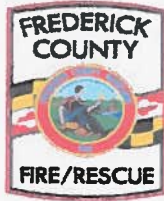


**FREDERICK COUNTY DIVISION OF FIRE AND RESCUE**



**Post Incident Analysis  
Incident # 13 – 3215**

**Date: January 31, 2013  
Location: 3915 Highland Ave.  
Myersville, Md. 21773**

**Prepared by:  
Lieutenant Donald Bennett Jr.  
Battalion Chief Paul Wallick Jr.**



## Overview

The purpose of this Post Incident Analysis is to gather knowledge and information that can be utilized to better the Fire Service in Frederick County. The times indicated throughout the report are gathered from a CAD printout and may not be real time. Additionally, it is important to note that some time stamps on photos are not accurate from the camera clock.

At 23:19 hours on Thursday, January 31, 2013, the Frederick County 911 Center received a call for a house on fire. The call was dispatched at 23:20 hours as "Box 8-8, house on fire across from 3918 Highland Ave." While units were responding, Frederick County 911 received several other calls reporting the fire, and communicating that children were trapped. This information was relayed to incoming units, and a Rapid Intervention Dispatch (RID) was requested along with a Tanker Task Force Dispatch due to the rural area of the call. At 23:27 hours, Chief 21, Steve Nalborczyk, arrived on scene with a two-story single-family home with fire on Divisions 1 and 2 on the "Alpha" side of the structure, and fire impingement on the roof. Chief 21 established command and confirmed that there were two children trapped inside the structure. Crews used large-capacity attack lines in an attempt to extinguish the majority of the fire as quickly as possible, while other crews attempted an unsuccessful rescue attempt through a second floor window on the "Delta" side of the home. After crews exited the structure, the attack was ordered "defensive" by command, and the fire was brought under control approximately 1-½ hours after arrival on scene. Crews then assisted the fire marshal's investigation and the body recovery of the two victims. ATR was called to assist in shoring up the first floor of the home so that investigators could safely complete their work. The Frederick County Fire Marshals, in coordination with the Fire Investigators from the Frederick County Sheriff's Department and the State Fire Marshal's office, worked to determine the cause/origin of the fire. Once the initial investigation was complete and the victims were located and removed from the scene, the fire and rescue units returned to service.

## Description of the Structure

The structure involved was a two-story single-family home built in 1975. It was constructed with a below-grade basement. The home was of ordinary construction, and it was a three-story house from side "Charlie" of the building. The home was approximately 32' wide by 26' deep with a "Florida" room on the rear "Charlie" side. The home featured a 4' balcony (approximately) that ran the length of the front "Alpha" side of the second floor. The home had an attached one-car garage on the right "Delta" side; this garage had been converted to a half-storage space in the front and a family room in the rear, with a sliding-glass door leading to the back yard. This door was elevated approximately 5 feet from ground level and was blocked by wood railing for safety purposes.



Side Alpha



**Side Charlie**

### **Initial Operations**

Engine 72 arrived on scene and utilized their "Blitz Fire" nozzle with a 3" line and a 1-3/4" attack line in an attempt to extinguish a majority of the fire from the front of the house. Tanker 7 and Tanker 1 responded to the scene to provide water to Engine 72. Rescue Engine 74 was called by Command to the Alpha side of the home for lighting. Arriving on the scene via Highland Court, Ambulance 89's crew and Battalion 902 assisted in the rescue attempt on the second floor, utilizing the garage roof as an operating point to enter the second floor "Delta" window. This attempt was unsuccessful due to the large volume of fire inside the structure and the resulting instability of the second floor. Crews entered and noted that the second floor had burned through from below and was collapsing into the first floor. The crew evacuated the building and an "exterior-only operation" was declared. Water supply was established, as folding tanks were placed at Highland Avenue/Harmony Road and Highland Court/Harmony Road to supply operations on both the front (Alpha) and rear (Charlie) side of the house.

### **Civilian Injuries/Fatalities**

Initial on-scene Command confirmed that there were two children trapped on Division 2, in bedrooms located to the rear of the home in quadrants "C" and "D". Crews also treated the four occupants of the home that escaped prior to the Fire/Rescue units' arrival on scene. EMS 901 was placed in charge of the EMS sector. The father, a 39 year old male, was treated on scene by Ambulance 78 and Medic Chief 79 (Washington Co.), and subsequently airlifted by MSP helicopter. An 8-year-old girl was treated on scene by Ambulance 89 and Medic 7910 (Washington Co.), and was subsequently transported by helicopter to Children's National Medical Center. An adult female and an approximately 7-month-old girl were transported to FMH for treatment of minor injuries by Ambulance 19.

Two girls, ages three (3) and six (6), died in the fire. The three year old was located in bed on what remained of her second-floor bedroom. The six year old was located near her bed on the first floor due to the collapse of her second-floor bedroom into the first floor.

### **Firefighter Injury**

One firefighter was twice injured during the course of this incident. The firefighter injury was reported to Command at 00:13 hours. Said firefighter was initially placing the 1-¾" attack line into service on the "Alpha" division of the structure, where he sustained first-degree burns to his neck and ears, and a second-degree burn to his hand due to radiant heat. He then joined the crew that attempted the unsuccessful rescue on the second floor of the structure. While exiting a window he fell onto the garage roof and sustained an injury to his back. The injured firefighter was treated on scene and was subsequently transported to FMH by Ambulance 791 (Washington Co.).

## **Command Structure**

<b>Command</b>	<b>Chief 21 - Nalborczyk</b>
<b>Operations</b>	<b>Chief 8 - Clipp</b>
<b>Fire Attack Group</b>	<b>Chief 7 – Loveless, Jason</b>
<b>Side “Charlie”</b>	<b>Chief 1-3 – Grossnickle, Brian</b>
<b>Safety</b>	<b>Safety 901 – LT. Thomas, then LT. Pryce and Safety 8 - Miles</b>
<b>EMS</b>	<b>EMS-901 - Gordon</b>

## **Findings**

As with any fire or emergency incident, the review found many positive and negative aspects, along with several significant areas that need to be improved upon. Below is a listing of the positive areas from this incident, with recommendations for improvement listed.

## **Positive Aspects**

1. **Command established immediately**
2. **Rapid Intervention Dispatch and Tanker Task Force called for early**
3. **Command requested Second Alarm assignment**
4. **RIT established and maintained**
5. **Crew Integrity maintained**
6. **Circle check done**
7. **Safety Officer in place**
8. **Rehab established**
9. **PAR check done**
10. **ATR Requested for structure safety**
11. **Different divisions had assigned officers**
12. **FM office requested**
13. **Red cross requested**
14. **Canteen service requested**

## Areas of Concern

1. Engine 82 responded to an incorrect location and upon realizing their mistake, attempted to turn around and got stuck in a ditch. This caused a significant delay in their arrival on scene after they had to wait for a large tow truck to pull them out of the mud. Their arrival on scene was 65 minutes.

### **Recommendation:**

*Crews need to ensure they know the location of the incident prior to leaving the station. There is no excuse for responding to an incorrect location when the CAD printer is working properly and the units can get a copy of the printed location prior to response. The county (IIT) is looking into printing more than one copy of the CAD information when stations are alerted for multiple unit response so all units can have a copy, not just one. Also, all units could be equipped with a Mobile Data Terminal and the information would be sent via CAD to the units. This can be accomplished when the CAD system is reconfigured to make the Fire/Rescue database available exclusively. Then, funding should be found to assist with this measure, and dispatch information would be in each unit automatically and updates could be received seamlessly.*

2. Ambulance 89 responded and followed Engine 82; they realized Engine 82 went the incorrect direction after passing the intersection of Route 40 and Harmony Road. The ambulance then turned around and followed Engine 72 to the scene. Ambulance 89 failed to attempt to contact Engine 82 to advise them of the incorrect response route.

### **Recommendation:**

*The ambulance crew should not have been following the engine blindly, they had the print out from CAD and should have followed the known travel direction. The crew should have attempted to contact Engine 82 and communicate to the officer on Engine 82 about their incorrect route of travel. All staff should be trained in Crew Resource Management and feel empowered to point out issues and offer suggestions for improvement.*

3. Engine 72 responded and saw the engine from station 8 going the incorrect direction; they requested confirmation of the address from ECC and proceeded to the scene, followed by ambulance 89 that had turned around. Engine 72 made no attempt to contact Engine 82 to advise them of their incorrect response route.

**Recommendation:**

*The engine officer should have attempted to contact Engine 82 and communicate to the officer on Engine 82 about their incorrect route of travel. All crew members should be trained in Crew Resource Management and work to communicate more effectively to other units.*

4. Engine 72 arrived in the area of the fire but incorrectly turned onto Highland Ct. instead of Highland Ave. They laid out their supply line (600ft.) and realized that the house was on the next street. The engine then turned around and proceeded to the correct street causing a several minute delay in arriving to position the engine for fire attack.

**Recommendation:**

*Crews had tunnel vision upon seeing the first sign with Highland lettered on it; this is understandable due to the dispatch information (high stress due to children trapped). Upon PIA investigation the "Charlie" side appears to be at the end of Highland Ct. further substantiating the mistake made by Engine 72 to be understandable. The unit officer should have looked in their map book or the ADC map book to ensure he and the engine driver knew the area. This is especially true since Engine 72 knew after seeing Engine 82 going the incorrect direction; they would be now first due. Engine 72 also did not announce they were taking the first due assignment at anytime. This would have been important for other incoming units to know due to county response policy. All companies should review the county response policy for both rural and urban response.*



5. Ambulance 89 made the same mistake as Engine 72 and used a third provider to move the ambulance after the other two crew members donned their PPE to assist with fire attack.

**Recommendation:**

*The crew had tunnel vision upon seeing the first sign with Highland lettered on it; this is understandable due to the dispatch information (high stress due to children trapped). Upon PIA investigation the "Charlie" side appears to be at the end of Highland Ct. further substantiating the mistake made by Ambulance 89 to be understandable. Again, the ambulance should not blindly follow the engine to a scene. Review of response policies and first due assignments should be completed by all company level personnel.*

6. Utilization of existing standard operating procedures: Some responding units still requested assignments from command. The County has established a policy that dictates unit assignments on the initial alarm.

**Recommendation:**

*A review of this policy is needed at the company level, for all companies. All unit and chief officers need to review the unit assignment policy and the assignments associated with each response arrival position.*

7. Water supply was not established early. Water supply was established but the first three units to access Highland Ave. did not lay out supply lines to the scene. Eventually an engine completed a reverse lay to the scene and a folding tank was placed at Highland Ave. /Harmony Rd for water supply. Although Engine 72 never was completely without water, the unit operator could not adequately supply all the fire lines that were in operation at the same time.

**Recommendation:**

*Command should have recognized the need for a Water Supply Officer sooner and water supply should have been established in a more timely fashion. Second and third due units were not utilized to their capability to complete a reverse lay to Engine 72 and tankers were used as "nurse"*

*tankers until water supply was established. A rural water supply drill with first alarm companies would assist in personnel being better prepared for another fire in the non-hydrant area.*

8. **Passport drop off policy needs to be followed and the passports must be utilized. Passports were essentially not used on this incident; the safety officer from station 8 was assigned this task but abandoned the task after searching several first alarm units only to find empty passport tags on the units.**

**Recommendation:**

*Utilize the existing accountability policy that outlines the procedure for accountability of personnel responding on units and in private vehicles. Just because the units did not have filled out passports, the safety officer should not have abandoned the task but reported to command the situation and ensured all incoming units reported their staffing to command. This became an issue later in the incident during the PAR check when not all units that were on the incident were accounted.*

9. **Safety Issues: Attempting an interior attack when conditions were hazardous on division two. Putting crews into a garage to make access to put out the fire when not necessary due to lines accomplishing this from the outside. Safety officers were in place but crews attempted to enter garage and ignored safety officer's orders to evacuate the structure. Crews should realize that the safety officer is in their position to see things interior crews cannot and crews should always obey orders from the safety officer for the protection and safety of all personnel on the fire ground. The attempt to enter the garage after command had verbally announced over the radio "exterior operations only" occurred at least three times. One Chief Officer attempted to supersede the safety officers by getting "permission" from command to enter the structure.**

**Recommendation:**

*Although the rescue attempt on the second floor was dangerous, it was a safe attempt to locate the known victims of this fire. The attack crew safely cleared the window and sounded the floor as they entered and used the attack line to cool the area prior to and during entry. Photos clearly show that this attempt although dangerous was a valiant attempt to save lives.*

*The second concern is the crew officers' disobedience to the on scene safety officer by entering the garage area of the structure after the attack was declared defensive and exterior only. Company personnel should review the standard operating procedures for safe interior structural fire fighting and the safety officer responsibilities and authority. This will ensure all staff are reminded of the important and tough job the safety officer has on every incident.*

10. PAR check was done once; starting at 00:29, but it was accomplished just this one time and took 18 minutes. This should have been done after the rescue attempt and anytime the fire operations changed tactics. It was noted by command that the initial attack was defensive in nature and once a portion of the fire was extinguished crews attempted one offensive rescue attack that was unsuccessful and the operations returned to defensive. PAR checks should have been done then as well as when the injured Firefighter was announced to command. This would have ensured there were no other firefighter injuries at that time.

**Recommendation:**

*Command and company level staff should review the safe-scene operations and mayday policies to get a better understanding of when and why PAR checks should be completed.*

11. Rehab was established but was not well attended. Crews were not documented by the rehab ambulance crew. Rehab is required by crews working in and around the fire to ensure firefighter safety.

**Recommendation:**

*Company level and command personnel should review the firefighter rehabilitation policies and procedures. Crews should be required to enter rehab as it is not a "suggestion" but a requirement for their safety and well being. Crew medical information is also a requirement to ensure personnel are fit to return to assist with the fire ground operations. Rehab is not to just keep personnel out of the weather and warm up/cool down.*

12. Ambulance 89 was not in a position to be able to transport a patient without moving several other pieces of apparatus.

**Recommendation:**

*Ambulances should be placed in a position to be able to leave the scene and not get blocked in; this was accomplished for the rest of the ambulances by command establishing EMS staging on Wistman Lane during this incident. Incidents that are located on dead end or short streets/courts pose this problem on a regular basis and all personnel need to work to ensure that ingress/egress availability is maintained as a priority. This will ensure that if a unit is needed at the scene it can be summoned and positioned for an effective conclusion to the incident.*

13. Upon review of Myersville Station 8 running routes, it was noted that the running route used is not the most direct and expedient route of travel.

**Recommendation:**

*The running route should be changed to the closest and quickest route as this cuts two miles off the route of travel and saves approximately 1 minute 30 seconds off response time to the Turkey Hill subdivision where the fire was located. A review of the entire area should be completed to ensure similar situations do not currently exist.*

14. Second alarm was requested by command but never dispatched. The units on scene were most likely the equivalent of a second alarm assignment but it was difficult for command to establish which units were assigned to which alarm. This occurs due to multiple units responding on the first alarm and RID from the same station, as well as the tanker task force. Example: Engine 72, Tanker 7 and Rescue Engine 74 all responded on the initial alarm.

**Recommendation:**

*Command was established by Chief 21 responding from his home in his personal vehicle. This is common in the county but when this occurs there is no space for establishing command with the normal command aides that*

*the chief vehicles provide. This underscores the need for the next arriving officer in a command unit to position as close to the command post as possible and to assist in establishing a well organized command. I don't think we can change officers arriving on scene first in their POV (nor do I want to discourage volunteer officers in responding to the scene if they are closer), but all company personnel and chiefs should review command procedures and practice with the command tools to improve efficiency.*