

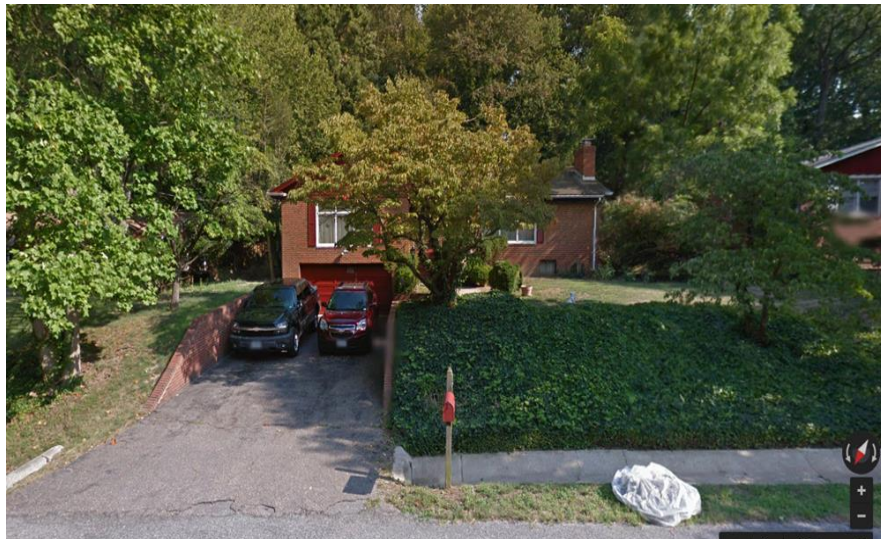


PRINCE GEORGE'S COUNTY FIRE/EMS DEPARTMENT

5007 SHARON ROAD

April 15, 2016

Incident # 16041500000361



Safety Investigation Team

SUMMARY REPORT



Prince George's County Fire/EMS Department

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Background

On April 15, 2016, firefighters and paramedics from the Prince George's County Fire/Emergency Medical Services (EMS) Department were alerted to respond to 5007 Sharon Road in Temple Hills, Maryland, for a call to check the welfare of a citizen. Shortly after their arrival, crews attempted to force entry into the residence and two members of the Department were struck by gunfire originating from the interior of the home. Thirty-seven-year-old Firefighter/Paramedic John Ulmschneider; a 13-year member of the Department, died as a result of his gunshot injuries. Volunteer Firefighter Kevin Swain; an 9-month member of the Morningside Volunteer Fire Department, was shot and critically injured and required aeromedical evacuation to a regional level one trauma center. Volunteer Firefighter Swain's injuries were extensive and resulted in a prolonged recovery period. The brother of the homeowner was also struck by gunfire when he attempted to enter the home with firefighters and paramedics. Two additional Firefighter/EMT's (Volunteer Firefighter Riley and Volunteer Firefighter Livingston) sustained injuries when they attempted to flee the immediate area after the gunfire erupted from inside the residence.

At 19:33 hours on Friday, April 15, 2016, Prince George's County Public Safety Communications (PSC) received a 911 call from the shooter's brother and indicated that he was unable to contact his diabetic brother (shooter), who was feeling ill earlier in the day. Based on the information received in the 911 call, PSC dispatched Rescue Engine 827 from Fire/EMS Station 827 located in Suitland, Maryland, and Paramedic Ambulance 823 from Fire/EMS Station 823 located in Forestville, Maryland. Rescue Engine 827 was first to arrive on the scene at 19:46 hours. Shortly thereafter, Paramedic Ambulance 823 arrived at 19:48 hours. Personnel from Rescue Engine 827 contacted the shooter's brother who stated that he felt his brother was experiencing a medical emergency and that he was inside the house. Five personnel from Rescue Engine 827 approached the front door, knocked and announced "fire department". Personnel from Rescue Engine 827 began the process of forcing entry into the home after multiple attempts to contact the resident were unsuccessful.

While personnel from Rescue Engine 827 were in the process of forcing entry, two members from Paramedic Ambulance 823 approached from the front sidewalk just below the landing at the front entrance of the home. Seconds prior to the front door being breached by Rescue Engine 827, a total of eight people, including the shooter's brother, were standing on the front porch. After the front door was forced open, personnel immediately encountered gunfire from the interior of the home. At 19:50 Rescue Engine 827 notified PSC that shots had been fired at that location. Volunteer Firefighter Kevin Swain, assigned to Rescue Engine 827, was shot once in the abdomen while standing in the threshold of the front door and twice in the lower back while retreating from the front porch.

Firefighter/Paramedic John Ulmschneider, assigned to Paramedic Ambulance 823, was shot once in the chest as he turned and attempted to retreat from the area. The shooter's brother was shot in the facial area while entering the home and was witnessed identifying himself to the shooter. Two additional personnel from Rescue Engine 827 sustained minor injuries as they exited the front porch.



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Firefighter/Paramedic John Ulmschneider was transported to Southern Maryland Hospital Center. After exhaustive efforts by Fire/EMS personnel and hospital staff, he succumbed to his injury. Volunteer Firefighter Kevin Swain was flown to University of Maryland Shock Trauma by Maryland State Police Trooper 2, where he underwent surgery as a result of his injuries. The two members of Rescue Engine 827 that sustained minor injuries, and the shooter's brother were transported to Prince George's Hospital Center for treatment.

The tragic events that occurred on April 15, 2016, left one career firefighter dead, one volunteer firefighter critically injured and sent two other volunteer firefighters to the hospital. The Prince George's County Fire/EMS Department tasked the Operational Safety office to assemble a formal Safety Investigation Team (SIT); referred to in this report as the "Team", to conduct an internal investigation of the incident. The investigation was initially delayed due to the ongoing criminal case. The criminal nature of the incident created challenges by limiting the Team's timely access to vital information typically utilized to conduct an internal investigation of this nature.

On December 1, 2016, Fire Chief Marc Bashoor authorized the Operational Safety office to begin assembling the Team in anticipation of the conclusion of the criminal investigation. The Operational Safety office solicited member participation from various stakeholder groups within the organization. Chief Bashoor reached out to the National Institute for Occupational Safety and Health (NIOSH), and requested an external review of the incident in addition to the Department's internal investigation. Members from NIOSH's Fire Fighter Fatality Investigation and Prevention Program worked alongside the Prince George's County Fire/EMS Department's Safety Investigation Team to conduct a parallel investigation.

The Safety Investigation Team submitted a Final Report report to the Prince George's County Fire Chief. The following account is a summary of events that occurred on April 15, 2016.



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INTER-OFFICE MEMORANDUM PRINCE GEORGE'S COUNTY, MARYLAND

November 21, 2016

TO: All Sworn, Civilian, and Volunteer Personnel **Memo #16-52**

FROM: Marc S. Bashoor 
Fire Chief

RE: Sharon Road Safety Investigation Team (SIT)

The horrific events of April 15, 2016, will remain forever etched in all of our minds. The internal healing processes continue, and our thoughts and prayers are with everyone involved.

The legal process has been difficult and will continue to extend for some time. Immediate investigative steps were taken, and some long term options have been discussed. However, the formal Safety Investigation Team (SIT) was delayed while the legal process continued to unfold.

The Safety Office will lead the SIT effort and will be contacting organizational members to participate, consistent with the Work Group/Task Force process. I have directed the Safety Office to make final selections for the SIT by December 1, 2016.

It is incumbent upon each organizational area contacted to ensure there is appropriate and engaged representation for the SIT process to be successful. It is part of our mission to ensure that no stone is left unturned through this process.

I appreciate everyone's patience and cooperation as the SIT begins their work.

MSB/msb

2016.11.21 ASCVP Memo #16-52-Sharon Road Safety Investigation Team



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Incident Summary

Members of Rescue Engine 827 were available on the air/radio in the greater Morningside area, when they were alerted for a “check the welfare” call at 5007 Sharon Road. They responded from the basketball court with six volunteer members. Rescue Engine 827 responded to the call with emergency lights and sirens and arrived on the scene at 19:46:08 hours. Rescue Engine 827 was the first unit to arrive on the scene. They pulled past the reported address and positioned on the Alpha -Delta corner of 5007 Sharon Road, facing Nile Place, and away from Old Branch Avenue.

Paramedic Ambulance 823 was in quarters at the time of dispatch at 19:34 hours. Paramedic Ambulance 823 responded with emergency lights and sirens and arrived at 5007 Sharon Road at 19:48:56 hours. Paramedic Ambulance 823 positioned in front of Rescue Engine 827 facing Nile Place, in front of 5005 Sharon Road. They were the second and last Fire/EMS Department unit to arrive on the scene.

Recommendation

The Department will review and consider changes in dispatch procedures.

- *Fire/EMS units should not be dispatched on “check the welfare” call types that involve acts of violence or reports of weapons without a verified response from law enforcement. Once Public Safety Communications receives confirmation that a police officer is responding, units may be dispatched on the call and provided with an estimated time of arrival.*
- *Ensure that Public Safety Communications asks if weapons are present from civilians at every request for a 911 response. Fire/EMS personnel should be made aware of this information verbally by dispatchers prior to arriving on scene.*
- *Currently, Public Safety Communications assumes every caller has access to a weapon. The Fire/EMS Department should work with PSC to refine this process, specifically when the potential to force entry into an occupancy exists.*

Rescue Engine 827 arrived on the scene at 19:46:08 hours. Six members were onboard; the Officer In Charge (OIC) Fitch, Firefighter Riley (Driver), Firefighter Swain, Firefighter Ward, Firefighter O'Brien, and Firefighter Livingston. Five members exited the apparatus while Firefighter Riley remained on the Rescue Engine in the driver's seat. The five members of Rescue Engine 827 immediately approached the Alpha side (front) of the house and came in contact with Mr. Keith Williams (calling party) in the driveway of 5007 Sharon Road. Mr. Williams told the Rescue Engine crew that he believed that his brother (Mr. Darrell Lumpkin) was having a medical emergency and that he needed immediate medical assistance. Mr. Williams told the crew that he attempted to call his brother (Mr. Lumpkin) several times throughout the day, but was unsuccessful.



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Mr. Williams advised the crew from Rescue Engine 827 that his brother had recently been experiencing a variety of medical issues. Additionally, his brother had been sent home from work the day prior, due to health concerns. Unable to reach Mr. Lumpkin by phone, Mr. Williams became increasingly worried and drove to his brother's house where he found Mr. Lumpkin's car in the driveway. All the doors were locked from the interior indicating that Mr. Lumpkin was home and was physically unable to answer the door. Mr. Williams was very insistent that his brother was inside and needed immediate medical attention.

Several members from Rescue Engine 827 knocked on the front door and front windows in an attempt to illicit a response from Mr. Lumpkin. According to County Police records, all members from Rescue Engine 827 recall announcing their presence at the scene and yelling "Fire Department" multiple times while knocking on the front door and front windows. Firefighter Ward was witnessed looking down the Delta side of the house for an alternative entry point. No evidence was presented that a complete 360 degree walk around of the house was ever completed. The decision to force entry through the front door of the residence was made by crew members from Rescue Engine 827. Initial attempts to gain entry through the outside storm door were unsuccessful.

Witness statements indicated that five members of Rescue Engine 827 were on the porch and that the storm door was more difficult to force than they anticipated. It took a considerable amount of time to force the outward swinging metal storm door and their forcible entry actions were notably loud. The iron tools (halligan bar and flat head ax), were used as the primary forcible entry method. Crew members struck the halligan bar with the axe multiple times making several loud noises. While the members from Rescue Engine 827 were attempting to gain entry, Mr. Williams became increasingly insistent that Mr. Lumpkin was inside and incapacitated due to a medical emergency.

The crew from Paramedic Ambulance 823 arrived on scene at 19:48:56 hours and proceeded to meet with the crew from Rescue Engine 827 on side Alpha (front) of the residence on the front porch landing. Firefighter Van Schoonhoven stated that he and Firefighter/Paramedic Ulmschneider arrived at the front porch after the outside storm door was forced and before the wooden front door was forced open. Firefighters Van Schoonhoven and Firefighter/Paramedic Ulmschneider both actively participated in knocking on the front windows, announcing the Department's presence. The five members from Rescue Engine 827 and the two members from Paramedic Ambulance 823 that were on the front porch landing were all actively engaged with announcing the Department's presence and making a considerable amount of noise while forcing the doors.

After successfully gaining access through the front storm door, Firefighters Swain, Fitch, and O'Brien began forcing the inner wooden door. While those members were attempting to force the inner door, Mr. Lumpkin's brother became increasingly impatient, voicing his concerns regarding his brother's wellbeing towards the crew of Rescue Engine 827 and Paramedic Ambulance 823. A decision was made to "shock" the door with several forceful blows from the forcible entry tools to break the inner wooden door's locks and enter the house faster. The last attempt at "shocking" the door resulted in the lower right wooden panel of



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the door being broken and the panel falling into the residence. Firefighter Swain, whom was striking the door, knelt on one knee and reached through the broken door panel and unlocked the inner dead bolt.

Witness statements indicated that while forcible entry efforts were occurring, all members that were located on the front porch of the house from Rescue Engine 827 and Paramedic Ambulance 823 were announcing "fire department". According to County Police reports, Firefighter Swain stated that as he reached inside of the broken panel door to unlock the dead bolt, he announced "fire department" several times while he was completing the task. Firefighter Swain was successful with unlocking the door through the broken panel.

Recommendation

Revise General Order 06-19 so that it clearly outlines the appropriate steps to managing an incident requiring forcible entry into an occupancy.

- *A revision of the current Forcible Entry General Order (06-19) should include the requirement for personnel to complete a 360 degree size up (if possible) of the residence or building. This shall also include but is not limited to knocking, banging, and verbal announcements prior to forcing entry. Every attempt to notify the potential occupant of the Fire/EMS Department's presence should be made prior to entering the occupancy.*
- *Develop parameters that identify when forcible entry is required.*
- *Consideration should be given to restricting the number of personnel standing near the entryway while attempting to force entry. Most of the personnel that responded to the initial incident were standing directly in front of the doorway while the door was being forced and then opened.*

After unlocking the door, Firefighters Swain, Fitch, and O'Brien were all positioned directly in front of the door, standing side by side. Firefighter Livingston, Firefighter Ward, and Mr. Williams were part of a group staggered on the front porch. Firefighter/Paramedic Ulmschneider and Firefighter Van Schoonhoven were last, standing on the front steps of the residence.

As the door swung open, Mr. Williams forced his way through and entered the structure with Firefighter Swain. As they entered, the remaining personnel were still standing on the porch. Almost immediately after the door was opened, and before Mr. Williams and Firefighter Swain were able to take more than a few steps, five shots were fired from a small caliber handgun in succession from approximately 8-10 feet away. Firefighter Swain was struck in the abdomen and as he turned to exit he was struck a second and third time in the buttocks and lower back while running down the steps. After the third shot, Firefighter Swain was incapacitated on the front landing of the house. Almost simultaneously, Mr. Williams was shot in the lower jaw and collapsed into the house. As gunshots were being fired, Firefighter/Paramedic Ulmschneider turned to flee and was struck in the chest. Firefighter/Paramedic Ulmschneider ran toward Paramedic Ambulance 823



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seeking refuge. Firefighter Fitch exited the front porch over the hand rail and retreated to Paramedic Ambulance 823. Firefighter Ward exited the porch, down the steps, and sprinted to a parked car on Sharon Road to seek shelter. Firefighter O'Brien fled from the front porch to the far side of Paramedic Ambulance 823 and took refuge inside the unit.

Recommendation

The Department should revise General Order 10-01 referencing personnel uniforms and equipment.

- *Personnel should wear a standard Fire/EMS Department or Volunteer Fire/EMS Station uniform. All attire should be easily identifiable as Fire/EMS Department personnel and not confused with County Police Department personnel.*
- *When forcing entry into an occupancy, the forcible entry team should wear some form of high visibility apparel with FIRE/EMS clearly printed on the front and rear.*

Recommendation

Enhance existing annual training requirements to include forcible entry tactics, identifying and managing risk, self-defense and de-escalation techniques.

- *Training to promote situational awareness, de-escalation techniques and self-defense training should begin in recruit school/VRS and can be provided annually to employees/members on Target Solutions.*

Mandate that all members and employees receive training to include proper personnel positioning for safety (off to side of the door being forced, not directly in front of the doorway) while performing forcible entry. As mentioned in the previous recommendation, responding personnel were positioned directly in the line of fire when the door was being forced and then opened. By limiting the number of personnel forcing entry and by proper positioning, the risk to employees/members will be reduced.

Firefighter Livingston was knocked down by crew members on the front porch and suffered injuries to her jaw and neck. Firefighter Livingston was able to self-extricate off the front porch and sought refuge at a house across the street with Mr. Williams. Firefighter Van Schoonhoven safely retreated to the passenger side of Paramedic Ambulance 823. After the five shots were fired, Firefighter Swain was the only member left on the property. At 19:50 hours, several members radioed shots fired with members down. Firefighter/Paramedic Ulmschneider was able to make it to the far side of Paramedic Ambulance 823 and asked Firefighter O'Brien and Firefighter Van Schoonhoven if he was shot and then collapsed onto the side of Paramedic Ambulance 823. Firefighters Fitch, O'Brien and Van Schoonhoven assisted with loading Firefighter/Paramedic Ulmschneider into Paramedic Ambulance 823 through the side door. Firefighter/Paramedic Ulmschneider was conscious but not alert. At 19:54 hours, Firefighters



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Van Schoonhoven and O'Brien rendered aid to Firefighter/Paramedic Ulmschneider while responding to Southern Maryland Hospital Center while Firefighter Fitch drove Paramedic Ambulance 823.

Recommendation

Create a pilot program to evaluate the use of Ballistic Vests.

- *The Department should conduct a feasibility study to determine if ballistic vests will provide a clear benefit to personnel placed in elevated risk environments.*
- *The SIT recommends an optional wear policy that clearly outlines the use of ballistic vests for certain call types.*
- *If a ballistic vest program is adopted, vests should be properly fitted to personnel.*
- *A ballistic vest will not eliminate all risk to Fire/EMS Department personnel. A ballistic vest provides significant protection from small caliber gunfire directed at the upper torso.*

Note: The Prince George's County Fire/EMS Department was in the process evaluating the purchase and use of ballistic vests at the time this report was being drafted.

Additional resources were requested to the scene by Paramedic Ambulance 823 and Rescue Engine 827. Public Safety Communications dispatched Medic 829, Paramedic Ambulance 806, Ambulance 825, and Battalion Chief 883 at 19:55 hours. Ambulance 825 and Medic 829 were in their own stations at the time of the dispatch. Battalion Chief 883, Southern EMS and Paramedic Ambulance 806 were all available on the radio.



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Recommendation

Improve command and control of incidents, particularly those that require a multi-agency response.

- *Provide aides to Battalion Chiefs to help manage communications, information, and accountability. (Chief Aides are also included in Recommendation #14 as part of the 57th Avenue SIT Report. This recommendation has not been implemented.)*
- *Restrict non-essential personnel from approaching the command post.*
- *Prohibit the frequent practice of trying to reach the Incident Commander by cell phone when he/she is actively managing an incident.*
- *Conduct inter-agency training to develop a better working relationship with other agencies. The inability to establish a functional unified command with the County Police highlights the need for improved inter-agency cooperation. The Department should develop and train on joint response guidelines for violent incidents. This training must include joint training exercises with local law enforcement. A clear vision of agency duties, responsibilities and information sharing, guided by the ICS framework, should be the focus for improved inter-operability between the County Fire/EMS Department and the County Police Department.*
- *Evaluate the type and amount of information that is relayed through the Watch Office.*
- *Pre-designate call back procedures for essential personnel at all ranks.*

As Paramedic Ambulance 823 responded to Southern Maryland Hospital Center (SMHC) with Firefighter/Paramedic Ulmschneider, the decision was made to attempt to rendezvous with an Advanced Life Support (ALS) unit. Paramedic Ambulance 806 was the closest available ALS unit and attempted to meet with Paramedic Ambulance 823 on Branch Avenue, in the area of Allentown Road. Paramedic Ambulance 806 was at Suitland Road and Silver Hill Road, approximately 10 minutes away, which prompted Paramedic Ambulance 823's decision to continue directly to SMHC without an ALS resource on board. While waiting on Branch Avenue for Paramedic Ambulance 806 to arrive, Firefighter Fitch changed positions with Firefighter O'Brien. Firefighters Fitch and Van Schoonhoven began to initiate advanced BLS care using the LIFEPAK 12 monitor that was on board Paramedic Ambulance 823.

While en route to SMHC, Firefighter Van Schoonhoven and Firefighter Fitch attached Firefighter/Paramedic Ulmschneider to the LIFEPAK 12 monitor, Automated External Defibrillator (AED) pads, 3 lead heart monitor, pulse oximeter, attempted to insert an Oropharyngeal Airway (OPA) to begin bag valve mask respirations, and started to suction his airway. Firefighter/Paramedic Ulmschneider was delivered to SMHC at approximately 20:07 hours.

Firefighter/Paramedic John Ulmschneider suffered one gunshot wound to the upper right torso. The .380 caliber bullet entered at the mid-axillary line, above the right nipple traveling diagonally into the cardiac cavity and into his left bicep. Firefighter/Paramedic Ulmschneider was pronounced dead at Southern Maryland Hospital Center at 20:38 hours after an exhaustive attempt to revive him was unsuccessful by hospital staff.



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Firefighters Van Schoonhoven, Fitch, and O'Brien were all taken from SMHC by the Prince George's County Police Department (PGPD) to their headquarters on Barlowe Road for questioning and statements. The three members were then transported by the County Police back to 5007 Sharon Road to provide details to investigators. They were all released to return home after PGPD obtained their initial statements.

After Paramedic Ambulance 823 departed from 5007 Sharon Road, Firefighter Swain self-extricated off the landing by rolling down the driveway where he was aided by Firefighter Ward. Firefighter Swain's injuries included gunshot wounds to the right lower abdomen, back and right buttocks.

Firefighters Ward, Livingston and Riley assisted Firefighter Swain into the rear crew compartment of Rescue Engine 827 and left the scene headed toward Nile Place. All three firefighters were onboard Rescue Engine 827 and requested a medevac for Firefighter Swain. Firefighters Ward and Livingston rendered aid to Firefighter Swain in the crew cab of Rescue Engine 827 as Firefighter Riley drove away from the scene and toward the landing zone located at 4904 Brinkley Road, Thurgood Marshall High School.

Upon arrival at the landing zone, Rescue Engine 827 was met by Ambulance 825. Ambulance 825 and Medic 829 were directed to the landing zone by command (Battalion Chief Reith) to assist with Firefighter Swain's injuries. Ambulance 825 was staffed by Firefighter/Paramedic Jake Brown and Firefighter Steve Simms. Firefighters Brown and Simms took immediate actions to assist with the injuries. Medic 829 staffed by Firefighter/Paramedic Rapheal Holt and Firefighter/Paramedic Cameron Brown, arrived at the landing zone and assisted Ambulance 825 with immobilizing Firefighter Swain, identified and stopped all uncontrolled bleeding, administered oxygen and obtained a baseline set of vitals. At approximately 20:05 hours, Maryland State Police Trooper 2 (medevac helicopter) arrived at the landing zone and assumed care of Firefighter Swain. At 20:17 hours, Trooper 2 transported Firefighter Swain to the R Adams Cowley Shock Trauma Center in Baltimore, Maryland with Firefighter Ward (Rescue Engine 827), on board to assist with patient care.

After Trooper 2 departed the scene with Firefighter Swain, medical attention was provided to Firefighter Riley (Rescue Engine 827) and Firefighter Livingston (Rescue Engine 827) by Ambulance 825 for minor injuries. Firefighter Riley suffered a knee injury while dismounting Rescue Engine 827 at 5007 Sharon Road and Firefighter Livingston sustained jaw and neck injuries after being knocked over on the front porch. Both members were transported to Prince George's Hospital Center by Ambulance 825. Ambulance 825 remained with the injured crew members of Rescue Engine 827 until relieved by the Southern EMS Duty Officer, Lieutenant Michael Hayter. Lieutenant Hayter, arrived at Prince George's Hospital Center approximately 90 minutes into the incident. Ambulance 825 returned to Fire/EMS Station 825 (Clinton) and remained out of service for unit decontamination. Upon their return to the station, they were met by volunteer members from Station 825 who relieved them from duty. Station 825 was scheduled to take part in Volunteer Staffing Utilization (VSU) that evening. Firefighter/Paramedic Brown and Firefighter Simms went home without being offered or directed to participate in Critical Incident Stress Management (CISM) or any form of counseling.



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Recommendation

Improved personnel accountability tracking system.

- *Provide a better accountability process for the Incident Commander to utilize. Incident Commanders should have immediate access to the name and riding position of every employee and member operating on an incident. This improvement may not have changed the outcome of the incident but it would have provided the Incident Commander with the tools necessary to account for all personnel involved in the shooting on Sharon Road.*
- *Command Officers have no accurate way of knowing the names and certification level of personnel riding on apparatus staffed by volunteer members.*

After Trooper 2 departed, the crew from Medic 829 were redirected by Battalion Chief Reith to the command post, located at 6104 Old Branch Avenue to assist with Mr. Keith Williams' injuries. Mr. Williams, Darrell Lumpkin's brother, was driven by a County Sheriff to the command post on Old Branch Avenue. Medic 829 arrived at the command post and began to render aid to Mr. Williams. Shortly thereafter, Mr. Williams was transported to Prince George's Hospital Center by Medic 829 with a single gunshot wound to the chin that travelled into his shoulder. Once Mr. Williams was transferred to the care of awaiting emergency room staff, Medic 829 returned to Fire/EMS 829 (Silver Hill) and remained out of service. They were relieved from duty for the remainder of the shift and sent home. Their station supervisor offered contact information for the Employee and Volunteer Assistance Program (EAP/VAP). No other CISM resources were offered or received by the crew from Medic 829.



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Recommendation

Improve assistance and counseling services available to Fire/EMS Department employees/members.

- *Create a fully funded and functioning CISM Team (or equivalent) with qualified personnel (internally and externally). The lack of investment in this program directly resulted in a considerable number of personnel of all ranks, not being provided with adequate support. Recommendation #22 of the 57th Avenue SIT Report addresses the need for the Department to adequately staff this program. The CISM Team remains underfunded and inadequately staffed.*
- *Create a check sheet to guide Incident Commanders when dealing with death or significant injury to both civilians and employees/members of the Fire/EMS Department. Incident Commanders and supervisors should be aware of the resources available to employees/members and how to activate these resources. Refer to previous similar recommendations in the 57th Avenue SIT Report. Recommendation #21 addresses similar deficiencies noted in 2012.*
- *Ensure that the Watch Office has a clear CISM notification procedure.*
- *Re-evaluate the current EAP/VAP system and address the inadequacies that have been noted in the past. Employees/members expressed concerns with the perceived lack of access to timely counseling and support services.*
- *Create a policy that ensures personnel involved in these types of traumatic incidents are immediately relieved from duty, offered counseling services, and given the appropriate amount of time off to recover from the incident.*



Additional Recommendations

Recommendation

Update the Fire/EMS Department's Line of Duty Death General Order

- *Develop a thorough guide to assist in all aspects of a Line of Duty Death.*
- *Provide an accurate list of internal and external resources available to the Fire/EMS Department. This list should be kept up to date and accessible to members of the Command Staff tasked with coordinating post-incident recovery efforts.*

Recommendation

Develop and periodically update a database to accurately track all employee/member training and certifications.

- *The Department should utilize readily available programs, such as Target Solutions to implement this recommendation. The Safety Investigation Team encountered numerous obstacles while attempting to access certifications for personnel involved in this incident. The SIT found that records maintained at the station level were inaccessible and/or incomplete. Recommendation #35 found in the 57th Avenue Safety Investigation Team's Report, emphasizes the need to maintain a formal database consisting of both career and volunteer personnel's training records. The Fire/EMS Department has not implemented this recommendation since it was made in 2012.*



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Recommendation

The Department should revise General Order 03-13 and mandate the carry and use of portable radios by all personnel actively engaged in an incident.

- *The Prince George's County Fire/EMS Department has made significant strides toward improving the safety of Fire/EMS Department personnel by issuing portable radios for each riding position on board apparatus. The Safety Investigation Team identified multiple employees/members that were not carrying portable radios after they dismounted their apparatus resulting in multiple personnel not being able to request emergency assistance. This issue is also referenced in the Roseld Court SIT Report (page 97, Section O, Recommendations 2&3). NFPA 1221, Standard for the Installation, Maintenance, and Use of Emergency Services Communications Systems states that all units shall be equipped with a two-way mobile and portable radio that is capable of communications with the communications center. The Prince George's County Fire/EMS Department has met the burden of this standard, yet responders failed to carry the assigned portable radios with them when they approached the house. The portable radios themselves did not have a direct impact on the shooting but should be considered a lifeline between Fire/EMS personnel and Public Safety Communications when the need to relay urgent information is critical.*

Recommendation

The Department should train personnel on the use of MDC/MDT's and ensure they are working properly.

- All personnel should be trained on the proper utilization of the MDC/MDT's.
- The Fire/EMS Department should develop and distribute procedures for requesting repairs and replacements for damaged or missing MDC/MDT's.
- Invest in periodic upgrades to MDC/MDT's to improve the performance and reliability of each unit.