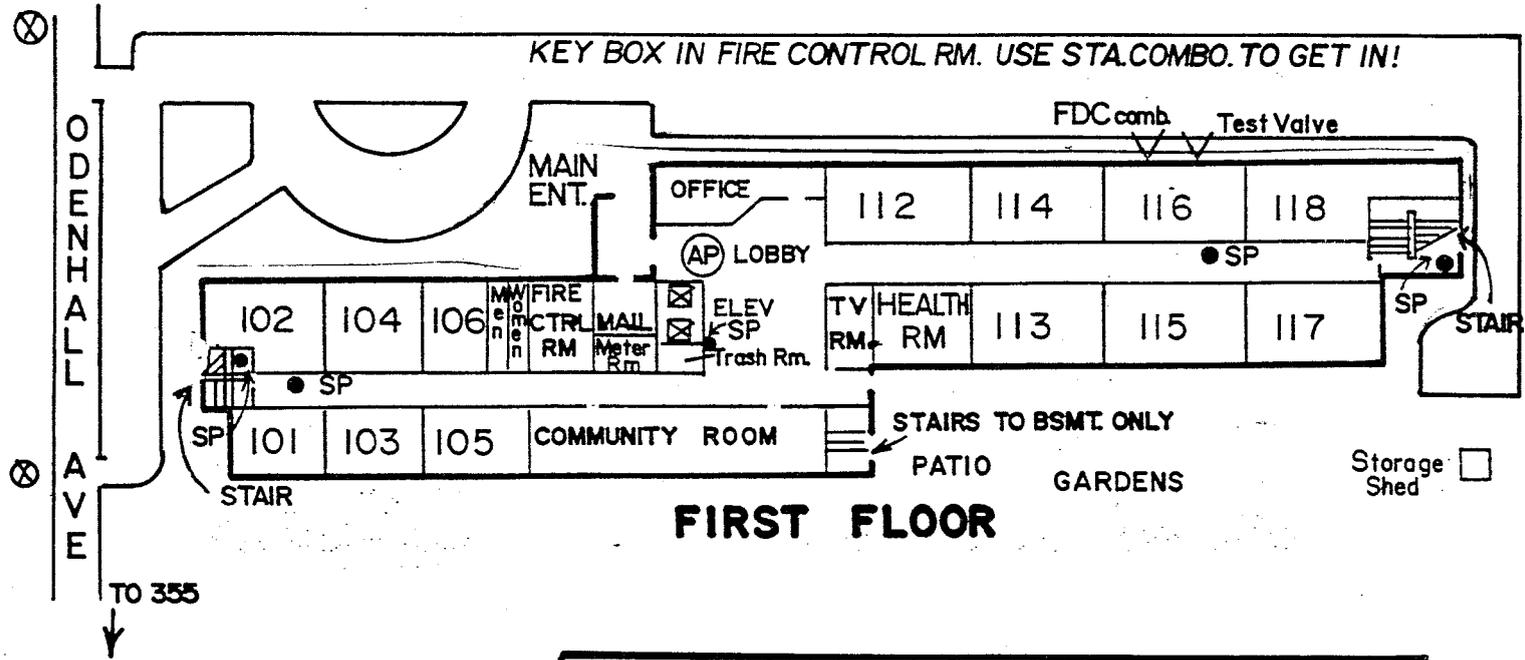
101 ODEN'HALL AVE 40-A

FOREST OAK TOWERS

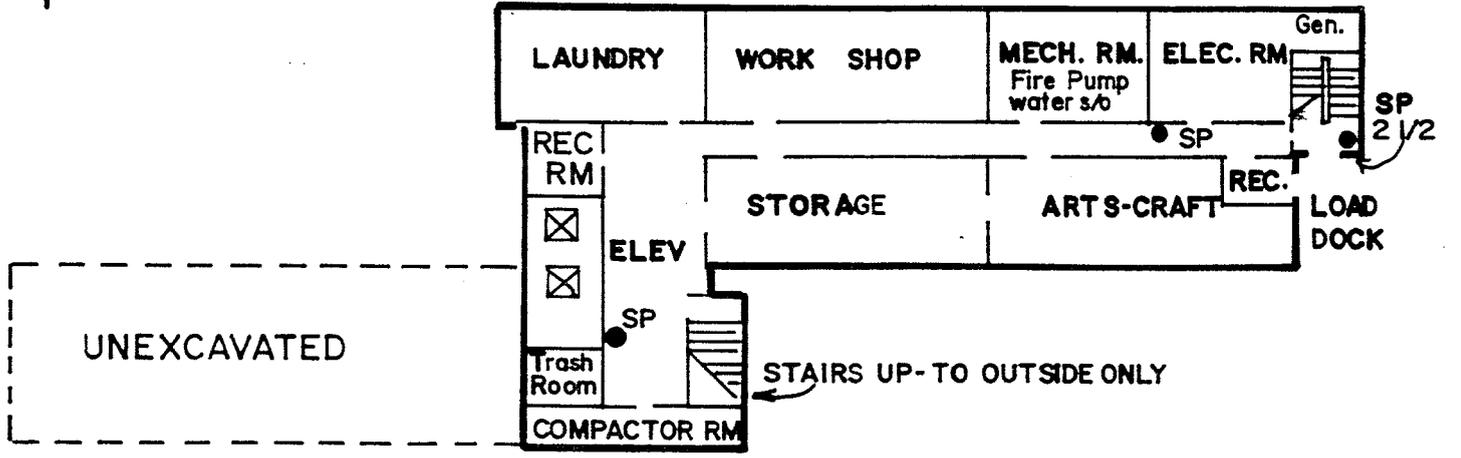
Appendix B



FLOORS 2-10



FIRST FLOOR



BASEMENT

UNEXCAVATED

GIS Ortho Photo - Building



Appendix C

Appendix D

 Maryland Department of Assessments and Taxation MONTGOMERY COUNTY Real Property Data Search (2007 vw5.1)	Go Back View Map New Search
--	---

Account Identifier: District - 09 Account Number - 02007753

Owner Information

Owner Name: FOREST OAK TOWERS LTD PTNSHP	Use: EXEMPT COMMERCIAL
Mailing Address: C/O REALTY MNGMNT SERVICES INC 7910 WOODMONT AVE STE 350 BETHESDA MD 20814-7013	Principal Residence: NO Deed Reference: 1) /34070/ 228 2)

Location & Structure Information

Premises Address 101 ODENDHAL AVE GAITHERSBURG 20877	Legal Description PAR B WHETSTONE
---	---

Map	Grid	Parcel	Sub District	Subdivision	Section	Block	Lot	Assessment Area	Plat No:	13087
FT42		N338		201				3	Plat Ref:	

Special Tax Areas	Town Ad Valorem Tax Class	GAITHERSBURG 49
--------------------------	--	--------------------

Primary Structure Built	Enclosed Area	Property Land Area	County Use
1981		139,324.00 SF	113

Stories	Basement	Type	Exterior

Value Information

	Base Value	Value			Phase-in Assessments		
		As Of	As Of	As Of	As Of	As Of	As Of
		01/01/2006	07/01/2008	07/01/2009			
Land	3,850,000	3,850,000					
Improvements:	13,569,000	13,569,000					
Total:	17,419,000	17,419,000	17,419,000	NOT AVAIL			
Preferential Land:	0	0	0	NOT AVAIL			

Transfer Information

Seller: FOREST OAK LTD PARTNERSHIP	Date: 04/02/2007	Price: \$20,700,000
Type: IMPROVED ARMS-LENGTH	Deed1: /34070/ 228	Deed2:
Seller:	Date: 09/19/1980	Price: \$0
Type: IMPROVED ARMS-LENGTH	Deed1: / 5578/ 766	Deed2:
Seller:	Date:	Price:
Type:	Deed1:	Deed2:

Exemption Information

Partial Exempt Assessments	Class	07/01/2008	07/01/2009
County	000	0	0
State	000	0	0
Municipal	000	0	0

Tax Exempt: COUNTY AND STATE	Special Tax Recapture:
Exempt Class: HOUSING AUTHORITY	* NONE *

101 Odend'Hal Ave
 August 16, 2008
 Report Completion Summary

Appendix E

Report Updated	Responsibility	Sta/Shift	UR Complete?	Read Receipt	2nd Notice	Fact Sheet	Alarm	Pos Due
Incident Report	Reid	Batt5B	Y	Y				
COMMAND								
BC703	Goldstein	EOB/D	Y	Y		Y	1	2
BC705	Reid	BATT5/B	Y	Y		Y	1	1
C703D	Leusch	3V	Y	Y		Y	1	
C708	Luper	8V	Y	N	Y	Y	1	
EMS703	Lofland	9A	Y	N		Y	1	
ENGINES								
E703	Bucholz	3B	Y				TF	
E708	Poole	8B	Y	Y		Y	1	1
EW717	Magruder	17V	Y				TF	
E753	Clary	53	Y	Y		Y	1	2
E728	Witt	28B	Y	Y	Y	Y	1	5
E729	Trice	29B	Y	Y		Y	1	4
E731	Williamson	PSTAD	Y	Y		Y	1	3
TRUCKS								
T706	DeMent	6B	Y	N		N	SPEC	
T731	Crawford	17B	Y	Y		Y	1	2
AT703	Polikoff	3B	Y	deleted		Y	RID	
AT708	Jamsa	28C	Y	N		Y	1	1
AT729	Triplett	29B	Y	Y		Y	1	3
AT735	Cochran	35B	Y				TF	
RESCUE SQUADS								
RS717	Gaskel	17V	Y	N		N	1	1
RS729	Gartner	29B	Y	Y		Y	RID	
EMS UNITS								
A708	Rosario	8B	Y	N		Y	1	1
M708	Schwab	8B	Y	N		Y	RID	
M731	Burger	31B	Y	Y		Y	SPEC	
MISC								
AR733		BATT3B	Y				TF	
CT733	Thomas		Y				TF	
CT708			Y				TF	
FM51	Hsu	FEI	Y					
FM62	Maxwell	FEI	Y					
FM31		FCE	Y					
FM								
ECC SUP	Better	ECC	N/A					

18Y20