



National Fire Fighter Near-Miss Reporting System  
 Safety, Health and Survival Week 2009  
 Committed to Long Term Results

**Topic #1: Safety – Emergency Driving**

- a. Lower speeds.
- b. Utilize seat belts.
- c. Stop at every intersection.

**a. Lower speeds** – stop racing to the scene. Drive safety and arrive alive to help others.

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**b. Utilize seat belts** – never drive or ride without them.

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**c. Stop at every intersection** – look in all directions and then proceed in a safe manner.

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**Report Number:** 08-623  
**Report Date:** 12/04/2008 2000

**Demographics**

Department type: Combination, Mostly paid  
Job or rank: Captain  
Department shift: 24 hours on - 24 hours off  
Age: 34 - 42  
Years of fire service experience: 21 - 23  
Region: FEMA Region X  
Service Area: Suburban

**Event Information**

Event type: Vehicle event: responding to, returning from, routine driving, etc.  
Event date and time: 12/02/2008 1900  
Hours into the shift:  
Event participation: Involved in the event  
Weather at time of event: Clear with Frozen Surfaces  
Do you think this will happen again?  
What were the contributing factors?

- Decision Making
- Individual Action
- Human Error

What do you believe is the loss potential?

- Property damage
- Lost time injury
- Life threatening injury

**Event Description**

While working at a structure fire, another call came in to a city four miles away. The deputy chief of the volunteer department self-dispatched himself on an engine to the reported dumpster fire. While driving code five to the dumpster fire, the deputy chief lost control of his engine and nearly ran over a command vehicle from the city department that was dispatched to the dumpster fire.

**Lessons Learned**

You should not put the public or other members of the fire department at risk to jump a neighboring district's calls. Local departments need to work together to best serve the community.

**Report Number:** 08-659  
**Report Date:** 12/22/2008 1216

### **Demographics**

Department type: Combination, Mostly paid  
Job or rank: BLS Provider  
Department shift: Other: This crew was on a 36  
Age: 43 - 51  
Years of fire service experience: 7 - 10  
Region: FEMA Region IV  
Service Area: Suburban

### **Event Information**

Event type: Vehicle event: responding to, returning from, routine driving, etc.  
Event date and time: 12/21/2008 1633  
Hours into the shift: 24+  
Event participation: Involved in the event  
Weather at time of event: Clear and Dry  
Do you think this will happen again?  
What were the contributing factors?

- Human Error
- Decision Making
- SOP / SOG
- Training Issue

### **What do you believe is the loss potential?**

- Life threatening injury
- Property damage

### **Event Description**

We were dispatched to a serious MVC [motor vehicle collision] pin job with fatality on a busy stretch of an interstate. Two rescues from our station responded. I was officer on the second rescue, following the subject rescue. We began our descent down the interstate; traffic was already completely stopped in both lanes. We needed to travel southbound two miles to the MVC. There was a narrow shoulder for our use and it was soft from the rain. Our heavy rescue's strategy is to go very slowly down the center, letting the cars pull to the right and left because passing on the left is not an option here. The rescue in front of us took the shoulder at 40MPH and lost control. The unit almost rolled over. If the ground had been a little softer, you wouldn't be reading this story here. [] indicate additions/deletions by Near-Miss reviewer.

**Speed and tunnel vision can kill. Take time and develop an SOG for interstate response. Take the initiative to learn from other responders' mistakes so in turn we can prevent these incidents. Don't leave the pavement traveling in heavy vehicles.**

**Report Number:** 08-664  
**Report Date:** 12/26/2008 1123

### **Demographics**

Department type: Paid Municipal  
Job or rank: Battalion Chief / District Chief  
Department shift: Other  
Age: 52 - 60  
Years of fire service experience: 30+  
Region: Canada  
Service Area: Suburban

### **Event Information**

Event type: Vehicle event: responding to, returning from, routine driving, etc.  
Event date and time: 11/27/2008 2130  
Hours into the shift:  
Event participation: Involved in the event  
Weather at time of event: Clear with Wet Surfaces  
Do you think this will happen again?  
What were the contributing factors?

- Individual Action
- Decision Making

What do you believe is the loss potential?

- Lost time injury
- Life threatening injury

### **Event Description**

We responded to an automatic alarm in a residential high rise, no back up call, no report of fire, or alarm ringing. I was a passenger in a command van and we were traveling at a high rate of speed, which in my estimation was extremely excessive. (Speed was 140KPH or 80MPH in a 60KPH or 40MPH zone.) Traffic was relatively light. I explained my concern to the driver, who indicated he thought this was a reasonable speed. At first I made light of this, thinking he was kidding me, as in my estimation this was a serious misjudgment. So I gave him another opportunity to comment and change behavior. This issue had to be forcefully addressed as he still maintained it was a reasonable response.

In my estimation, balancing risk versus gain in this type of response shows a very serious lack of good judgment on the part of this firefighter. Although there was no accident or close call in this incident, at speeds such as these, we outpace any traffic control features we have (traffic lights, etc.). We simply cannot react safely should a mechanical, pedestrian or vehicle come into our path.

## **Lessons Learned**

It is apparent that we need to address training issues in our driving training program. Also, using sites in regular training like firefighterclosecalls.com, which have almost daily vehicle incidents may help. I am unsure of how one can correct what I view as a different form of common sense. In this case the firefighter really maintained he was utilizing safe actions. Strong feedback was provided to correct the behavior and compliance obtained. However, the fact is this person still honestly believes he was operating safely. We absolutely need stronger training for drivers. In our department everyone drives. Perhaps it is time to revisit how selections are made.

**Report Number:** 09-122  
**Report Date:** 02/05/2009 1117

### **Demographics**

Department type: Paid Municipal  
Job or rank: Fire Fighter  
Department shift: 24 hours on - 48 hours off  
Age: 34 - 42  
Years of fire service experience: 21 - 23  
Region: FEMA Region V  
Service Area: Urban

### **Event Information**

Event type: Vehicle event: responding to, returning from, routine driving, etc.  
Event date and time: 12/05/2008 1500  
Hours into the shift:  
Event participation: Witnessed event but not directly involved in the event  
Weather at time of event: Clear and Dry  
Do you think this will happen again?  
What were the contributing factors?

- Decision Making
- Human Error
- Training Issue
- Individual Action

What do you believe is the loss potential?

- Lost time injury
- Property damage
- Life threatening injury

### **Event Description**

While responding to an automatic fire alarm with a two piece engine company, we approached a city circle with traffic and noticed a small passenger vehicle stopped and slightly to left of traffic flow. Without hesitation, the engineer of the lead engine went around the right side of civilian vehicle with no slowing. As soon as the lead engine past by, the driver of the civilian vehicle thought to go right for sirens and attempted to do so, narrowly missing side impact on the trailing engine. If the trailing engineer had not had situational awareness, and had not been driving with due regard, he would not have been able to slow and avoid the collision.

**Lessons Learned**

1. Always have situational awareness no matter what task is being completed.
2. Drive with due regard.
3. Never pass vehicles on the right.
4. Have better drivers training in place.
5. Have officer/firefighter in charge, in control of ALL personnel to include engineer.

**Report Number:** 09-224  
**Report Date:** 02/28/2009 1139

### **Demographics**

Department type: Volunteer  
Job or rank: Fire Chief  
Department shift: Respond from home  
Age: 25 - 33  
Years of fire service experience: 14 - 16  
Region: FEMA Region III  
Service Area: Rural

### **Event Information**

Event type: Vehicle event: responding to, returning from, routine driving, etc.  
Event date and time: 02/12/2009 0600  
Hours into the shift:  
Event participation: Told of event, but neither involved nor witnessed event  
Weather at time of event: Cloudy and Dry  
Do you think this will happen again?  
What were the contributing factors?

- SOP / SOG
- Human Error
- Communication
- Decision Making
- Individual Action

What do you believe is the loss potential?

- Property damage
- Environmental
- Lost time injury

### **Event Description**

Our station was dispatched for a non-emergency detail for tree and wires pulled down. A mini-pumper responded to an emergency with two personnel. An additional pumper responded with five personnel non-emergency. Upon approaching the incident scene, the driver of the second apparatus reached down to turn on a portable radio assigned to the driver. When this was done, the driver took his attention away from the road and allowed the vehicle to run off the roadway. The shoulder of the road was very soft due to recent heavy rain and snowfall. The driver attempted to regain control of the pumper but was unable to get out of the shoulder, pulling the pumper into a guardrail. The pumper struck the guardrail on the officer's side, causing minor to moderate damage to the body.

**Lessons Learned**

Due to this event, an SOP has been written for the use of portable radios by the drivers of the apparatus while responding to incidents. Also the driver training program has been looked at to stress the awareness of roadway shoulder conditions and apparatus widths.

**Report Number:** 05-586

Report Date: 10/25/2005 0817

### **Demographics**

Department type: Combination, Mostly volunteer

Job or rank: Fire Chief

Department shift: 24 hours on - 24 hours off

Age: 34 - 42

Years of fire service experience: 24 - 26

Region: FEMA Region IV

Service Area: Rural

### **Event Information**

Event type: Vehicle event: responding to, returning from, routine driving, etc.

Event date and time: 10/24/2005 1923

Hours into the shift: 9 - 12

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?

- Decision Making
- Individual Action

What do you believe is the loss potential?

- Property damage
- Life threatening injury

### **Event Description**

I was responding to residential fire alarm activation in our rural response district. I was driving a 2005 Chevrolet 4x4 Tahoe, which is my issued Chief's vehicle. Our department was having a bi-monthly training meeting, so I responded from the station. This occurred at night with misty rain and windy conditions. Our department Chaplain was riding with me, and we both were wearing our seatbelts. While traveling on a straight stretch of a 2-lane rural highway, I approached a vehicle with only my emergency lights operating. When leaving the station, I had discovered that my siren was inoperable due to a blown fuse. I was traveling at a speed of approximately 65 mph and was having a conversation with my passenger. The vehicle I approached applied its brakes and I assumed he/she was yielding to my approach. I pulled into the passing lane and began to accelerate. The driver of the vehicle immediately turned to the left into a driveway. My immediate reaction was to jerk the steering on my vehicle to the right to keep from hitting this vehicle. My vehicle went into a sideways skid in which I steered into it. My vehicle then went into a skid into the opposite direction. To the best of my recollection, my vehicle skidded sideways approximately 6 times before I regained control. There is no doubt that this vehicle would have flipped on dry pavement.

## **Lessons Learned**

**Lessons Learned:** Always anticipate what the driver of the vehicles in front of you **MAY** do. **NEVER ASSUME!** Drive accordingly to weather conditions and type of call in which you are responding. This fire alarm was set off due to a power glitch. With no operable siren, I would have been at fault if I had hit this vehicle. I should have responded in routine mode until the siren was repaired, our Department SOG on Emergency Response

1. It is the responsibility of the driver of each fire department apparatus to drive safely and prudently at all times.
2. Fire department apparatus shall be operated in compliance with the (state deleted) Motor Vehicle Laws, which provide specific legal exceptions to regular traffic regulations for fire department apparatus when responding to an emergency incident.
3. Emergency response does not release the driver of any responsibility of driving with due caution.
4. When the fire apparatus is responding in the emergency response mode, emergency lights and sirens shall be used to warn drivers of other vehicles. The use of emergency lights and sirens does not automatically give the right-of-way to the fire apparatus, only simply requests the right-of-way from other drivers based upon their awareness of the fire apparatus.
5. Drivers of the fire apparatus must make every possible effort to make their presence and intended actions known to other drivers and must drive defensively and be prepared, anticipate, for the unexpected inappropriate actions of others.
6. Fire apparatus are allowed to exceed 10 mph over the posted speed limits only when responding in the emergency mode under favorable conditions. Favorable conditions include light traffic, good roads, good visibility, and dry pavement.
7. When conditions are less than favorable, the posted speed limit is the absolute maximum permitted.
8. When the fire apparatus must travel in center traffic lanes, the maximum permitted speed shall be the posted speed limit except when within 250 of a street intersection. At this point, the fire apparatus shall slow to maximum of 20 mph.
9. When the fire apparatus is approaching or crossing an intersection with the right-of-way, green traffic light or no stop sign, drivers shall not exceed the posted speed limit.
10. When the fire apparatus must travel in the center or oncoming traffic lanes to approach controlled intersections, the driver shall come to a complete stop before proceeding through the intersection.
11. When the fire apparatus approaches negative right-of-way, red traffic light or stop sign intersections, the driver shall come to a complete stop and shall only proceed when all oncoming traffic in all lanes are accounted for.
12. When the first arriving fire apparatus arrives on the scene and the officer reports "Nothing Showing" or if the "Brief Initial Report" indicates a minor incident, all other responding fire apparatus shall slow to non-emergency response.

13. The Incident Commander shall slow all fire apparatus down to non-emergency response as soon as possible.
14. Fire apparatus drivers shall avoid backing whenever possible. When backing is unavoidable, a spotter shall be used. If no spotter is available, the fire apparatus driver shall dismount the fire apparatus and complete a 360-degree walk around before backing.
15. ALL PERSONNEL ON-BOARD ANY MOVING FIRE APPARATUS SHALL BE REQUIRED TO WEAR SEAT SELTS AT ALL TIMES WHILE THE FIRE APPARATUS IS IN MOTION. THE DRIVER OF THE FIRE APPARATUS SHALL ENSURE THAT ALL PASSENGERS ARE SEATED AND SEAT-BELTED BEFORE MOVING THE FIRE APPARATUS AND WHILE THE FIRE APPARATUS IS IN MOTION.
16. NO MEMBER OF THE TOWN OF (name deleted) FIRE DEPARTMENT SHALL EVER RIDE THE TAILBOARD OF ANY FIRE APPARATUS.
17. No fire apparatus shall pass another emergency vehicle during emergency response unless permission is obtained/granted by the drivers through radio communications. Passing shall be completed under extreme caution.
18. The unique hazards of driving on or near an emergency incident required the fire apparatus drivers to use extreme caution and be alert and prepared to react unexpectedly. Fire department personnel and spectators may be pre-occupied with the emergency and may inadvertently step in front of or behind a fire apparatus.
19. The Town of (name deleted) Fire Department apparatus shall be operated in a manner that provides the utmost of safety for all persons and property. Safe arrival shall always have priority over unnecessary speed and reckless driving.

**PROMPT AND SAFE RESPONSE CAN BE ATTAINED BY**

1. Being Prepared
2. Quickly Mounting the Apparatus
3. All Fire Department Personnel On-Board, Seated, and Belted
4. Knowing Location and Direction of Travel
5. Driving Defensively and Professionally at Reasonable Speeds
6. Using Warning Devices to Move Around Traffic
7. Requesting the Right-Of-Way in a Safe and Predictable Manner

**Report Number:** 06-397

Report Date: 08/01/2006 1714

### **Demographics**

Department type: Combination, Mostly paid

Job or rank: Fire Fighter

Department shift: 24 hours on - 48 hours off

Age: 16 - 24

Years of fire service experience: 4 - 6

Region: FEMA Region V

Service Area: Urban

### **Event Information**

Event type: Vehicle event: responding to, returning from, routine driving, etc.

Event date and time: 07/21/2006 1300

Hours into the shift: 5 - 8

Event participation: Involved in the event

Weather at time of event:

Do you think this will happen again? Yes

What do you believe caused the event?

- Unknown

What do you believe is the loss potential?

- Property damage
- Lost time injury
- Minor injury
- Life threatening injury

### **Event Description**

I was assigned the back of the medic unit that day. We had a full-time experienced driver operating the medic unit and a squad leader in the passenger seat. We got called to a possible heat stroke in the lower part of the township. The weather was clear and hot. The particular station we were responding from is the farthest north in our fire district. We began to make our emergency run. Our SOP/SOG's require us to stop completely at each intersection, which was followed. We had gone about 3 miles and came upon a divided 4 lane road with a concrete shoulder and a concrete divider in the middle. Traffic was moderate that day, like normal. The cars in the far right lane began to pull over for us. We were behind a person in the left lane when all of a sudden; the driver slammed on his brakes, causing us to lock our brakes and almost rear end him. The driver of the car in front of us had an open lane next to them but chose not to veer right. The same event happened again on the same call just about 2 miles farther toward our destination. The second occurrence was just as close and was almost the same condition.

### **Lessons Learned**

There were a lot of lessons learned that day. Do not take for granted that people will pull over to the right even if they have plenty of room. Our SOP/SOG's require us to always wear our seatbelts while we are in any apparatus. While on that call, we had to lock up our brakes. Wearing seatbelts helped us keep our heads and knees out of the dash. Another important lesson to take with you is to always view your surroundings. Have a safe escape route to get around drivers who do the unexpected. And always remember to maintain a safe following distance to cars you are coming up on. Drivers do crazy things when they see lights or hear sirens.

**Report Number:** 08-010

Report Date: 01/04/2008 1554

### **Demographics**

Department type: Paid Municipal

Job or rank: Assistant Chief

Department shift: 10 hour days, 14 hour nights (2-2-4)

Age: 34 - 42

Years of fire service experience: 17 - 20

Region: FEMA Region I

Service Area: Suburban

### **Event Information**

Event type: Vehicle event: responding to, returning from, routine driving, etc.

Event date and time: 12/03/2007 0500

Hours into the shift:

Event participation: Told of event, but neither involved nor witnessed event

Weather at time of event: Cloudy and Snow

Do you think this will happen again?

What do you believe caused the event?

- SOP / SOG
- Decision Making

What do you believe is the loss potential?

- Life threatening injury

### **Event Description**

An on-duty member was plowing the front apron of the firehouse with a FD pickup truck. He was not wearing a seat belt. The operator struck a granite curb with the plow blade. The impact threw him forward into the windshield and cracked the windshield. The member was transported to the emergency room where he was treated and fortunately released.

### **Lessons Learned**

Policies are in place to wear seatbelts. Members need to be vigilant about following the safety policies. Poor decision making could have resulted in a very serious head injury.

**Report Number:** 08-312

Report Date: 06/26/2008 1711

### **Demographics**

Department type: Paid Municipal

Job or rank: Fire Fighter

Department shift: 24 hours on - 24 hours off

Age: 34 - 42

Years of fire service experience: 7 - 10

Region: FEMA Region IX

Service Area: Urban

### **Event Information**

Event type: Vehicle event: responding to, returning from, routine driving, etc.

Event date and time: 08/28/2007 1500

Hours into the shift:

Event participation: Told to and submitted by safety officer

Weather at time of event: Clear and Dry

Do you think this will happen again?

What do you believe caused the event?

- Human Error
- Equipment
- Training Issue
- Situational Awareness
- Decision Making

What do you believe is the loss potential?

- Life threatening injury
- Lost time injury

### **Event Description**

The crew of 4 was seated and restrained when they left the fire station enroute code-3 to a "working fire" when the Engineer "slowed the apparatus to approximately 10-15 M.P.H. to make a controlled right hand turn. It was at this moment when the #4 door unexpectedly swung open during the right turn. Immediately prior to the right turn, FF #4 made a decision to unfasten his seatbelt and exit his seat. FF #4 states: "After securing my SCBA shoulder straps I decided to put on the rest of my equipment in a kneeling position because I felt it would be faster and easier to get ready this way." FF #4 is unknowingly leaning backwards towards the open door due to the momentum of the right turn. FF #3 yells to the Engineer over the headset intercom that "the door was open and to STOP!" FF #3 grabbed FF#4 and assisted him to the center of the floor of the moving apparatus. The Engineer stopped the vehicle, the door was shut, and the Engine Company continued their response without further incident. The apparatus involved in this incident was a 2005 (8 passenger) enclosed cab pumper. The FF #4 position seatbelt was the original factory equipment and

noted to be in working order. The open door alarm was also observed to be in full working order with the ignition/batteries ON and the parking brake disengaged. It was discovered however, that the alarm volume had been turned down to its lowest setting and would be difficult to hear even under ideal conditions (vehicle stationary, engine not running, no outside traffic, road noise or sirens). Factors normally present during emergency response (headsets, radio traffic, etc.) would make it virtually impossible to hear the audible open door alarm. Upon investigation, the FF #4 door appeared to be in full working order without any malfunctions noted before the incident. Statements given by FF #4 and the Engineer indicate the door appeared to be closed when leaving the fire station. Both indicated the retractable stairs were in the stowed position with no audible alarms sounding. Closer examination of the #4 door revealed a 2-position latching mechanism that marries a door latch to a Nader pin. In the primary position, the latch barely catches the Nader pin and only latches securely in the secondary position. While the door is only partially secured in the primary position, it was observed that there is still sufficient pressure applied to a pressure switch that retracts the stairs and deactivates the open door alarm. The forward location of the pressure switch in the door jam may contribute to the false reading.

### **Lessons Learned**

The chain of a potentially tragic event was broken due to following factors: The attentiveness of FF #3 (watching out for each other) The controlled driving of the fire apparatus as demonstrated by the Engineer Both firefighters credit the Engineer's driving habits as a key factor in avoiding a tragic outcome, commenting; due to the experience, skill and controlled driving demonstrated by the Engineer when making the right turn, -we averted disaster.

1. The Fire Department REQUIRES that ALL fire fighters who ride on ANY moving emergency fire apparatus are seated and secured by seat belts. [Policy number deleted] Discussion: The Fire Department has been aggressively addressing the issue of seat belt compliance. A SCBA & Seatbelt Awareness presentation was presented to ALL Firefighters during the 2007 2nd quarter company training. The training boldly stated that the Fire Department was taking a ZERO TOLERANCE view on the adherence of the seat belt policy. This ZERO TOLERANCE campaign was further reinforced during the 2007 National Safety Stand-down Day for ALL shifts in June 2007. The training echoed the same concepts of the Seat Belt Awareness Presentation as well as addressing, safe methods of donning turnout gear and SCBA's during code 3 responses while using the seat belt restraint system. The Safety Stand Down also addressed the use of seat belts in the back of ambulances.

2. Revision to SOP [# deleted] to include that emergency apparatus will NOT move without personnel seated and in seat belt restraints, including a verbal confirmation of the seat assignment with a "READY". A "READY" meaning that the person in that assigned position is seated and belted. Personnel will NOT don personal protective equipment (turnout gear and SCBA) in ANY moving fire apparatus, PPE must be donned while the apparatus is in a stationary position prior to initiating a response OR upon arrival on scene. Personnel will NEVER be

onboard a moving fire apparatus while not seated and unrestrained under ANY circumstances.

3. Incorporate the available audible/visual warning device technology indicating when a fire fighter is un-restrained or not seated.

4. Update SOP's to address tampering with or disabling warning devices.

5. Make fire apparatus manufacturer aware of the potential design flaw that exist with the present location of the pressure switch (door alarm). Recommend that the pressure switch be relocated towards the aft end of the door jam.

6. Advocate for participation of compliance with the National Fire Fighter Safety Seat Belt Pledge department wide.

7. Truly adopt and enforce a "ZERO TOLERANCE POLICY" within department SOP's and policy. Squared brackets [] indicate reviewer added/changed content

**Report Number:** 08-506  
10/07/2008 2216

### **Demographics**

Department type: Combination, Mostly paid  
Job or rank: Driver / Engineer  
Department shift: 24 hours on - 48 hours off  
Age: 52 - 60  
Years of fire service experience: 21 - 23  
Region: FEMA Region III  
Service Area: Urban

### **Event Information**

Event type: Vehicle event: responding to, returning from, routine driving, etc.  
Event date and time: 04/22/2008 2230  
Hours into the shift:  
Event participation: Involved in the event  
Weather at time of event:  
Do you think this will happen again?  
What do you believe caused the event?

- Human Error

What do you believe is the loss potential?

- Lost time injury

### **Event Description**

The brackets [] denote reviewer de-identification. While returning from an incident, I was driving E [1] back to the station. I was driving due to the fact, that I had lost my driver who had upgraded an ambulance for a transport. I had been the unit officer for the shift on E [1]. We were returning back to the station understaffed because I had no qualified unit officer or third. I had 2 volunteers with me. I was traveling back to the station and had exited off at the ramp for [name deleted]. Approaching the road, we had a red light. I stopped well before the intersection at the first white stripe indicating the proper stopping area. While awaiting the change of the light to proceed, I had observed a blue compact in the lane to turn left. He was stopped at the same stopping point as E [1]. He was in the inside left turn lane (to my left) and I was in the outside left turn lane of the 2 lanes to make the left turn. This intersection has 2 left turn lanes with green arrows for westbound [name deleted]. When the left turn green was indicated, the blue compact immediately proceeded through the intersection without incident. I hesitated, checking intersection clearance before proceeding through. The intersection was clear and I proceeded into the intersection with green arrow active. A bus was traveling at a high rate of speed eastbound on [name deleted]. The bus immediately slammed into E [1] after running the red light. I was hit at the driver's compartment side. The engine was rocked and pushed a distance from impact point. I looked over at the driver and raised my arms up to indicate what are you doing? The driver said (I could read her lips) "it

wouldn't stop." At impact, I observed the passengers on the bus thrown to the floor. I also looked back up and our green arrow was still active and she still had a clear red. I called our communication center, requested an assignment, and advised them of our location. I told them that we had been smeared by a bus that ran a red light. I was initially stunned and shocked and remained in the driver's seat before climbing over the engine cowl and exiting out of officer's door to evaluate the situation. There were no skid marks from the bus indicating any brake activation. Units were on scene immediately. The bus occupants and my crew were attended too. My crew and I were transported to the emergency room for evaluations. I did have neck and back pains. In regards to the blue compact, if he had not immediately proceeded through the intersection he would have been struck first and pushed into us. In my opinion, we definitely would have had a fatality. There was nothing different I would have or could have done to avoid this collision. I exercised all possible safety procedures. There are traffic cameras at this intersection and all of my personnel were belted at the time of the collision.

### **Lessons Learned**

I have always been an advocate of seat belt use both on and off the job. I always make sure that all of my crew is belted, whether I am driving or the OIC of the apparatus. If they are not belted, then we go nowhere until they are. I always verbally check with my crew for an acknowledgement that they are belted and ready. In this incident, there was nothing else that I could have or would have done differently. This was an unavoidable incident on my part. This incident would have been much more serious with possibly fatal repercussions, if my crew and I were not belted. I feel that if we all were not belted, then someone may have been ejected at impact when we were hit by the bus. I can say to all who have hesitations or just blatantly ignore seat belt use, if you are involved in a similar incident it would make you a believer. Where seat belts for your safety. To give you an indication of what non belted passenger's experience, all of the passengers on the bus that struck us were forcefully thrown to the bus floor upon impact. I witnessed this with my own eyes. In summation, I would urge drivers and passengers to use your seat belt. It does not matter what your job may be. Also, wear a seat belt in your personal vehicle. If you care about yourself or your loved ones, you will wear your seat belt at all times when in a moving vehicle. It makes no difference if it's a law or department policy, wear it. Don't feel that an incident such as this could not happen to you. It can at any time. Belts are there. Wear them!

**Report Number:** 05-362  
**Report Date:** 07/31/2005 1123

### **Demographics**

Department type: Paid Municipal  
Job or rank: Driver / Engineer  
Department shift: 24 hours on - 48 hours off  
Age: 34 - 42  
Years of fire service experience: 11 - 13  
Region: FEMA Region VI  
Service Area: Urban

### **Event Information**

Event type: Other  
Event date and time: 07/25/2005 1330  
Hours into the shift: 0 - 4  
Event participation: Involved in the event  
Weather at time of event:  
Do you think this will happen again? Uncertain  
What were the contributing factors?

- Human Error
- Situational Awareness
- Individual Action

What do you believe is the loss potential?

- Lost time injury
- Property damage
- Life threatening injury

### **Event Description**

I was driving an engine company to a reported fire with the first in unit reporting "fire through the roof" when I approached an intersection. Our department policy is to come to a complete stop at all red lights and gain control of the intersection. My light was red. I had sounded both the air horn and the mechanical siren. The cross street was a 5 lane street with a center turn lane. The traffic on this street was stopped in all three lanes to my left. The traffic to my right was stopped in the right lane and the center turn lane. The middle lane was empty. Having slowed to approximately 20-25mph I thought I was clear to go when my Lt. screamed "STOP-STOP-STOP." I slammed on the brakes just in time to stop before crashing into a small sedan that had come through the middle lane. My failure to come to a complete stop and "control the intersection" could have injured my fellow firefighters and possibly killed civilians.

### **Lessons Learned**

I re-learned to not let the nature of the call that I am responding to dictate the way I drive or compromise my judgment. I will no longer "bust" an intersection.

**Report Number:** 06-176

Report Date: 03/22/2006 1220

### **Demographics**

Department type: Combination, Mostly volunteer

Job or rank: Driver / Engineer

Department shift: Respond from home

Age: 25 - 33

Years of fire service experience: 4 - 6

Region: FEMA Region VIII

Service Area: Suburban

### **Event Information**

Event type: Vehicle event: responding to, returning from, routine driving, etc.

Event date and time: 03/12/2006 1225

Hours into the shift: 0 - 4

Event participation: Involved in the event

Weather at time of event:

Do you think this will happen again? Uncertain

What were the contributing factors?

- Human Error
- Weather
- Situational Awareness
- Decision Making

What do you believe is the loss potential?

- Property damage
- Minor injury

### **Event Description**

Dispatched to report of a traffic crash on a highway. Upon leaving, the station came to the first controlled intersection near station, which is also a blind intersection for fire apparatus leaving the station. When attempting to stop the fire apparatus, apparatus was unable to stop before entering the intersection due to the slick conditions of the road and the road surface.

Note: While responding to the station, traction conditions in my POV appeared to be reduced, but not as slick as they proved at this near miss. The apparatus entered the intersection extending into the right turn lane, but not the through lane of the intersection. A civilian vehicle also was approaching the intersection and was unable to stop due to the road conditions and speed of the vehicle. Said vehicle went through the intersection and contacted a fixed object. No injuries resulted but there was property damage to the fixed object and the civilian vehicle.

**Lessons Learned**

To prevent more occurrences of this type, the engineers should be more aware of the situation. They need to realize that road conditions can deteriorate in minutes when the weather is bad. Speed was a factor for the apparatus and civilian vehicle. Fire apparatus must come to a complete stop to clear a blind intersection when the green light is for cross traffic. Speed needs to be reduced for intersections wet or snow packed, especially when turning, or when on concrete rather than asphalt. Opticom or other traffic light control devices may help at this particular intersection, since it is blind, narrowed due to "traffic calming," and near the fire station.

**Report Number:** 07-966

Report Date: 06/20/2007 1016

### **Demographics**

Department type: Combination, Mostly paid

Job or rank: Battalion Chief / District Chief

Department shift: 24 hours on - 48 hours off

Age: 43 - 51

Years of fire service experience: 30+

Region: FEMA Region III

Service Area: Suburban

### **Event Information**

Event type: Vehicle event: responding to, returning from, routine driving, etc.

Event date and time: 06/20/2007 1000

Hours into the shift: 0 - 4

Event participation: Involved in the event

Weather at time of event: Clear and Dry

Do you think this will happen again? Yes

What were the contributing factors?

- Situational Awareness
- Decision Making
- Individual Action
- Human Error
- SOP / SOG

What do you believe is the loss potential?

- Minor injury
- Property damage
- Lost time injury

### **Event Description**

My driver and I were responding to a truck fire along with two engines, 1 aerial tower and an EMS unit. The first engine arrived and reported a utility truck fully involved. The utility truck was a small bucket style truck used for replacing street lights. It was parked on a narrow street in a town center style community.

We were approaching the scene with emergency lights on and siren sounding. We had to pass through a "T" intersection about two blocks from the scene. We were proceeding along what would be termed the top of the "T". The right of way was in our favor. A stop sign was posted for vehicles approaching on the leg of the "T". My driver slowed and stated, "I hear someone coming." He came to a stop just short of the intersection as the aerial tower made a right turn in front of us without stopping at the stop sign. The EMS unit was behind the tower. We waved them through and proceeded to the scene without further incident.

Had we proceeded into the intersection on the right of way, we would have collided with the tower.

### **Lessons Learned**

1. Caution needs to be exercised at all times when responding.
2. The right of way is not a guarantee for safe passage.
3. Instincts should be listened to. My driver said when we saw the smoke column, heard the on scene report, and got closer to the scene on the narrow streets, he had a sense that he should slow down.
4. The driver and officer of the tower were counseled on the scene. Our department has an SOP in place that states vehicles approaching stop signs and red lights should stop to ensure the intersection is secure before entering.
5. The tower driver stated he was focused on making the turn into the narrow street. He heard our siren, but believed we were farther away than we were when he entered the intersection. His reaction was "Holy \*#&^" when he saw how close we were, but by that time he was well into his turn.
6. Officers need to exercise leadership and discipline over their crews. The tower officer at first indicated he didn't have a brake on his side of the tower. He was reminded that he's responsible for the overall safe operation of the vehicle.

**Report Number:** 07-1096

Report Date: 10/19/2007 1554

### **Demographics**

Department type: Combination, Mostly volunteer

Job or rank: Lieutenant

Department shift: Respond from home

Age: 25 - 33

Years of fire service experience: 7 - 10

Region: FEMA Region V

Service Area: Urban

### **Event Information**

Event type: Fire emergency event: structure fire, vehicle fire, wildland fire, etc.

Event date and time: 09/11/2007 2015

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?

What were the contributing factors?

- Situational Awareness
- Individual Action
- Decision Making

What do you believe is the loss potential?

- Property damage
- Life threatening injury
- Lost time injury

### **Event Description**

[Date and time deleted] our department was dispatched for a furnace that had exploded in a mobile home causing injury to the homeowner. It was also reported that the home was filled with smoke and natural gas. Three engine companies and one ladder company responded emergency to the scene. We already had a captain, lieutenant, and a fire fighter at the station. The captain filled in as the driver and I assumed the officers role with one fire fighter in the back of the ladder. While we were enroute to the call one of our engine companies that is approximately 3 miles from the scene of the explosion, checked on the radio that they were enroute. Both the driver of the ladder and I commented on how we would most likely meet at the intersection nearest to the scene. This was based on where we were at the time that they called enroute and how long it would take for them to reach that intersection. We were traveling on a four lane freeway and the engine company was on a two lane road. As we came up to the intersection, we had the green light and the engine company had a red light. The Captain that was driving followed proper SOG's. He slowed down before the intersection even though we were coming off the freeway and had the green light. As we were slowing down, we glanced down the road and saw the engine company coming emergency

through the intersection. The engine driver did not even slow down. The estimated speed of the engine was 40 MPH. If we had not slowed down and continued at speed through the green light, we would have been T-boned by our own engine company. As soon as the engine cleared the intersection we continued to the scene of the explosion.

### **Lessons Learned**

It is preached over and over again that when you are driving apparatus in the emergency mode in accordance with our departments SOG's and even certification at the state level, you are to slow down at every intersection and be ready to stop in case vehicles are unable to see or hear you. It is something that is taught in our department's "In-House" driver training and is taught when fire fighters complete the engine or aerial certification from the state. Too many times drivers tend to get "tunnel vision" when they are driving to and from an incident and in the aftermath of this incident, we could have had two of our own apparatus involved in an accident. This not only creates the potential for significant injury to our personnel, but also lengthens the time it would take to get help to the incident that we were dispatched to. After slowing down before a driver reaches the intersection, it only takes 2 seconds for that driver and officer to scan the intersection and deem it safe to travel through. In those 2 seconds, great injury and possible injury to civilians could have occurred if the driver had not been paying attention. As fire fighters, we are responding to emergencies and not trying to create them. In the aftermath of this incident, it has come to light that we need to start paying more attention. We need to think about how we are getting to the scene and respond in the safest manner, then worry about what we are going to be doing at the incident scene after we get there.

**Report Number:** 08-228

Report Date: 05/07/2008 2349

### **Demographics**

Department type: Volunteer

Job or rank: Captain

Department shift: Respond from home

Age: 25 - 33

Years of fire service experience: 4 - 6

Region: FEMA Region II

Service Area: Suburban

### **Event Information**

Event type: Vehicle event: responding to, returning from, routine driving, etc.

Event date and time: 11/12/2007 2100

Hours into the shift: Volunteer

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 were the contributing factors?

- Human Error
- Individual Action
- SOP / SOG
- Protocol
- Decision Making

What do you believe is the loss potential?

- Life threatening injury
- Minor injury
- Property damage

### **Event Description**

The department was alerted for an automatic residential fire alarm at the very far South end of the district. All companies were alerted. The first due, Engine [number deleted] is approximately four to five blocks away. The truck company is located in the middle of town, approximately a .5 mile response. Engine [number deleted] had an approximately 1.5 mile response. Chiefs were enroute and received no additional information regarding the alarm. The area is prone to false alarms. The captain of Engine [number deleted] was driving. All lights and audible warning devices were operating. As the vehicle approached a red traffic signal, the captain said he brought the apparatus to a full stop before entering the intersection. Vehicles approaching from either side stopped. The captain stated that he moved the apparatus to the middle of the intersection and stopped again. As he proceeded further, he noticed out of the corner of his eye, a rapidly approaching vehicle coming from the left around the stopped vehicles in the left hand turning lane. The impact occurred between the apparatus front left bumper

and the vehicle's front right tire. The apparatus pushed the vehicle approximately 100 feet past the intersection. The two occupants of the vehicle were transported to the hospital with minor injuries. The captain and crew were all transported to the hospital for precaution. None of the crew, including the captain, was wearing their seat belt. It is unknown as to whether the two vehicle occupants were wearing their seat belts.

Brackets [ ] denote identifying information removed by the reviewer.

### **Lessons Learned**

The intersection where this incident occurred is one of the more dangerous within our district. Responding from Engine [number deleted] quarters south of this intersection, is almost totally blind to oncoming cross traffic until actually in the intersection due to buildings. However, the two more critical factors with regard to this accident are the lack of use of seat belts by the crew, including the captain, and more importantly the denial of the captain of any responsibility in the cause of this accident.

Brackets [ ] in this report denote identifying information removed by the reviewer.

The captain claims that he stopped the vehicle not once but twice before the impact occurred. Yet the apparatus pushed the vehicle approximately 100 feet after impact. It doesn't seem that the apparatus could push a vehicle that far from a dead stop. The captain claims that instead of stepping on the brake at impact, he stepped on the accelerator in order to keep the vehicle from pushing the apparatus into the gas station. It doesn't seem that a vehicle weighing approximately 1/4 of the weight of the apparatus would be able to push it that far. In addition, most would agree that the normal reaction for most people when they are involved in an accident is to brake. The captain claims he made the split second decision to accelerate over the basic instinct to brake.

The captain has had a previous history of aggressive driving and this incident has done little, if anything, to change that.

Our department officers do little with regard to correcting aggressive driving which is pretty obvious as the driver in this incident is a company captain. The officers and membership have an extremely lax attitude with regard to seat belt use. One of the members riding in the back of this apparatus had the point of his helmet flattened out due to this accident. This incident occurred only three days after another member riding in this same apparatus had to be transported to the hospital with a head laceration because he was standing up when the truck stopped short. I believe my department needs to implement and fully enforce a no tolerance seat belt policy. I also believe that a crackdown on aggressive driving must take place. The department officers are very lax in these areas because nobody wants to be the "bad guy" and enforce these policies. We also need to address the response policy to certain calls. Every call that comes in, no matter what, is a full speed, lights and siren response for all units. We had a chief get into an accident just four days before this accident going to an automatic

commercial fire alarm. The third activation in under a week! So, we basically sent eight members to the hospital in five days from vehicle incidents. Even when the chiefs radio to slow the response down, apparatus are still responding full tilt. We are a LODD or civilian death just waiting to happen.