

Item Title: Post Incident Review Program Update

Specific Action Requested:

That the Fire Commission receives information related to the Post Incident Review Program.

Item Summary:

The Wake County Fire Training Division was charged with delivering Post Incident Review training to fire department personnel. The Train-the-Trainer class was delivered December 6, 2011. Thirty students attended the training presented by North Carolina Forest Service instructors. In FY12 the following incidents were reviewed:

<u>Incident Date</u>	<u>Address</u>	<u>Reason for Review</u>	<u>Primary Department</u>
July 2, 2011	1108 Leach Street	Civilian Fatality	Fuquay-Varina
January 20, 2012	2632 Dun Loring Drive	Large Loss	Wake Forest
January 22, 2012	7605 Fox Knoll Drive	Civilian Injury	Fuquay-Varina
April 03, 2012	255 Lakewood Drive	Civilian Fatality	Wendell
April 29, 2012	128 Bridge Street	Two Civilian Fatalities	Fuquay-Varina

Attachments:

1. Post Incident Review Program Guidelines
2. Post Incident Report Leach Street
3. Post Incident Report Dun Loring Drive
4. Post Incident Report Fox Knoll Drive
5. Post Incident Report Lakewood Drive
6. Post Incident Report Bridge Street

Wake County Post Incident Review

Purpose

Effective fire and emergency service delivery is an important value for the fire protection system. Incorporating lessons learned from previous responses is a highly effective method for improving the effectiveness of service delivery. This program is intended to provide a systematic and consistent approach for reviewing and evaluating incident response. There are several reasons for conducting Post Incident Reviews. Paragraph 20(e) of Wake County's fire protection agreement states:

TRAINING: Each fire department shall conduct a regional post incident review for the following incidents: fatal fires, fires involving more than \$250,000 property loss, fires involving civilian injury requiring hospitalization for more than 23 hours, fires involving firefighter injury requiring hospitalization for more than 23 hours, and any other incident as determined by the department. Post incident reviews will be facilitated by a fire service member that has completed a post incident review training program approved by the Fire Commission, or equivalent training as determined by the Fire Commission.

Benefits include:

- Provide emergency service personnel with a clear indication of the impact their actions had on the general outcome of an incident;
- Used to analyze and compare how different applied strategies and tactics affect the outcome of incidents;
- Identify trends and patterns in errors during emergency operations so that immediate action can be taken to prevent them from reoccurring;
- Identify positive outcomes that reflect proper attention to procedures, good decision-making, leadership skills, and so forth;
- Serve as a catalyst for revisiting flawed tactical plans and Standard Operating Procedures (SOPs);
- Used as a test bed where alternative tactics and evolutions are attempted, and to study their effect on the outcome of the incident;
- Help identify additional or remedial training for personnel;
- Used as technical reference material and catalogued for retrieval and examination during any similar future incidents;
- Disseminate critical lessons learned during an incident to personnel throughout the fire department;
- Identify fire prevention and code enforcement deficiencies;
- Determine the need to install fire detection and suppression systems;
- Identify illegal and required modifications to structures;
- Identify structural and fire protection system failures; and,
- Identify built environment and operational challenges that contribute to civilian and firefighter injuries and fatalities.

Review Types

There are two types of reviews to be conducted, informal and formal.

Informal Review (internal only)

The informal review shall be conducted at the departmental level. The best time for the informal review is immediately after the incident while hoselines are still deployed. In cases when this is not possible, this should occur as soon as possible at the station. The informal review should be conducted at the company level and should cover how well tactics worked and what changes might be needed. The company officer should lead the informal review and serve as the moderator to keep the discussion on track. Each crew member shall be given the opportunity to explain his/her assigned tasks and identify any problems encountered. The main points of the informal review should be documented for future training and improvements. This documentation should remain at the company level.

Formal Review

The formal review is intended for large scale incidents involving tactically challenging incidents. The formal review is used to reconstruct the incident and should include supporting documentation to have a clear understanding of the chain of events. The formal review should take place on the same shift within a few days of the incident. This review should not be open to media or political office holders. The formal review should answer four major questions:

- What was expected to happen?
- What actually occurred?
- What went well, and why?
- What didn't go well, and why?
- What can be improved, and how?

Incidents requiring a formal review:

- Fatal fires
- Fires involving more than \$250,000 property loss
- Fires involving civilian injury requiring hospitalization for more than 23 hours
- Fires involving firefighter injury requiring hospitalization for more than 23 hours
- Any other incident as determined by the department

Incident examples when a formal review is recommended:

- Fires in high-risk buildings
- Incidents involving unusual circumstances
- Multiple alarm fires
- Major vehicle accidents
- Technical rescues
- Major hazmat incidents
- Training incidents with injuries and/or fatalities
- Full scale exercises
- Multiple patient incident
- Evacuation of health care or long term care facility

- Incidents involving public disorder or violence
- Where ICS issues impeded effective incident management
- Where CISD is needed for more than one single crew
- Incidents where an uninvolved vehicle penetrated an incident scene regardless of responder injuries.
- Near miss incidents

Other incidents may be selected by the department.

Post Incident Review Coordinator

The Wake County Fire Training Director will serve as the Post Incident Review Coordinator. The purpose of this position is to be a single point of contact for the requesting agency and coordinate the review program.

Post Incident Review Notification

The requesting agency shall notify the Post Incident Review Coordinator of the incident to be reviewed. When possible, notification should be made before the end of the same working shift. A post incident review notification form is provided.

Facilitator Responsibilities

Facilitators shall be assigned to conduct formal review meeting. It is recommended a team of three trained personnel should be assigned to the review with one serving as a scribe to collect information for the final report.

The facilitator shall be responsible for ensuring all documentation, maps, communication audio and reports are generated for the formal review.

The Facilitator Checklist form shall be completed when collecting data.

The facilitator should encourage personnel to participate openly in the process.

The main points of the formal review should be documented for improving emergency response.

This review should include all agencies responding to the incident at a central location.

The incident facilitator should not be affiliated with the responding agencies or incident being reviewed.

The following materials and data should be collected by the facilitator and utilized in the formal review:

- ✓ Maps - this may include, but not limited to, aerial photos and area drawings.
- ✓ LCD projector
- ✓ Computer
- ✓ TV, VCR
- ✓ Flip Charts
- ✓ Scene photographs
- ✓ Whiteboards
- ✓ 9-1-1 audio
- ✓ Informal review documentation
- ✓ ICS structure
- ✓ Tabletop equipment

- ✓ Incident report
- ✓ Firefighter narratives
- ✓ Completed formal review form
- ✓ Attendance Roster (Sign-in sheet)
- ✓ Handouts

It is recommended that the facilitator include the follow information. A power point presentation example is provided.

Post Incident Review Meeting Agenda

- Welcome and introductions
- Ground rules and role of the facilitator
- What was expected to happen?
- What actually occurred?
- What went well, and why?
- What didn't go well, and why?
- What would we do different?
- Trends
- Closings comments and summarize discussion
- Follow-up needed

Post Incident Review Ground Rules

- Stay on task
- Everyone participations
- Open to new ideas
- Critical thinking
- Group consensus

At the conclusion of the formal review a report will be generated to include notes from the meeting. Copies will be sent to responding agencies and one will be kept on file with Wake County Fire/Services.

Post Incident Review Report

House Fire with Fatality
1108 Leach Street
Raleigh, NC 27603
Incident 11-0015384

July 2, 2011

Ricky L. Dorsey - Facilitator
Wake County Fire Services

On July 26, 2011 a Post Incident Review meeting was conducted to discuss the events related to the house fire on July 2, 2011 at 1108 Leach Street. The meeting was held at Fuquay Fire Department Station One at 10: 00 AM. Attending agencies were Fuquay-Varina Fire Department, Garner Fire Department, Fairview Fire Department, Wake County Fire and Emergency Management and Wake County EMS.

Incident Overview

On Saturday morning July 2, 2011 fire and EMS units were dispatched at 07:06 AM to a house fire at 1108 Leach Street. The call started with C – Shift and ended with A – Shift. Agencies dispatched were Fuquay-Varina FD, Fairview FD, Garner FD and Wake County EMS. While responding, Raleigh/Wake 911 advised an occupant was trapped inside. Further information was this would be an infant in the rear bedroom. Fuquay E-2 was already on another call and Fairview E-3 would be the first engine to arrive. Fuquay Battalion 1 and Fairview Car 2 arrived to find a single story wood-frame dwelling with 1,100 sqft heavily involved with fire. Fuquay Battalion 1 established Command and made assignments. Fairview Car 2 was assigned Fireground Operations. Fairview Car 2 was informed by a family member that the victim would be in the rear bedroom. Car 2 immediately went to the location described and found conditions too severe for firefighters to enter and a rescue was not an option. Fairview E-3 was assigned Fire Attack. Garner Rescue 2 was assigned Search and Rescue. Command advised to go to a Defensive Operation. In the review meeting everyone agreed it was a good decision to go to a Defensive Attack and not jeopardize personnel for a body recovery. Conditions on arrival were described as fire blowing from all Division “A” windows and door with the exception of the far left, Division “B”, attached apartment. This room was searched with nothing found, but did experience excessive heat damage. Garner Car 2 was assigned Safety and Accountability. Water Supply was established with a LDH manifold from the roadway to the scene. Tankers supplied the LDH Supply. Dump tanks were not required due to the LDH manifold supplied by tankers on-scene. Two tankers were connected at all times and supply was never interrupted. The Water Fill Point was located at Precision Walls on Banks Road. Approximately 13,500 gallons of water were shuttled during the incident. The Water Supply Officer advised they never were below 6,000 gallons on-scene. Wake County EMS treated and transported three civilian injuries that were non-life threatening. Wake EMS also provided Medical Monitoring and Rehab. for responders. Wake County Comm. 1 was utilized for on-scene investigation support. WSO and CCBI will be responsible for the cause of death investigation. WC1 was contacted and will be responsible for the fire origin and cause investigation.

Weather Conditions at Dispatch

- Temp. 66.9 degrees F.
- Humidity 87%
- Winds calm
- Scattered clouds

Unique Circumstances

- Civilian Fatality
- Fire too advanced for Offensive Strategy

Building Description and Real Estate Records

Assessed Building Value: \$60,266.00

Assessed Land Value: \$20,000.00

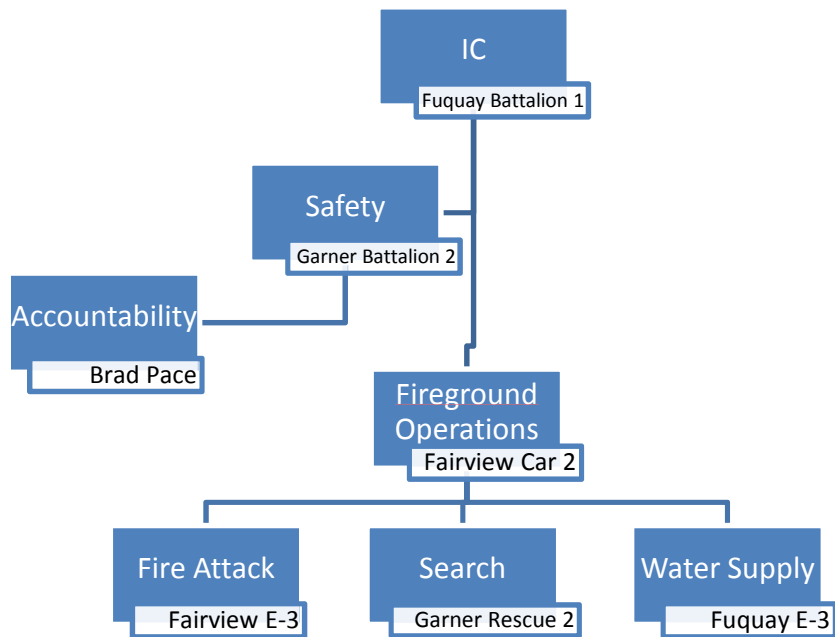
Total Assessed Value: \$80,266.00

Heated Area: 1120

Year Built: 1974

Type and Use: Single Family

Organizational Chart



Incident Photos



- The above photo was taken by a firefighter shortly after arrival.



What Went Good?

Water Supply went very smooth with no interruptions.

The consensus of the group is all agencies worked very well together.

Communications were good. The scene size-up was good for all in-coming resources.

Personnel accountability was maintained through the incident

Improvements and Lessons Learned

- The IC advised he could have done a better 360 of the scene to check for hazards in the rear.
- Several commented in the review meeting they learned how to correctly identify the appropriate jurisdiction for documentation purposes. The Insurance District Map is most accurate. This did not impact the response or scene operation.
- Remember to request Battalion Chiefs if needed as their pagers may not activate on mutual aid type calls.

Follow-up

None identified.

Post Incident Review Report

House Fire

2632 Dun Loring Drive

Wake Forest, NC 27587

Incident 12-0001606

January 20, 2012

Participating Agencies:

Wake Forest FD

Falls FD

Stony Hill FD

Bay Leaf FD

Brassfield FD

Wake County Sheriff's Office

Wake County Fire Services

Ricky L. Dorsey - Facilitator

Gerald Atkins – Facilitator

On March 12, 2012 a Post Incident Review meeting was conducted to discuss the events related to the house fire on January 20, 2012 at 2632 Dun Loring Drive, Wake Forest NC. The meeting was held at Wake Forest Fire Station One at 7: 00 PM. Attending agencies were Wake Forest FD, Bay Leaf FD, Falls FD, Stony Hill FD, Brassfield FD, Wake County Sheriff's Office, and Wake County Fire Services.

Incident Overview

On the evening of January 20, 2012 fire and EMS units were dispatched at 20:51 PM to a house fire at the given address. Units arrived to find a 2-story wood framed dwelling with heavy fire showing in Division C and detached garage. Command was established and assignments were given. An offensive strategy was implemented. Homeowners were not at home at the time of the fire. The neighbor that reported the fire advised there was a large amount of fire at the rear of the house in the area of the porch.

Command directed units to set up a water shuttle. A water supply officer was assigned and an initial attack was deployed. The following assignments were established: Safety Officer, Accountability, Rehab, Treatment/Transport, RIT, Divisions A, B, C, D, 1 and 2. Law enforcement handled traffic on both sides of the scene. WC1 was contacted for the cause and origin investigation.

Post Incident Review Meeting Discussions

When first units arrived they encountered a large amount of fire in the rear portion of the structure. Units implemented an offensive strategy that became unsustainable.

The consensus of the group is the water flow from attack lines was adequate during the initial stage of the fire. While the water flow needed at the time of arrival was appropriate, the fire continued to progress. The detached garage was protected (Division D Exposure). Additional lines were not deployed due to an inadequate water supply from a water shuttle. Units eventually established a sustainable water supply with a hydrant and later went to a defensive operation. The building was evacuated and an aerial operation was deployed later in the operation. Some options discussed for better water supply were; assigning personnel to locate a better water source and developing a system to identify where reliable water points are located.

There was discussion of poor communication issues. Several options were discussed to better communicate in dead areas and with out-of-county units responding as mutual aid. Some options discussed were patching channels, using direct channels and possibly using vehicle repeaters. The group also said identifying these areas in advance will help prepare responders for future incidents.

The group also said scene safety became a high priority as the structure weakened during the operation. It was mentioned that safety did a good job and there were no injuries. Accountability and rehab proved to be very efficient. The group commended personnel working to overcome water supply issues and pump operations for such an extended period. The group advised they had very little time to do any salvage work.

Incident management became overwhelming when units were trying to establish a reliable water supply and an aggressive interior attack was initiated. The span of control was eventually exceeded as indicated on the organizational chart. Some options discussed to relieve the workload were; adding an operations

section chief, adding fire, law enforcement and ems branch directors and putting accountability under safety. Other options were also discussed.

The group also recommended starting the primary search sooner. Regardless if the ladder company is assigned to do that work on every incident, search should be assigned early.

Weather Conditions at Dispatch

- Temperature: 45 degrees F.
- Wind Chill: 38.9 degrees F.
- Humidity: 86%
- Winds: NE at 12.7 mph gusting to 19.6 mph
- Visibility: 10 miles

Unique Circumstances

- Incident was located just outside normal hydrant area.
- Fire was well advanced at the time of dispatch.

Building Description and Real Estate Records

Occupancy: Two-Story Single Family dwelling

Heated Space: 2,409 sqft

Date Constructed: 1995

Detached Garage Constructed: 1998

Exterior Finish: Wooden Siding

Roof: Composite Shingles

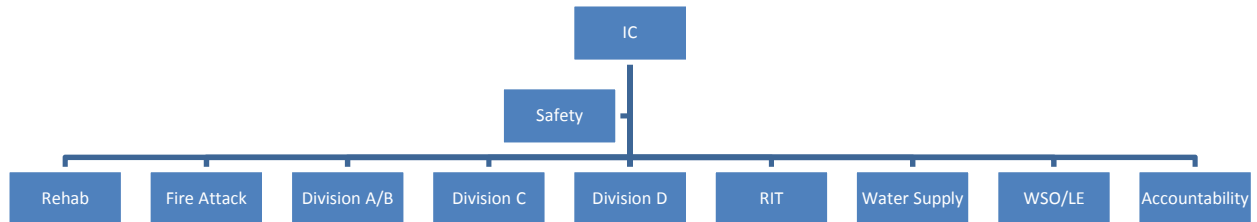
Interior Finish: Gypsum Wallboard

Fire Protection Systems: None

Security Systems: None

Electrical: Underground, entry on the East side NE corner

Organizational Chart

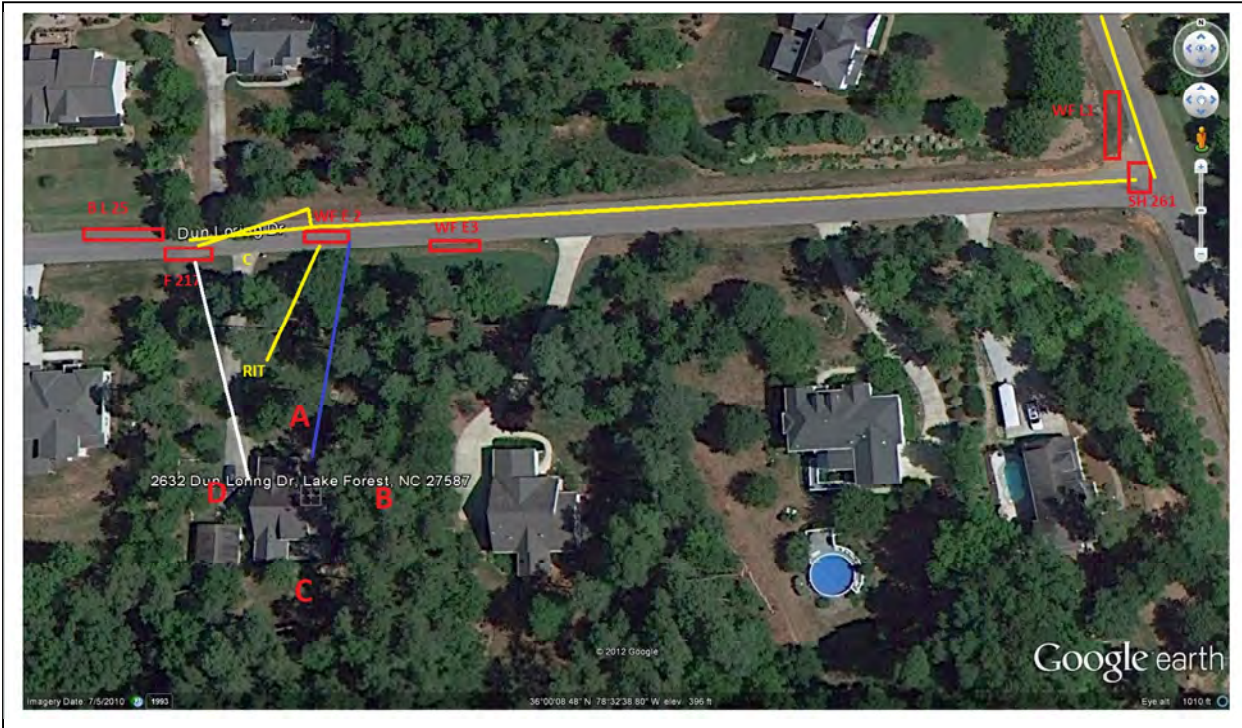


Incident Photos



- The above photos are from the tax records.

Overview of Incident

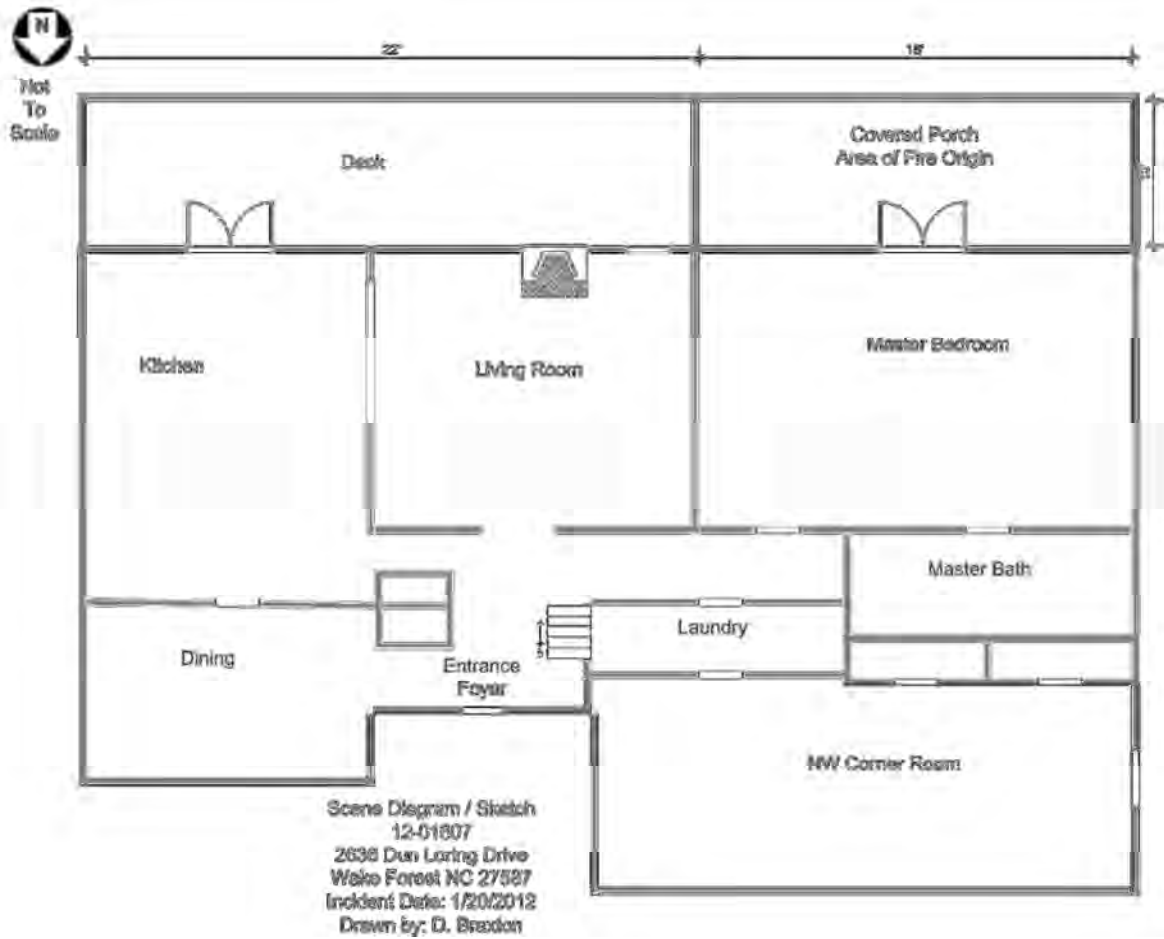


Incident Photos



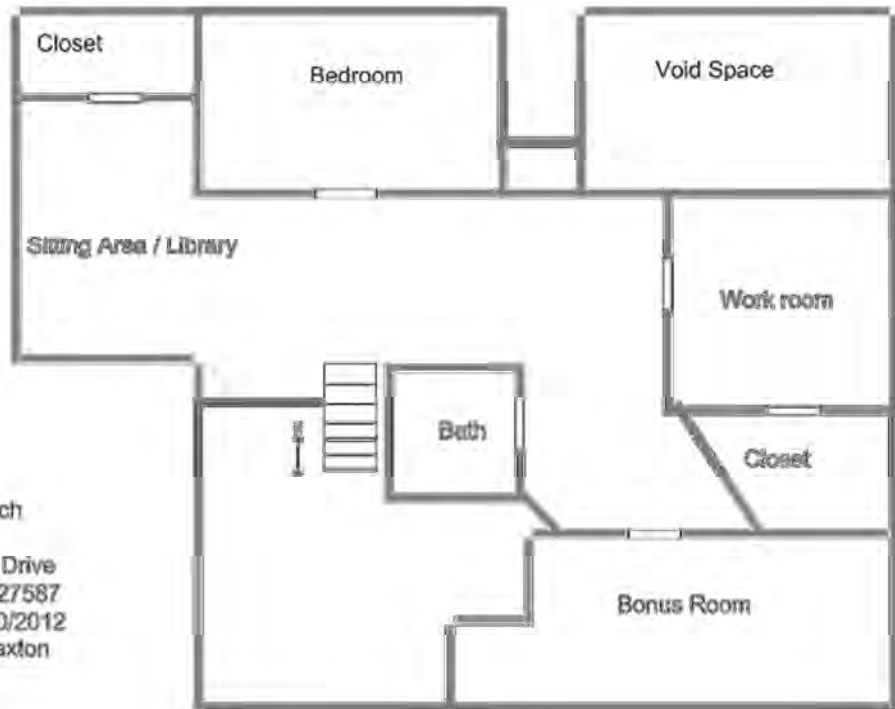


Drawing





Not to Scale



What Went Well and Why?

Personnel accountability was maintained through the incident

Once the hydrant lay was established, a reliable water source was maintained throughout the remainder of the incident.

Ladders were deployed for egress

RIT was assigned early

Departments/Agencies worked well together overall.

Improvements and Lessons Learned

Establish better water supply sooner.

Deploy additional lines if fire is still progressing.

Plan for aerial operations in case the offensive attack doesn't work

Assign search sooner

Know what channel LE is operating on and be ready to get them on your channel if needed.

Consider using the courtyard lay more often.

Draw out the org chart to help realize the complexity of the incident

During the post incident review meeting the group identified many options to improve and the discussion was very positive.

Follow-up

More training with vehicle repeaters to evaluate coverage issues

More multi-departmental training

Additional ICS training for more efficient assignments

Post Incident Review Report

House Fire with Civilian Injury
7605 Fox Knoll Drive
Fuquay-Varina, NC 27526
Incident 12-0001702

January 22, 2012

Ricky L. Dorsey - Facilitator
Donel Braxton - Notes

On February 8, 2012 a Post Incident Review meeting was conducted to discuss the events related to the house fire on January 22, 2012 at 7605 Fox Knoll Drive. The meeting was held at Fuquay Fire Department Station One at 1:30 PM. Agencies in attendance were Fuquay-Varina Fire Department and one EMS member from EMS17. WSO and EMS were requested to attend. This review was conducted primarily due to the civilian injury requiring hospitalization. The patient was transported to Wake Med and then to the burn center.

Incident Overview

On Sunday morning January 22, 2012 fire and EMS units were dispatched at 06:16 AM to a house fire at 7605 Fox Knoll Dr. Agencies dispatched were Fuquay-Varina FD, Wake County Sheriff's Office, Wake County EMS, Wake County Fire Services (WC1) and Red Cross. Units arrived to find a single wide mobile home with fire showing from Divisions A and C. Occupants were out of the structure on arrival. An offensive interior attack was made. E3 made an interior attack. A male occupant was very upset and uncontrollable. WSO Deputy assisted with occupant. EMS attended the subject and transported him to the hospital for further evaluation. The subject did receive burn injuries. Due to the heavy fire load and unstable floors, fire crews were not able to maneuver well inside the structure. Fire crews moved to the exterior and conducted most of the suppression through windows. There was a short time when the IC was distracted by the hostile occupant in the front yard. The IC was concerned for firefighter's safety when the subject became hostile. WC1 was contacted to conduct a fire cause and origin investigation. Red Cross was contacted to assist the occupants with clothing, medications and housing.

Weather Conditions at Dispatch

- Temp. 36 degrees F.
- Humidity 93%
- Winds 13.8 mph NNE with higher gusts
- Overcast

Unique Circumstances

- Civilian with hostile mental status
- Interior too cluttered with debris for safe interior operations

Building Description and Real Estate Records

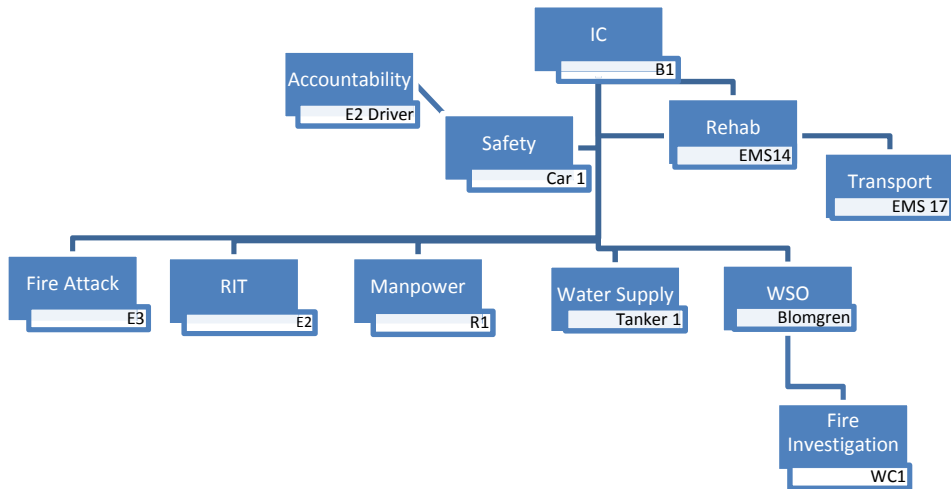
Estimated Total Value: \$13,400.00

Heated Area: 1,120 sqft (14' X 80') Singlewide mobile home

Year Built: 1997 Oakwood

Type and Use: Single Family

Organizational Chart



Incident Photo



- The above photo was taken by a firefighter shortly after arrival.

What Went Good?

Water Supply went well with no interruptions. Crews chose a good water supply point easy for tankers to operate.

No safety issues except the IC said he had to be too committed to the mental subject and there could have been a communications gap during that time.

Size-up

360 of house

Rapid suppression

Good crew rotation

Good communication between crews

Scene Safety

Accountability and PAR reports

Overall suppression efforts went better than expected based on interior conditions.

Improvements and Lessons Learned

LE needed to maintain contact with the subject until being transported from the scene. There was a concern that this person may create an unsafe situation for the crews working or for himself. There was a 20 minute period where the subject was left to freely wonder around the scene.

If WSO was on the same fireground channel the IC could have advised them of the hostile subject sooner.

There were several unsuccessful attempts to contact Red Cross by pager. It took approximately six hours for Red Cross to arrive.

The IC said they could have called for another crew to provide RIT and should get in the habit of doing this in the future.

Follow-up

Consult WSO and determine how to better handle hostile mental patients during fireground operations
Why there was a delayed response for Red Cross

Post Incident Review Report

Wendell Fire Department

Incident Date: April 03, 2012

Time of Incident: 01:54 a.m.

Incident Number: 12-0007449

Incident Address: 255 Lakewood Drive, Wendell, N.C. 27591

Incident Type: Building Fire Involving a victim

Facilitator: Brian Amerson, Captain / Wendell Fire Department

A post incident review was conducted on April 11, 2012. See attached training roster for attendees for this review. Each fire company's duties were reviewed. Wendell Fire Department's procedures were reviewed. The Post incident Review met the requirements of the Wake County Contract.

WENDELL FIRE DEPARTMENT TRAINING ATTENDANCE SHEET

DATE OF TRAINING 4-11-2012
 SUBJECT OF TRAINING Post incident Review - 255 Lakewood
 LOCATION OF TRAINING STAF 1
 INSTRUCTOR NAME(S) T. Vaughan, B. Staples
 TOTAL NUMBER OF HOURS (Training) 2.5 (Business) _____
 BEGIN TIME 1930 END TIME 2200

TRAINING CATEGORIES (CHECK ALL THAT APPLY)

- | | | |
|--|--|--|
| <input type="checkbox"/> Single-Company Training | <input type="checkbox"/> Officer Training | <input type="checkbox"/> Haz Mat Training |
| <input checked="" type="checkbox"/> Multi-Company Training | <input type="checkbox"/> Driver Training | <input type="checkbox"/> Recruit Training |
| <input type="checkbox"/> Department Training | <input type="checkbox"/> New Driver Training | <input type="checkbox"/> Auto-Aid Training |
| <input checked="" type="checkbox"/> Night Drill | <input type="checkbox"/> EMS | |

ATTENDEES

Place check beside personnel who attended full class; Enter hours beside those members who attended partial class.

- | | | |
|--|--|--|
| <input checked="" type="checkbox"/> Adams, Sherwood | <input type="checkbox"/> Johnson, Sherill | <input type="checkbox"/> Thornton, Candier |
| <input checked="" type="checkbox"/> Alford, Joshua | <input type="checkbox"/> King, Scott | <input type="checkbox"/> Underhill, John |
| <input checked="" type="checkbox"/> Amerson, Brian | <input checked="" type="checkbox"/> Lanphere, David | <input checked="" type="checkbox"/> Underhill II, John |
| <input checked="" type="checkbox"/> Boyette, John | <input type="checkbox"/> Montague, James | <input type="checkbox"/> Vardy, Mark |
| <input type="checkbox"/> Boykin, Kimbry | <input checked="" type="checkbox"/> Norris, Tim | <input checked="" type="checkbox"/> Vaughan, Tom |
| <input checked="" type="checkbox"/> Bryant, Billy | <input checked="" type="checkbox"/> Olson, Jon | <input checked="" type="checkbox"/> Vaughan, Vickie |
| <input checked="" type="checkbox"/> Bryant, Gregg | <input checked="" type="checkbox"/> Ramsey, Herb | <input type="checkbox"/> Vaughan, Wayne |
| <input checked="" type="checkbox"/> Chamblee, Justin | <input checked="" type="checkbox"/> Reid, Tony | <input checked="" type="checkbox"/> Wall, David |
| <input checked="" type="checkbox"/> Cooper, Kevin | <input checked="" type="checkbox"/> Robertson, Chris | <input checked="" type="checkbox"/> Walls, Ray |
| <input type="checkbox"/> Davis, Tim | <input checked="" type="checkbox"/> Rowe, Steve | <input checked="" type="checkbox"/> Withrow, Wayne |
| <input checked="" type="checkbox"/> Dillard, Brandon | <input type="checkbox"/> Ruey, Kyle | <input type="checkbox"/> Yeager, Mart |
| <input type="checkbox"/> Griffin, Ben | <input type="checkbox"/> Scarboro, Trae | |
| <input checked="" type="checkbox"/> Hales, Brandon | <input checked="" type="checkbox"/> Shea, Raymond | |
| <input checked="" type="checkbox"/> Hargreaves, Ryan | <input checked="" type="checkbox"/> Smith, Chris | |
| <input checked="" type="checkbox"/> Hartley, Brian | <input checked="" type="checkbox"/> Spain, Garry | |
| <input checked="" type="checkbox"/> Hunter, Josiah | <input checked="" type="checkbox"/> Staples, Brian | |

B. Phamra, T. T. T.

Completed and Verified by H. Ramsey & B. Amerson

Description of training Rescue, FT, vent., Q&A completes questions, programs

Post Incident Review Report

House Fire with Civilian Fatality
128 Bridge Street
Fuquay-Varina, NC 27526
Incident 12-0009545
April 29, 2012

Review Date: May 24, 2012

Participating Agencies:

Fuquay-Varina FD

Fuquay-Varina PD

Holly Springs FD

Wake County Fire Services WC1-B

Ricky L. Dorsey - Facilitator

Demetric Potts – Observer

On May 24, 2012 a Post Incident Review Meeting was conducted to discuss the events related to the house fire on April 29, 2012 at 128 Bridge Street, Fuquay-Varina, NC. The meeting was held at Fuquay-Varina Fire Station One at 8:300 AM. Attending agencies were Fuquay-Varina FD, Holly Springs FD, Fuquay-Varina PD, and Wake County Fire Services. 31 personnel attended.

Incident Overview

On Sunday morning April 29, 2012 fire, EMS and law enforcement units were dispatched at 07:32 AM to a house fire at West Academy and Bridge. The house was located at 128 Bridge Street, Fuquay-Varina, NC. Agencies responding were Fuquay FD, Holly Springs FD, Wake County Fire Services, Wake County EMS and Fuquay PD. Units arrived to find a single story house with a basement. Battalion 1 gave the size-up and was told by an occupant that someone was still inside the basement. An offensive attack was deployed and was later told a second person was also missing. Arriving units found heavy fire conditions in Divisions "C" and "D". The fire had progressed greatly upon arrival.

Unique Circumstances:

No dispatch information of a subject trapped.

After suppression had begun, crews were advised another person was missing.

Strategy:

Offensive – locate and remove victims and suppress the fire.

The fire cause investigation was conducted by Wake County Fire Services and the cause of death investigations were conducted by Fuquay-Varina PD.

Post Incident Review Meeting Discussions

Units responding were advised by Raleigh Central that the house was on Bridge Street just off of West Academy Street. Battalion 1 arrived and gave a size up and established Command. Smoke was very thick and laying low in the front of the house. Visibility was poor. B1 was immediately met by the property occupant and advised that someone was still inside in the basement division. Initial fire attack started and was advised by the property occupant that there was a second victim not accounted for. There was a heavy fire load in Divisions C and D. Fire was already venting from Division D. The unique circumstances encountered were that there was no information given that someone was trapped while they were enroute to the scene. The plan was to establish a water supply, contain the fire and remove the victim if possible without any injury or harm to responders. Once arriving and seeing the scene the decision was made to deploy two inch and three quarter lines for fire attack. The first on scene crew would initiate fire attack in basement division and the second unit (Engine 2) would be fire attack division 1 to extinguish the fire that had extended into division 1. The main priority was to knock the fire down and locate the victims as quick as possible. The third crew (Engine 3) pulled the third line off of the rear of Engine 5 and established RIT.

The IC advised there was a dog chained in the back yard that prevented him from completing a full 360 of the rear, but never hampered their offensive actions. During discussions the group advised crews did a great job knocking down the fire given the fire load.

Weather Conditions at Dispatch

Temperature: 55.9 degrees F.

Humidity: 87%

Winds: Variable at 3.5 mph

Visibility: 5.0 miles

Unique Circumstances

Two civilian fatalities

Smoke was heavy lying low around the house. Visibility was poor upon arrival.

Pit bull in the back yard

Plenty of personnel due to shift change

Building Description and Real Estate Records

Occupancy: Single-story dwelling with a full basement

Heated Space: 1,320 sqft

Date Constructed: 1959

Wood Frame with stucco exterior finish Roof: Composite shingles

Interior Finish: Gypsum wallboard and wood panel

Fire Protection Systems: None

Security Systems: None

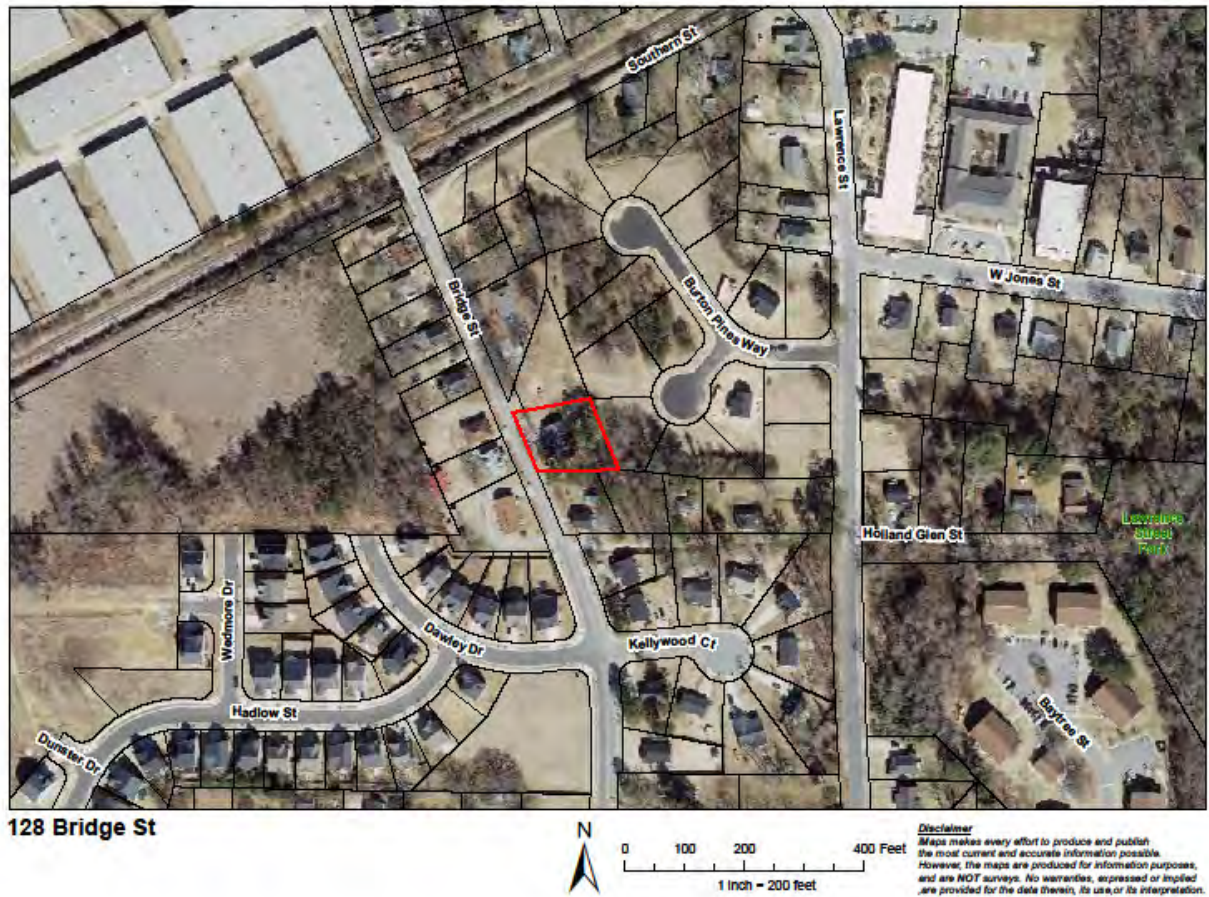
Electrical: Overhead, entry on the south side

200 amp panel

The structure involved in this incident is a one story residential structure, built over a full basement, that occupied 1320 square feet of heated space on the first floor. The structure was originally constructed in 1959 according to the Wake County Tax Records. The structure is constructed of wood framing materials and the exterior walls were covered with a stucco type material. The roof was finished with composite shingle material. The first floor was divided into a living room, kitchen, three bedrooms, and one bathroom. The interior of the structure was finished with a combination of gypsum wallboard, and wood paneling materials. The basement area was divided into five rooms. Four of the basement rooms served as bedrooms, and the main area served as a kitchen / bedroom combination and was identified as the area of fire origin. The interior finish of the basement area consisted primarily of concrete block exterior walls. The interior rooms that had been apparently added over time were framed with wooden framing materials and finished with OSB style sheathing that had been covered with wood paneling. The basement's ceiling consisted of exposed wooden floor / ceiling joist. Electrical service entered the structure via an overhead service drop on the structure's south side. The overhead service drop served a 100 amp meter base that supplied a 200 amp interior panel located on the south wall of the basement. Greg Newkirk, son of the property owner, stated during the investigation that the structure contained an Edison (screw type) fuse panel however it was replaced approximately three years prior to the fire in an attempt to upgrade the structures electrical system. The structure contained an oil

furnace, however it should be noted that the furnace was not in use and the exterior oil tank was found to be empty and the oil line was found to be disconnected during this investigation. Portable electrical space heaters and window unit air conditioners were noted throughout the structure during the investigation which further corroborates the fact that no central heating or air conditioning equipment was in use. The remains of two smoke detectors were noted during the investigation. One was located on the first floor of the structure in the center portion of the hallway outside the upstairs bedrooms. The remains of another smoke detector was discovered in the basement area in the hallway directly outside the SW corner bedroom. During initial witness interviews, one occupant reported that he might have heard faint smoke detector activation, however he couldn't be sure that a smoke detector was actually what he heard. The structure did not employ the use of any other fire detection or suppression equipment.

Aerial of incident area

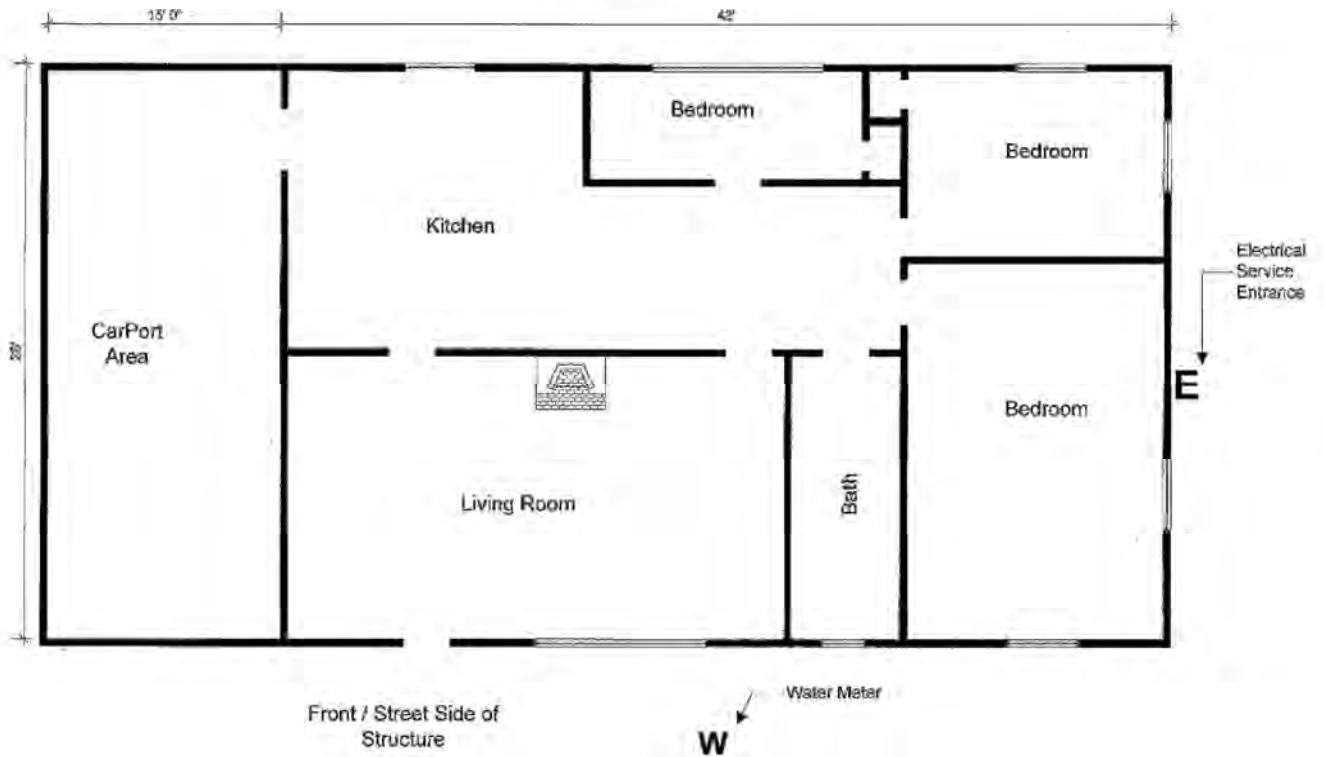


Drawing 1st Floor



Not to Scale

WCFM Case # 12-09547
128 Bridge Street
Fuquay-Varina NC 27526
1st Floor Sketch
Drawn by: D. Braxton

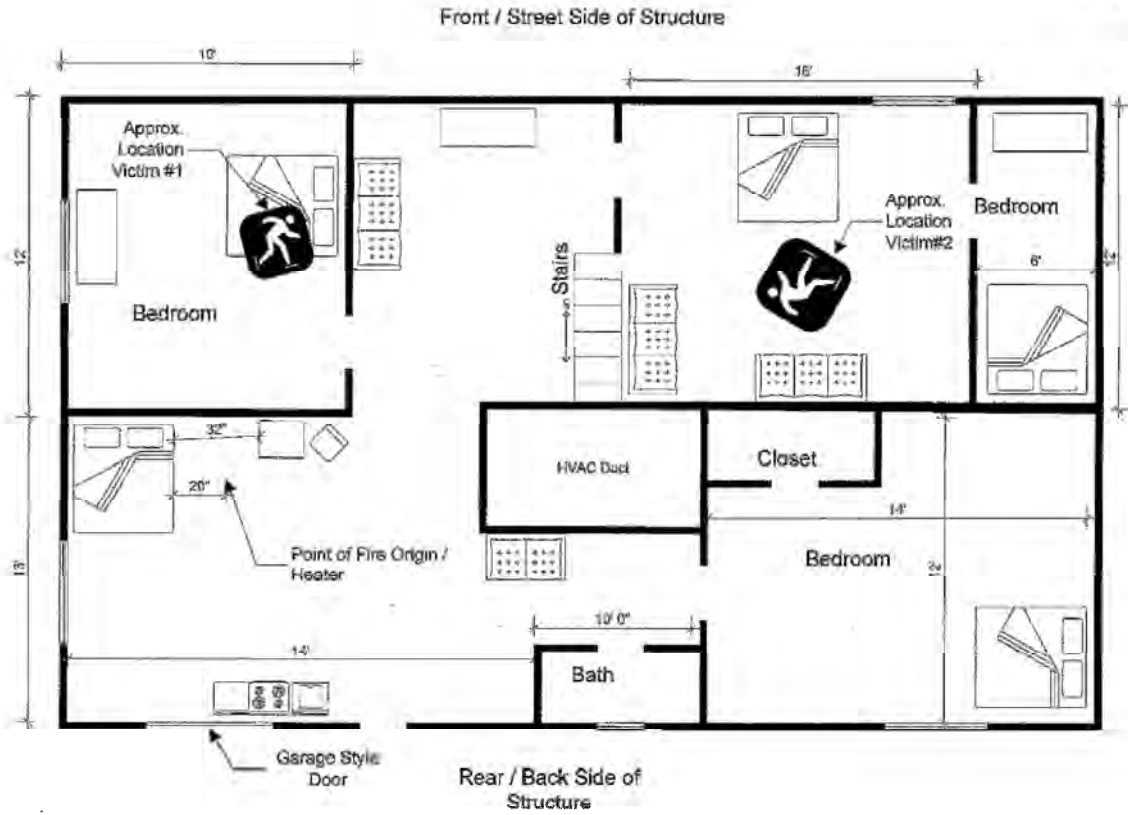


Drawing of Basement

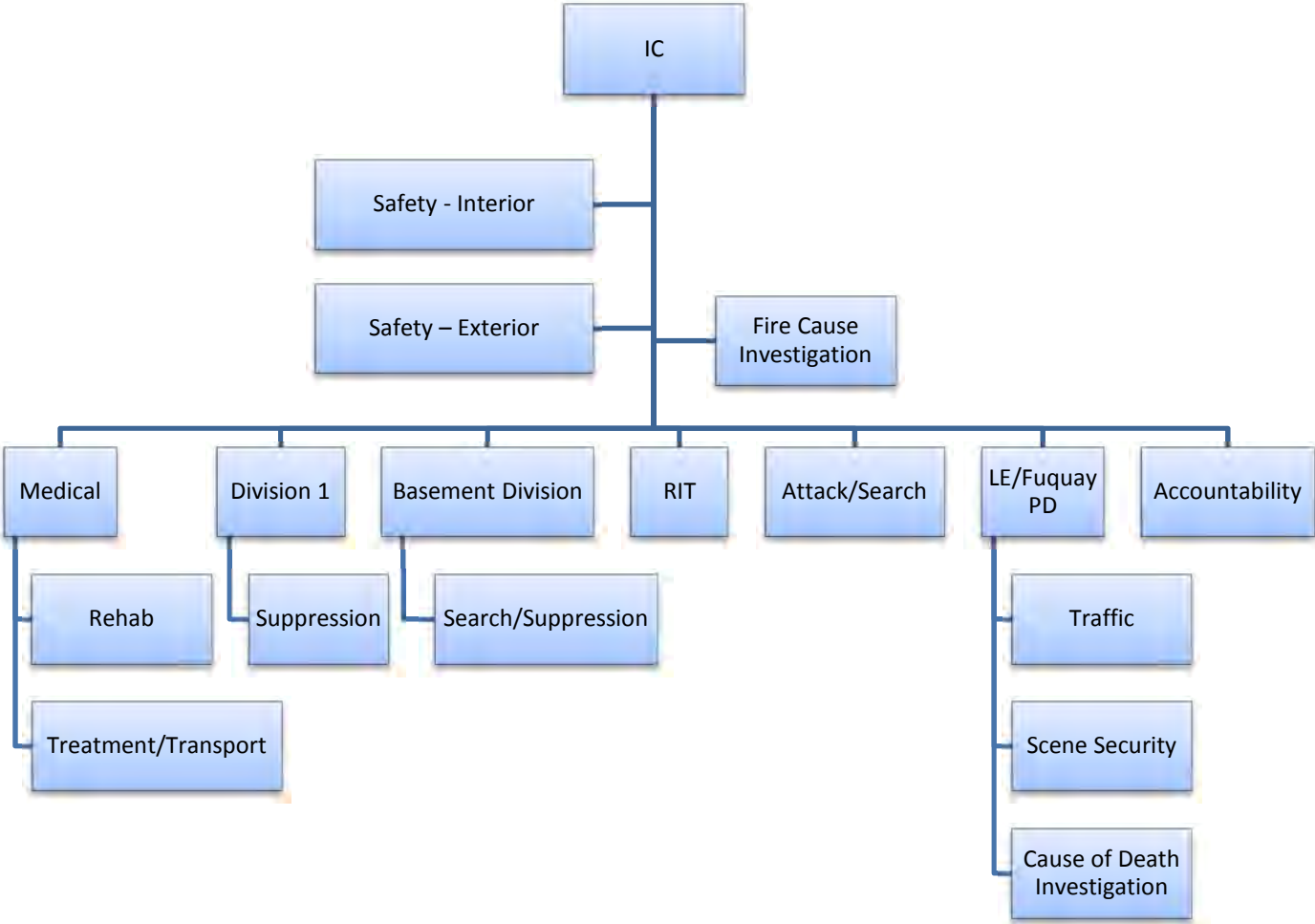
WCFM 12-09547
128 Bridge Street
Fuquay-Varina NC 27526
Basement Area Detail Diagram & Sketch
Drawn by: D. Braxton



Not to Scale



Organizational Chart



Incident Photos



What Went Well and Why?

Tactics were assigned early.

For some time Fuquay Fire Department has been conducting Company Training as described in NFPA 1410. Everyone felt this training paid off at this scene given the complexity of the incident. Firefighters encountered low visibility around the house upon arrival. Inside firefighters encountered high heat conditions in the basement, victims, deteriorating floor issues and the fire had progressed greatly upon arrival.

Law enforcement did a great job with security and communicating with the fire department personnel. All agencies worked well together including the investigation team with multiple agencies.

Improvements and Lessons Learned

Better scene log when the investigation begins. This was addressed.

Reiterate to all crews the importance of deploying egress ladders.

Continue to train on company type drills. This is not mentioned here for improvement, but to remind us how important company training is when faced with challenging incidents.

Interior air monitoring should be done before releasing the scene.

Good accountability tracking may help prevent too many personnel in the same area and help identify available crews.

Officially establish a RIT crew and communicate this so it is clear when the crew has been established.

Follow-up

EMS should attend the Post Incident Review Meetings.