8509 Scarboro Court
Box Area 33-05
April 24, 2011
House Fire with Civilian Death
Incident Number 11-0044722

Submitted by Battalion Chief Barry C. Reid
Incident Commander

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On April 24, 2011 at 04:35 units were dispatched for a house fire to the rear of 10416 Gainsborough Court. While units were en route, the Emergency Communications Center (ECC) received additional information placing the incident at 8505 or 8509 Scarboro Court.

Units were following appropriate SOPs and communicated water supply instructions for the revised address on Scarboro Court. At 04:41, Engine 733 arrived and reported a two-story house with fire and smoke visible at the front door. The address was confirmed (8509 Scarboro Court), command was established in the attack mode, and the appropriate accountability report was transmitted.

Units began an aggressive interior attack on the fire which was located in Quadrants C and D on the first floor. During the initial attack, water supply issues were reported by the primary attack engine (Engine 733). The primary supply line had been caught up in the wheels of T710 and was rendered out of service (1). Engine 726 and Engine 730 developed an alternate water supply for Engine 733. This allowed Engine 733 to safely continue their mission which was fire attack.

Battalion Chief 703 arrived at 04:51 and assumed the command. The command post was located nearly a block away behind other apparatus. Since the command post was a distance away, Battalion Chief 702 was assigned to give command an operating picture, including building, geographical and functional features present.

Command confirmed personnel and unit accountability and verified that SOP's were being followed (2). A Task Force was requested and the Rapid Intervention Dispatch was already en route.

At 04:58, Safety 700 reported that he found a victim on the second floor. Units were immediately deployed to assist with the removal and treatment of same. The Rapid Intervention Group (RIG) medic unit (M730), which was not yet on the scene, was assigned to care for the patient. Once the delay was known, an AFRA medic was assigned to assist. Another medic unit was requested to fill out the RIG.

After removing the unresponsive occupant, command requested a report by divisions on the results of completed searched. All were confirmed negative shortly after 05:00.

The victim on the second floor was transported to Suburban Hospital where he was pronounced. According to investigators, he had suffered significant burns from high-heat but not direct flame contact. The cause of death was later determined to be smoke inhalation.

It was also determined that a friend of the deceased was in the home at the time of the fire. First arriving units observed a number of bystanders near the scene but none gave any immediate indication that they were in the fire building. Nor did anyone indicate that there was someone still in the fire building. It was later determined that the survivor was sleeping in the basement, woke up and smelled smoke then exited through the basement garage. He was also transported to the hospital for a check up.

At daybreak, command was transferred to Battalion Chief 703B and a relief plan was in place to switch out B-Shift for C-Shift personnel. A small contingency of units remained to complete overhaul and assist Fire and Explosives Investigators.

Property Information:

Year Built: 1972
Construction: Ordinary
2 stories with a basement
Enclosed Area: 3,000 sq. ft.
Property Value: $844,400

Loss: $400,000

Concerns and Recommendations

As with every incident, there is room for improvement. This event was challenging from the time of dispatch. The first alarm made timely and efficient adjustments when the location was verified, an aggressive attack was made and the fire was quickly extinguished. A victim was discovered on the second floor, treated, but was tragically pronounced shortly after arriving at the hospital. With the intensity of the fire and the delayed alarm, the victim had succumbed to injuries before the arrival of fire/rescue.

While no firefighters sustained injury, issues that follow did produce conditions that could have resulted in firefighter injury, delayed task completion, and developed personnel accountability concerns. These issues were collected by personal observation, experience, interviews, incident audio and post-incident documentation. Recommendations are offered in blue.

(1) The primary supply line became entangled under T710 – picked up by the duel wheels.

The miscue with T710 also crippled the truck. As the truck attempted to proceed, the hose became wrapped around the axle and it literally began pulling the hydrant out of the ground. The truck was unable to take a tactical position, it blocked out other apparatus, and two of the three crew members became focused on removing the supply line. This delayed key tactical activities that were required.

The rig was blocking the road making limited tactical impact. Ladders, tools and equipment had to be carried further and the aerial would not reach the target dwelling. With the residential street was impassable, the second truck (AT723) had to park West of Scarboro Lane.

The driver and tiller of T710 became focused on removing the hose while the officer proceeded to the fire building. On self-admission,

T710's officer entered the building alone and began following the SOP (1st Truck – Fire Floor). T710's officer then proceeded to the second floor – encountering E730 on the stairs. T710 and E730 came back down the stairs when they heard water supply issues over the radio for E733.

Rapid horizontal ventilation still had not occurred at this point. With the building of ordinary construction, it was holding heat like an oven. T710's officer then grabbed a hook off of E733 and began taking out windows. RS741 was directed by SA700 to assist in vent and AT723 and the RIC (E730) had to ladder Side A and their required Side C.

The mishap of T710 started a domino effect that delayed necessary tactics to prepare the building for safe firefighter operations and a search. The driver and tiller became focused on removing the hose line, removing themselves from their assigned tasks and never informing command of situation. Other units had to complete tasks required by the first truck including "rapid horizontal ventilation," "laddering Side A, "etc.

The contribution of special services can not be over emphasized. It is understandable to try to fix your mistake. During the entire process, it was never directly mentioned (by radio) the cause of the interrupted water supply. E726 mentioned that the hydrant was OOS. E733's driver is warning crews of the impending dry spell. E726's driver did the right thing by hand-laying a line to give them a safety net with their tank water then E730's driver also provided E733 with water and ultimately an uninterrupted water supply.

Straddling a supply line takes skill and coordination to do it effectively. On a curvy residential street it also takes additional time. It may take less time to get a couple of people and move the supply line to the side of the road (as directed in a rural incident). The officer could have also dismounted and guided T710 to avoid the hose.

Tactics still must be completed. Once it was realized that the hose was a lost cause, make a radio announcement and work around it. T710 should have continued with their assigned task.

The officer on T710 violated Policy 26-04 Section 5B by entering an IDLH alone. Personnel must enter and work in pairs. With a three-person truck it will require predetermined roles before the incident (2 in / 1 out).

(2) As mentioned above, with exception of T710, personnel began tasks based on SOPs. The first engine transmitted water supply instructions and an excellent initial on scene report (IOSR), including an accountability report required by Policy 26-04. E733 also established command in the attack mode. The officer proceeded with a circle check. The fourth engine (E730) also completed a circle check and reported conditions on Side C.

There was no indication of anyone trapped. One miscue by E733 was the failure to verbally assign a two-out. However, by the time he completed his circle check, other resources had arrived and were present at the point of entry when E733 entered for attack and had command in the attack mode.

The first arriving company that assumes command MUST assign a two out and this information must be transmitted over the radio. One person must be in position to monitor the crew entering the IDLH before entry is made.

The incident with the supply line and T710 required others to complete those additional tasks that were required by that unit. AT723 and E730 (RIC) had to throw ladders on Side A, RS741 was directed by SA700 to take out the windows on the second floor. This may have delayed that unit's primary role of a systematic search.

Safety 700 (SA700) arrived on the scene at 04:49 according to CAD records. According to written documents, SA700 arrived and operated as ISO (Incident Safety Officer). He completed his exterior survey and then entered Side D of the structure alone, documenting he was evaluating the layout of the second floor. It is noted that an IDLH did exist. During this evaluation, it is documented that SA700 began a left hand search pattern and found the victim.

Command had been established by E733 until the arrival of BC703 at 04:51. SA700 failed to report to command and advise he was on the scene.

Once SA700 entered the structure, he was violating numerous sections of Policy 26-04, Personnel and Unit Accountability Systems.

The Safety Officer Position is assigned – not assumed. By definition, the Safety Officer is a member of the Command Staff responsible for

monitoring and assessing safety hazards and unsafe situations and for developing measures for ensuring personnel safety. Lack of clear procedures for the assigned county safety officer compounds issues. Roles, responsibilities, and duties on the fireground seem to vary among those individuals filling the roles. A checklist was established by Assitant Chief Nelson (Safety Chief) when he was the sole safety officer in the county (see attachment). Regardless, any Field Operations Guide (FOG) on any key staff position requires the individual to check in with the supervisor before engaging.

As an incident commander, I would expect Command and General Staff to lead by example. In this particular case, the individual was violating what he should have been preventing.

Summary

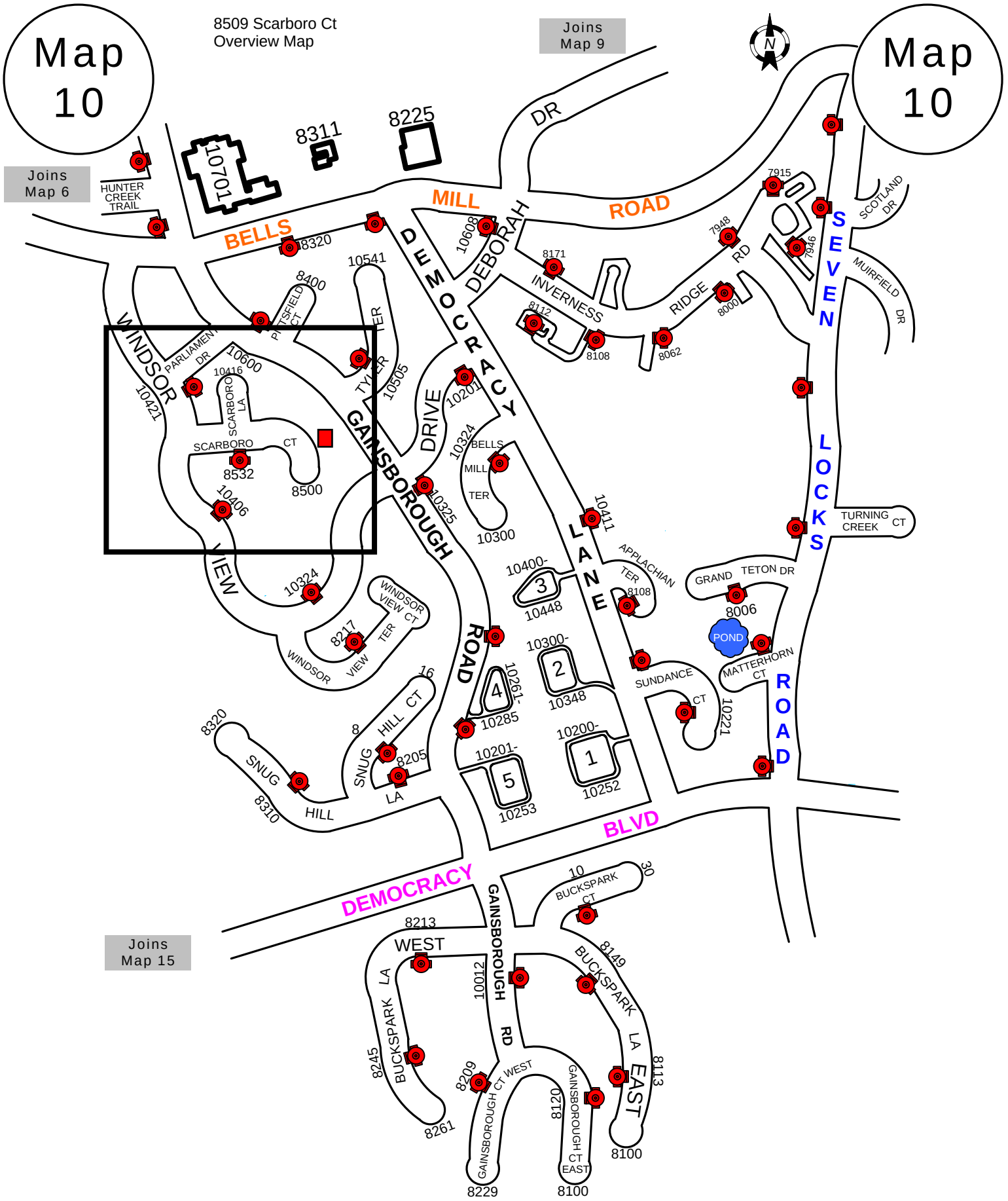
Personnel overcame a number of obstacles to successfully mitigate this incident. A change in dispatched location, delayed alarm, and a mishap with the water supply was no match for the skill and fast-thinking crews.

Loss of focus, mission creep, and the inability to stay in one's lane may have led to further disaster due to lack of accountability, incomplete tasks, and free-lancing. Unfortunately the resident perished in the fire but issues addressed within this document were not a factor in his death.

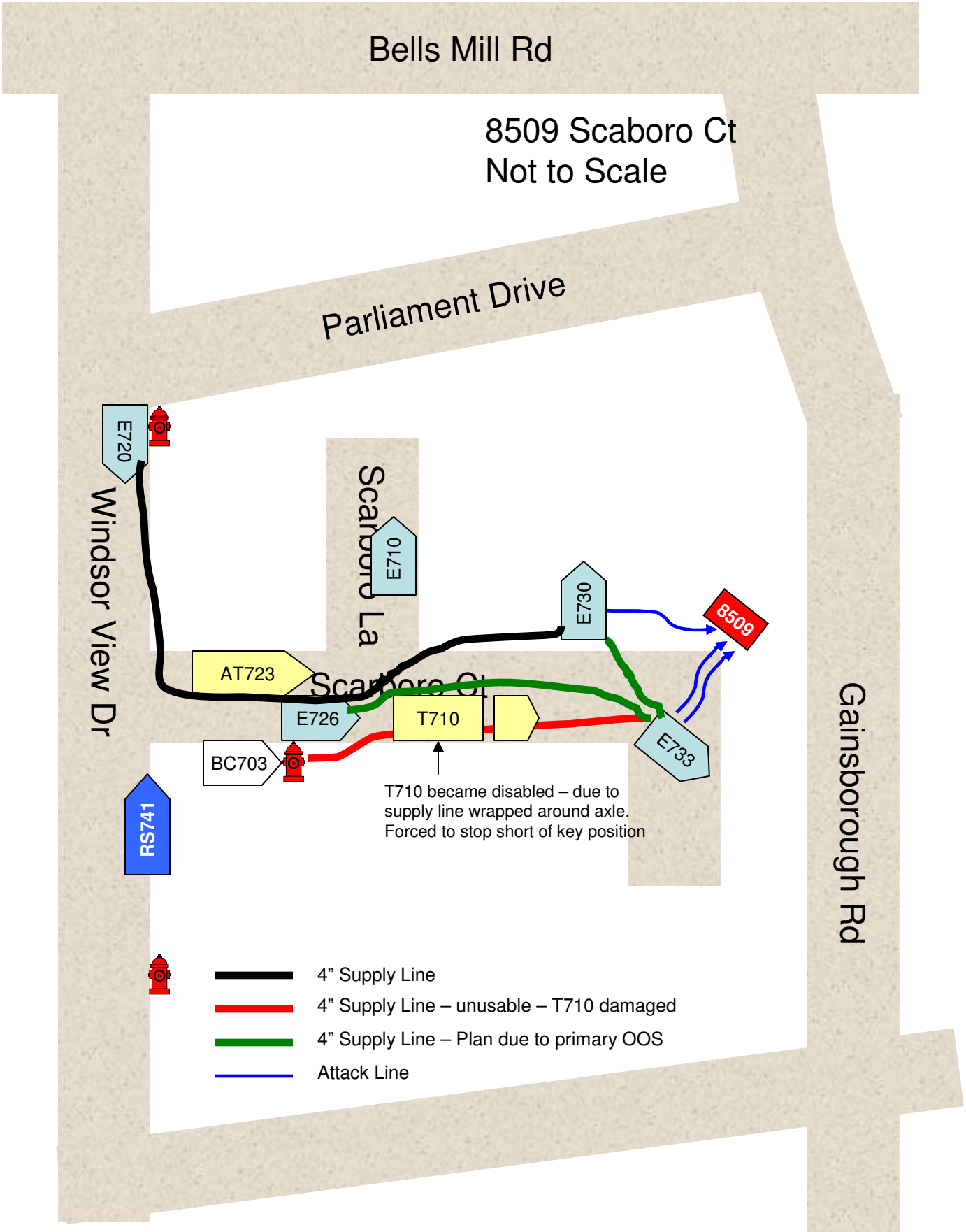
By bringing these issues to bear and applying lessons learned, I have confidence that similar miscues will be avoided in the future.

Signature Not Verified

Digitally signed by Barry C. Reid
Date: 2011.07.20 10:36:24 EDT
Reason: I am the author of this document
Location: Rockville, Maryland



Drawn by:	**CAPT CHRIS STROUP**
Station: **33**	Date drawn: **1/2006**


Bells Mill Rd
8509 Scaboro Ct
Not to Scale
Parliament Drive
Windsor View Dr
Scaboro La
Gainsborough Rd
E720
E710
E730
8509
AT723
Scaboro Ct
E726
T710
E733
BC703
RS741
T710 became disabled – due to
supply line wrapped around axle.
Forced to stop short of key position
4" Supply Line
4" Supply Line – unusable – T710 damaged
4" Supply Line – Plan due to primary OOS
Attack Line

MONTGOMERY COUNTY FIRE AND RESCUE SERVICE

MCFRS SAFETY OFFICER CHECK-LIST

FIRE INCIDENTS

Incident #_____ Location: _____ Date:_____

_____ ISO wearing appropriate protective clothing /equipment, including safety vest.

_____ Accountability tag given to IC.

_____ Face-to-face briefing with IC.

_____ Understand the IC's incident action plan (IAP).

_____ Ensure suitable, safe command post is set up and visible.

_____ Ensure Incident Management System (IMS) is in place.

_____ Develop and implement an incident safety plan.

_____ Perform a 360 – degree circle check of incident.

_____ Ensure appropriate use of PPE & SCBA, as needed, by all personnel.

_____ Conduct rapid emergency incident risk analysis.

- _____ Risk a lot only to save a lot.
- _____ Risk a little to save a little.
- _____ Risk nothing to save what is already lost.

_____ Ensure appropriate safety zones are set up (collapse, etc.).

_____ Ensure rapid intervention company (RIC) is in place and briefed.

_____ Ensure Accountability is in place.

_____ Ensure provisions for rehab group have been made.

Montgomery County Fire and Rescue Service

101 Monroe Street, 12th floor; Rockville, Maryland 20850-2589, 240-777-2469, TDD **240/777**-4625, FAX 240/777-2443
Service with dedication, courage and compassion

_____ Monitor atmosphere for use of SCBA by crews (35 ppm for CO Level ____).

_____ Consider the need for additional ISO's.

_____ Ensure that all personnel know the level of operation.

_____ Offensive

_____ Defensive (time:_____)

_____ Monitor fire conditions.

_____ Increasing

_____ Decreasing

_____ Monitor structural conditions.

_____ ID Building construction indicators. (Type I, II, III, IV, or V)

_____ Ensure crew integrity (**NO FREELANCING**)

_____ Ensure roof operations are supervised.

_____ Ensure second means of egress for interior/roof crews.

_____ Ensure utilities are secured.

_____ Ensure crews go to rehab.

_____ CISM in cases of fatal fire or serious FD injury

_____ Other issues not covered (specify):

_____

_____

Notes/comments or Post Incident Analysis (PIA) issues (positive & negative)

Benchmarks (minutes)

10 20 30 40 50 60 70 80 90