CIRMA

Hot Zone Series
for Fire Services

May 2018

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July 2017

Planning Training Exercises

Background

The injured worker, a paid firefighter with 16 years of service, sustained an injury while performing an extrication training exercise.

The injury occurred during a planned extrication drill that required the set up and use of hydraulic rams. Because the department had several calls for service that day, the training officer did not have the time to establish a formal written training plan or perform a safety review of the training. The extrication drill took place in a sloped and sandy parking lot, using a donated vehicle with four different sized tires.

The training officer, being conscious of the shift hours and trying to save on overtime expenses, asked the Engine Company members to perform a training evolution before the end of their shift. The Engine Company accommodated the request and began the extrication of a "victim" from the vehicle. Because the training officer was called to another meeting, he asked the engine officer, a Lieutenant, to oversee the training. The Engine Company officer directed the injured worker to set up the hydraulic rams and begin "rolling" the dashboard. In an effort to complete the evolution expeditiously, the injured worker did not properly secure the rams and did not "size up the scene and ensure scene safety" – noting the vehicle had four tires of all different sizes and was located on a slope with sand underneath the tires. As the injured worker began to engage the rams, the vehicle began to slip, causing the rams to disengage from the vehicle. In an effort to prevent the rams from falling onto his legs, the injured worker reached out abruptly to catch the rams. He then slipped and twisted his back, immediately felt the onset of lower back pain, which radiated down his right leg. The incident was reported immediately to the Engine Lieutenant and the injured employee was directed to be seen by the department's Initial Care Provider. He was placed on temporary total disability and diagnosed with an acute lower-back sprain.

The injured worker was later evaluated by an orthopedic physician, given a referral for a short course of physical therapy, and released for transitional duty. Subsequently, while descending stairs at home, his right leg gave way, causing him to fall down the steps. He was admitted to the hospital, where admitted for four days. Post discharge, the injured continued to experience leg pain with associated numbness and tingling. Following a 16-week period of transitional duty, pain management treatment, and physical therapy, a surgical recommendation was made to address his lumbar issues, which the injured worker declined.

Prior to this injury, the injured worker had experienced eight prior work-related lower back injuries, the most significant necessitated a lumbar spine decompression surgery and two lumbar spine fusions. A 38% permanent partial disability rating was given following his surgeries.

Investigation and Damages/Injury

The Fire Chief and department administration confirmed that the injury occurred on a training assignment which the Fire Company was directing.

There was insufficient planning for this drill, as a formal written training curriculum and safety plan were not drafted, and a lack of supervision. There were also hazardous actions performed by each member of the engine company as they were all "rushed" to complete the training before the end of the shift.

As a result, neither the Engine Company officer nor the injured employee identified the hazards associated with the scene and did not ensure scene safety prior to starting the evolution.

CIRMA Liability Assessment

CIRMA is 100% responsible for this work-related training claim. The reserves on this claim were significant given the prior history of work-related lower back injuries, surgeries, and pre-existing medical conditions. Although the injured worker eventually resumed working in a full duty capacity, there was significant future exposure in the event another low back injury were to occur. Given the future exposure, CIRMA settled this case on a full and final, global basis. The total cost of this claim was over $350,000.

Key Recommendations

1. Training should be pre-planned, include objectives, and incorporate both functional and cognitive skills. The planning should include a step-by-step process in achieving the training goals, including steps to avoid injury.
2. A training checklist should be completed to support all steps of the training, to include attendance, accountability, placement of safety officer, start and end times, whether training is hazardous.

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3. The training site and any objects or items should be free from sand and debris. The tires on the vehicle should match or be deflated to ensure stability.
4. Staff should be briefed on training expectations and intended results.
5. All potential safety issues should be identified and reviewed.
6. Equipment and operations should be inspected prior to use.
7. The senior member, the one with the most knowledge, should assist in providing direction to the junior member, person learning the procedure, in the placement of tools.

For more information, please contact George Tammaro, Risk Management Services Manager at CIRMA, (203) 946-3700 or gtammaro@ccm-ct.org.

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Operational Awareness

Background

The claimant is a 50 year-old Chief of a volunteer fire department. While attempting to fight a residential structure fire, he sustained severe injuries while falling down the basement stairs.

The Chief was the first person on the scene at the structure. Upon arrival, he saw visible smoke coming from the structure. The occupants were standing outside and advised smoke was emanating from the basement. The Chief immediately proceeded into the structure to identify the seat of the fire. He was not wearing any self-contained breathing apparatus and did not have the protection of a hose line.

While the Chief descended the stairs to the basement, he lost his footing, and fell, striking his head and arm on the concrete floor. His helmet was dislodged in the fall as there was a failure to effectively use the chin strap. The Chief managed to radio incoming units that he had fallen and requested the assistance of EMS. When EMS and fire department personnel arrived, the Chief was extracted from the structure fire, and later transported to the nearest hospital for treatment and evaluation of his injuries. The injuries were serious in nature and included a closed fractured skull and open fracture of the left arm. Surgery was required for the left arm and the skull fracture required extensive medications, diagnostic testing, and neurological follow up. Hospitalization extended for 2 weeks. The Chief was completely disabled for a period of 36 weeks, and while a transitional work release was given, he was unable to return to his full-time employment as a general contractor for another 16 weeks. After reaching maximum medical improvement, he was assigned a 10% permanent partial disability rating to the skull and a 20% permanency rating to his left, non-dominant arm. The Chief is no longer an active participant within the volunteer fire department.

Investigation and Damages/Injury

The Chief's actions, although admirable, jeopardized his own life and safety as well as other first responders. The department had an established set of guidelines for structural fires which the claimant failed to follow. In violating department policy and operating outside the scope of his responsibilities as the incident commander, he created an unsafe working environment.

CIRMA Liability Assessment

CIRMA accepted this case as a compensable Workers' Compensation claim. There were no other responsible third parties from whom to pursue subrogation.

Key Recommendations

As a best practice departments should:

1. **Review and follow policies and procedures**:
    a. The Chief Officer and Incident Commander should have completed an assessment of the scene for evaluation of risk vs. benefit. Since all of the occupants were safely out of the structure, no attempt should have been made to enter the structure until additional department resources arrived on scene.
    b. The NFPA standard related to 2-IN / 2-OUT and proper scene staffing levels would have eliminated the Chief's entry to the structure. A complete 360-degree scene would have helped in the decision making process.
    c. Command structure. Maintain a command and control presence while assuring all safety parameters of the operation are followed.
2. **Training Records**: Ongoing training should be conducted to cover department policies and policies, as well as any and all safety protocols. Leadership training should be required for executive level officers. Training attendance should be document in personnel records.
3. **Personal Protective Equipment (PPE)**: Appropriate attire PPE should have been used in this situation when entering an IDLH atmosphere, including use of Self Contained Breathing Apparatus (SCBA) and proper securing of the helmet.

For more information, please contact George Tammaro, Risk Management Services Manager at CIRMA, (203) 946-3700 or gtammaro@ccm-ct.org.

Questions? Ask your Supervisor or CIRMA Risk Management Consultant.

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May 2018

Forced Entry Procedures

Background

The fire department is a combination organization with eight personnel on duty at a time; two are assigned to EMS coverage and six are assigned to fire coverage. There is no chief officer on shift. There is a career lieutenant; otherwise senior fire personnel or volunteer officers will take command.

Incident

On January 25, the fire department was dispatched to an automatic fire alarm at a residential structure. The department had responded to alarms at this address several times over the past few years, all which turned out to be alarm malfunctions. On the January 25, the fire department responded with an engine company, truck company, ambulance, and two additional personnel responding in a utility vehicle. The police department, who were first on scene, noted nothing visible from the exterior, there were no occupants present, and the structure was locked with no access. The police cleared the scene when fire apparatus arrived and took over command. The engine arrived first and the senior member established command and reiterated that there was nothing visible from the structure, side "A- alpha," of a one-story ranch structure, alarms were sounding.

A walk-around of the structure revealed no visible smoke condition or odor of burning product. The two-person crew advised command of their findings and related that they were unable to see inside the structure because all the blinds were closed on the windows and doors. Upon arrival of the truck company, the command requested that the crew force entry and check on the situation within the structure. The crew obliged and forced open the front double-french door entryway, which caused significant damage to both the doors and their frame work. Once inside the residence, personnel reported that there was no fire or smoke in the structure and that it appeared to be a malfunctioning alarm. Once the all clear was given, the alarm was deactivated and, before leaving the residence, the fire department attempted to re-secure the damaged french doors with nails and boards.

On January 27th, upon returning home from their vacation and seeing their home, the homeowners called the police to report a burglary. The police responded to the home where the homeowners showed them the damaged door and reported that there were multiple items missing from their residence. As part of their investigation the police department checked and verified that fire department responded to an alarm at the residence two days earlier and forced entry. The police department concluded that at some point between the forced entry, and the homeowners returning, the residence was entered by unknown person(s) and burglarized.

Damages

- The cost to replace and repair the front door and frame was **$10,000**.
- Due to the damage to the front door and the fact it was not fully secured in a way to protect against the weather, snow or rain damaged the hardwood floor of the entryway and an oriental rug and nearby furniture, resulting in **$22,000** in damage.
- The reported cost of items stolen from the residence was **$25,000**.

Total cost of this claim was **$57,000**.

Liability

The fire department was found to be 100% liable for the losses of this claim. They forced entry on the residence, causing damage to the door, which also resulted in the damage to property from the snow/rain. Additionally, due to the extensive damage to the front door, the alarm system could not be reactivated by the monitoring company. Lastly, the burglary that took place was a result of the fire department leaving the house unsecured.

Key Recommendations

1. The fire department should establish a policy clearly defining when and when NOT to force entry to any structure. The policy should include a statement that an executive officer of the department is requested to respond to, or at least be notified, of the actions that have occurred. Local law enforcement should also be notified to assist and witness entry, eliminating any possible concerns and establishing a chain of custody for the structure.

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2. Careful consideration to "on-air" communications regarding the status of the structure ("vacant, unoccupied") to help prevent tipping off potential burglars.
3. Entry techniques should be regularly practiced to help eliminate or minimize the damage when a forced entry is required.
4. Tactical considerations should be evaluated to help limit the damage if a non-emergency entry is needed. The path of entry should be one least noticeable by the public and with the least damage.
5. Proper securing of the structure upon departure of all agencies shall be required.
6. Follow-up process put in place to ensure that the structure remains secure until confirmation by the owners is received.

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