

**LINE OF DUTY  
DEATH REPORT  
REPORT SLIDES**



## **F2019-02**

Captain Died After Crew was Trapped During a Search for a Civilian in a 3rd Floor Apartment Fire – Maine



# Summary

- On March 1, 2019, a 32-year-old male captain was killed by rapid-fire progression while fighting a fire in a three-story apartment building.
- Also, four firefighters were injured.
- At 1105 hours, the town fire department was dispatched with automatic aid resources for a report of smoke in a 6-unit apartment building with one civilian occupant trapped.
- A civilian occupant was the 9-1-1 caller and trapped on the 3rd floor in an apartment bathroom.



Initial arrival conditions. Showing Side Alpha and Side Delta. The victim was at window on 3rd floor on Side Bravo. The time was approximately 1108 hours.

(Photo courtesy of the town police department)



# Summary

- Engine 2, which consisted of a captain, 2 firefighters, and driver/operator, arrived on-scene at 1108 hours and reported heavy smoke showing from the rear of the structure.
- The captain advised the regional communication center (RCC) that Engine 2 (the captain and FF1) were going to make entry into Side Alpha with a 1<sup>3</sup>/<sub>4</sub>-inch hoseline to perform a primary search for a reported trapped civilian occupant.
- The captain of Engine 2 told the other firefighter (FF2) from Engine 2 to get a ground ladder to the 3rd floor to rescue the trapped civilian occupant.
- The captain and FF1 entered the interior stairwell through the front door on Side Alpha at 1109 hours and proceeded to the 2nd floor.
- A police officer identified as PD113 and FF2 placed the ground ladder to the 3rd floor bathroom window on Side Bravo where the trapped civilian was located.



# Summary



The orange arrow identifies the window where the civilian was located upon arrival of the fire department. The civilian was removed from the 3<sup>rd</sup> floor window via the ground ladder. (Photo provided by the Maine Office of the State Fire Marshal)

- The trapped civilian occupant climbed out the window and onto the ground ladder.
- The police officer (PD113) notified RCC that the civilian occupant was out of the building at 1109 hours.
- This message was delayed getting to the captain of Engine 2 because the information was transmitted on a police channel by PD113.
- Engine 2 was operating on the 3<sup>rd</sup> floor when the message was transmitted on the fire channel.
- A decision was made to leave the hoseline on the 2<sup>nd</sup> floor and search the 3<sup>rd</sup> floor.





# Summary

- The captain and FF1 from Engine 2 were unable to make entry into a 3<sup>rd</sup> floor apartment due to the fire.
- The captain made the decision to back out of the structure.
- The crew's exit was blocked by heavy fire traveling up the central stairway.
- They were forced to search for another exit.
- The crew made their way towards the back of the structure in the center hallway and into an apartment on side Charlie.



# Summary

- The captain reportedly threw himself on top of FF1 as conditions deteriorated.
- Between 1112 - 1113 hours, the captain called a Mayday, which was not acknowledged by any resources on the fireground or by RCC.
- At 1114 hours, Engine 4 from a mutual aid company arrived on-scene.
- The lieutenant recognized that the captain and FF1 from Engine 2 were missing and called Command and initiated a Mayday.



# Summary

- As additional companies arrived on-scene, a rapid intervention group was assigned to locate the Engine 2 crew.
- Also, crews began attacking the fire on Side Charlie while the rapid intervention group was trying to access the 3<sup>rd</sup> floor.
- FF1 was able to make his way out onto the porch on Side Charlie and called for help to the crews on the ground at 1116 hours.
- A ground ladder was placed to the 3<sup>rd</sup> floor on Side Charlie.
- FF1 climbed down the ladder and was out of the building at 1122 hours.



The Side Charlie 3<sup>rd</sup> floor porch where the captain and firefighter 1 were removed. (NIOSH Photo)



# LINE OF DUTY DEATH REPORT REPORT SLIDES



Ground ladders extended to a 3rd floor porch where the captain and firefighter 1 were removed from the structure. (Photo provided by the Maine Office of the State Fire Marshal)





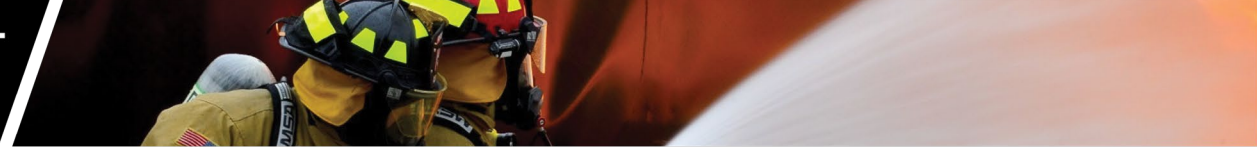
# Summary

- The rapid intervention group located the captain in a room adjoining the Side Charlie porch.
- They moved him to the Side Charlie porch. The captain was lowered down a ground ladder and moved to a stretcher.
- He was out of the building at 1132 hours.
- EMS crews began resuscitation efforts and transported the captain to a trauma hospital in New Hampshire at 1152 hours.
- The captain was pronounced deceased at a trauma hospital in New Hampshire at 1201 hours.



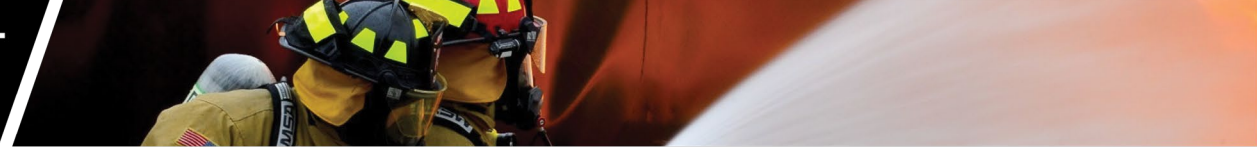
# Contributing Factors

- Incomplete size-up and risk assessment
- Lack of incident management
- Lack of personnel accountability
- Inadequate fireground communications
- Rapid fire spread in the interior center stairwell
- Lack of situational awareness
- Lack of fire sprinkler system in a multi-family residential occupancy.



# Recommendations

- Fire departments should ensure a detailed scene size-up and risk assessment is conducted during initial fireground operations and throughout the incident.
- Fire departments should ensure that once command is assumed, command is maintained until command is transferred, the incident is stabilized, or the incident is terminated.
- Fire departments should ensure firefighters communicate critical incident benchmarks to incident commanders throughout the incident.



# Recommendations

- Fire departments should ensure firefighters are trained in procedures for conducting search and rescue, especially above a fire.
- Fire departments should ensure hoselines are deployed, staffed, and appropriately utilized to protect crews operating in the hazard zone.
- Fire departments should ensure that firefighters are trained in situational awareness.
- Fire departments should use a functional personnel accountability system, requiring a designated accountability officer or resource status officer.





# Recommendations

- Fire departments should use resources from the National Institute of Standards and Technology (NIST), Underwriters Laboratories (UL) Fire Safety Research Institute (FSRI), and the International Society of Fire Service Instructors (ISFSI) to develop and revise operational procedures on fireground tactics and provide training in fire dynamics in structures for all members.
- Governing agencies (state, regional, and local) should consider adopting and enforcing regulations for interventions to reduce or eliminate the spread of fire in multi-family structures, including automatic sprinkler systems and self-closing doors.

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