National Fire Fighter Near-Miss Reporting System
Reports Related to Emergency Evacuation

Report Number: 06-0000309
Report Date: 06/01/2006 1521

Demographics
Department type: Paid Municipal
Job or rank: Lieutenant
Department shift: Other: 24on, 24off, 24on, 24off, 24on, 96off
Age: 43 - 51
Years of fire service experience: 27 - 30
Region: FEMA Region V
Service Area: Suburban

Event Information
Event type: Fire emergency event: structure fire, vehicle fire, wildland fire, etc.
Event date and time: 02/25/1994 1456
Hours into the shift: 5 - 8
Event participation: Involved in the event
Weather at time of event:
Do you think this will happen again? Uncertain
What do you believe caused the event?

- Situational Awareness
- Command
- Decision Making

What do you believe is the loss potential?

- Lost time injury
- Life threatening injury
- Minor injury

Event Description
(Store name deleted) Fire February 25, 1994 Incident time: 14:56 hours. The weather was cold with snow, but it had little to do with the near miss. The building was a pole barn type structure. The on-duty shift of six personnel was dispatched for a furnace fire, possible explosion, in the warehouse area. An off-duty captain in the area reported a working fire and requested the normal recall of all off-duty personnel. Staffing is normally a large problem in our department and additional help was called. Three other departments assisted during the incident. The first-in shift found the building hot and fully charged with smoke. A ventilation hole was cut early and an interior attack was made. As more help arrived, off-duty personnel also made interior attack. The fire was extremely hot and the interior crews were taking a beating. Six other firefighters and I were inside, operating two 1 3/4" handlines and one 2 1/2" handline near an overhead doorway leading from the front half of the warehouse into the rear half of the warehouse, close to the seat of the fire. I became more uncomfortable with our situation as we were fighting a losing battle. I communicated my thoughts to my usual partner and he was just doing the same thing to the others inside, having arrived at the same conclusion. As we were relaying the plan to get out, which all of us agreed to, and were making sure we would leave no one behind, the evacuation air horns sounded at the same instant the roof came down upon us. Miraculously to us, none of us were seriously injured

and we began to really scramble to exit together. The event happened very fast, and we were all about half shocked and half focused on our exit plan. Our initial exit route was blocked by the downed roof. We were unable to follow our hoselines out due to the debris. A couple of us saw a dim light about 90 degrees from our intended exit. We followed the light through the debris until we realized it was a partially open overhead door to the outside. We all exited together safely, feeling very fortunate to be alive. Our lieutenant on the outside, who had collected our (accountability) tags, verified we were all accounted for. We discovered later that this lieutenant was the one that sounded the evacuation signal and that the IC had not identified the impending collapse. The IC also did not believe that an emergency evacuation was necessary. This was a factor in the late signal to evacuate, rather than an earlier warning. The lieutenant could not afford to debate any longer and sounded the signal as the roof came down. We also discovered later that the only reason we were not injured more than bumps and bruises was that the roof in our area fell upon a parked forklift to our left side, and vertically stacked carpet rolls to our right. This created a small umbrella area under which we were spared the bulk of the roof load.

Lessons Learned

Accountability is a huge issue. It must be performed and not be allowed to become a forgotten task. Communication between crews is imperative, both inside and outside. Crew Resource Management may have helped the lieutenant and IC to communicate better and make the correct decision sooner rather than later. Ongoing situational awareness should be performed by all on scene, and observations communicated. In this situation, the interior crews were nearly as adept at reading the situation in the hazard area as those outside. Expanding the Incident Command System is a problem in poorly staffed departments. There are simply too many jobs to do initially. The ICS expands later as staffing approaches recommended levels, but staffing shortages early lead to an overburdened ICS. This staffing shortage produces mistakes and a reduction in safety. The building responded just as we have been trained. After being subjected to heavy fire, this steel pole type building with wood trusses failed. It should have been anticipated and prepared for. The crews inside should not be the ones who decide when it is time to exit.

Report Number: 07-0000736
Report Date: 02/20/2007 2136

Demographics
Department type: Volunteer
Job or rank: Captain
Department shift:
Age: 34 - 42
Years of fire service experience: 21 - 23
Region: FEMA Region I
Service Area:

Event Information
Event type: Fire emergency event: structure fire, vehicle fire, wildland fire, etc.
Event date and time: 07/16/2006 0100
Hours into the shift:
Event participation: Involved in the event
Weather at time of event: Clear and Dry
Do you think this will happen again? Uncertain
What do you believe caused the event?

- Teamwork
- Human Error
- Training Issue
- Situational Awareness
- Communication

What do you believe is the loss potential?

- Life threatening injury

Event Description
We arrived on the scene to find fire on the third floor of the structure. I entered the structure as a member of the search crew with the attack crew following shortly behind us. The floor layout and placement of furniture hindered the attack crew in finding the seat of the fire. After completing our search we assisted the attack crew in locating the fire. Because of the fire load and a lack of rapid ventilation, conditions started to deteriorate and an evacuation was called. During the evacuation someone proceeded past me and started ventilating a window. I attempted to catch up with the FF but was unsuccessful in reaching him. I wanted to contact him to make sure he knew that an evacuation had been ordered. I decided to wait but my low air alarm started to sound. After a long wait, I decided to change my location to the top of the stairwell. When I attempted to move in the direction of the stairs, I realized I was lost. I became disorientated attempting to catch the firefighter that advanced ahead of the crew. I started skip breathing and called a mayday. Since we were operating on our dispatch frequency my mayday was walked over by a dispatching department. I attempted to find a window on an outside wall when I realized I was in a walk-in closet. I started thinking, “I can't believe I got myself into this.” I eventually found my exit after breaching a wall. I found the room that I started in at the top of the stairwell and made contact with the crew that was

looking for me. I was able to exit on breathing air but the firefighter that advanced during the evacuation exited the building without my knowledge.

Lessons Learned

Crew integrity is imperative and freelancing should never be tolerated. Evacuation procedures should be followed by everyone for their safety and their brother's safety. Dispatch frequencies should be separate from fire ground and interior operations. Ventilation should be coordinated with fire attack. When the unexpected happens make sure you know where you are, how you got there and remember how to get out.

Report Number: 08-0000151
Report Date: 03/20/2008 1150

Demographics
Department type: Volunteer
Job or rank: Safety Officer
Department shift: Respond from home
Age: 34 - 42
Years of fire service experience: 17 - 20
Region: FEMA Region III
Service Area: Suburban

Event Information
Event type: Fire emergency event: structure fire, vehicle fire, wildland fire, etc.
Event date and time: 03/18/2008 1230
Hours into the shift: 5 - 8
Event participation: Told of event, but neither involved nor witnessed event
Weather at time of event: Clear and Dry
Do you think this will happen again? Yes
What do you believe caused the event?

- Protocol
- Accountability
- Individual Action
- Command
- SOP / SOG

What do you believe is the loss potential?

- Lost time injury
- Life threatening injury

Event Description
First arriving unit went on the scene of a single family structure, and reported a working fire, with heavy fire Quad B, Division 2. Attack crews advanced lines into the structure to attack the fire. Approximately 5-10 min. into the operation a F/F notified IC that the roof was collapsing on the second floor and that he had self-extricated himself via a second floor window, and to have communications hit the evacuation alarm due to severe structural damage Quad B, Division 2. It took approx. 3-4 min. for the IC to notify communications to sound the evacuation alarm, due to heavy radio traffic, then after it was sounded, several crew members in the structure did not evacuate, but told the IC they had a knockdown on the fire. The IC advised them they still had heavy fire coming through the roof, and to evacuate. They did not evacuate the structure, but insisted they had a knockdown on the fire, then approx. 5 min after the first evacuation alarm, the IC advised communications to sound it again. This time all F/F's evacuated the structure.

Lessons Learned
I believe no lesson was learned from this incident. A complete investigation of the incident needs to be done by our County, and the personnel involved need to be held accountable for

their actions. Our communication center tests the evacuation alarm once a month on a Monday night at 1900 hrs., and gives oral instructions after this test to advise all stations and personnel what is to be done in the event a structure/incident has to be evacuated in an emergency situation.