



**FCM 053-2016**

**FIRE CHIEF MEMORANDUM**

**DATE:** May 10, 2016

**TO:** All DFD Members

**THROUGH:** Eric C. Tade, Chief of Department *ECT*

**FROM:** Todd A. Bower, Deputy Chief of Department *TAB*

**SUBJECT: PIA FOLLOW-UP: INFORMATION REGARDING DFD 2012 INCIDENT (#12-0040771)**

**This correspondence is intended to provide Denver Fire Department members with an insight into the circumstances surrounding incident #12-0040771.**

On November 9, 2015, the Denver Fire Department (DFD) Internal Affairs (IA) was directed to investigate the circumstances surrounding the Facilitated Learning Analysis (FLA) of a near-miss incident at Crusher Auto Salvage. This post incident document was authored by a Lieutenant who was assigned to that incident in 2012. IA also investigated the appearance that “no follow up” was completed with the document in terms of developing educational safety and training due to the circumstances surrounding the near-miss event.

**The Lieutenant’s FLA:**

Following the incident in 2012, the Lieutenant wrote the FLA. Information from the FLA included:

The FLA produced by the Lieutenant articulated his perspective on how decisions and actions as a result of the incident transpired, without identification of any concerns for how the incident was managed. The information about the roofing material was identified by the Lieutenant before he stepped on the non-weight bearing panel. He stated that “While waiting I discussed the roof stability with the crew emphasizing the limited areas of structural support under the steel panels and pointing out the existence of the fiberglass “skylight” panels and the need to absolutely avoid stepping on them. The crew concurred with my assessment of the roof and voiced their understanding of the situation....At this time we were hearing from the interior companies that the smoke was from a commercial waste oil heater and not from any type of structural fire. We started to prepare to come down from the roof via aerial ladder. I received a radio message from command asking me to verify the penetration area of the vent pipe was still in good shape and not showing any signs of issue due to heat etc. I responded “wilco”.” The Lieutenant went on to convey that “I was standing on the ridge of the roof, facing the IC (Alpha side of the building) and the vent pipe was to my 7 o’clock, the C/D quadrant. Up until this moment I had

maintained consistent focus and had probed before every step along the roof. After the quick radio exchange with the IC I turned around and stepped out with my left foot, no probing. I heard a crunching crack and pitched forward to my hands and right knee. My left foot and leg was through the roof.”

In that document the Lieutenant also listed his lessons learned as follows:

- ✓ “Roof operations are dangerous and require complete focus and continual updating of your Situational Awareness (SA). A moment of distraction can interrupt your SA and have immediate consequences.”
- ✓ “Consider other options to gain intelligence from the roof level. Staying on the aerial apparatus could have likely provided us with the same information.”
- ✓ “Stop and think when you change your tactical plan. I said clearly “...we’ll operate from the stick. We’re not getting on this roof” and yet I did, without any conscious consideration of the hazards or why they were no longer an issue for me.”

### **Investigation Interviews**

IA interviewed the Lieutenant who stepped on, and subsequently partially fell through, a roof skylight made out of non-load bearing material, during the incident in 2012. IA also interviewed the Assistant Chief who had been the incident commander on that scene.

The Lieutenant was interviewed on November 18, 2015 and was very clear on the details of the actual event, but could not recall the details of his conversations with the Assistant Chief regarding the handling of his FLA. According to the Lieutenant, after he finished the FLA, he subsequently gave it to the Assistant Chief for his input. The Lieutenant stated that he believed the Assistant Chief was going to give his input, edit the document, and then forward it on to the Safety and Training Division for further action. The Lieutenant also conveyed that many Department members had asked him for copies of the document for educational purposes, but he could not remember to whom it was actually given.

The Assistant Chief/Incident Commander of the Crusher Auto Salvage incident was interviewed on December 9, 2015 and was also asked of his recollections of speaking with the Lieutenant regarding the FLA. The Assistant Chief stated he assigned the Lieutenant to write the document due to the Lieutenant’s first-hand knowledge and experience of the event. The Assistant Chief instructed the Lieutenant to submit the document to the Safety and Training Division. The Assistant Chief stated that he had every reason to believe the Lieutenant would follow through as directed.

The Assistant Chief did not recall ever receiving a copy of the FLA from the Lieutenant. The Assistant Chief stated he felt it was important to thoroughly document the incident, for training purposes, in the National Fire Incident Reporting System (NFIRS) so everyone Department-wide would have access to the details. The Assistant Chief chose to use the NFIRS platform to help spread the information from the Incident Commander’s standpoint.

### **Further Updated Information since December 10, 2015:**

Subsequent to the above summation, additional information has been obtained. An email from the Lieutenant to the Assistant Chief on July 29, 2015 identifies that the Lieutenant believed that he

forwarded the FLA to the Safety and Training Division back in 2012 for identification of this potential Department-wide training opportunity. However, the exact recipient of that prospective email could not be located. Further, there's no information to date to verify that the Safety and Training Division actually received that communication.

### **System Changes to-Date**

- The Shift Commander Position has been implemented with job description requirements, a focus on safety, and 24/7 daily coordination of communication throughout the Department.
- All four Shift Commanders have completed initial Safety Officer training which consisted of a two-day course in preparation for the Pro Board Safety Officer certification.
- Raptor Leatherman tool purchased, distributed, and training provided for use in removing bunking gear in an expedient fashion
- Safety Tab has been created for daily safety concerns notification to the Department.
- All truck companies recently received new Bullard TIC and training has been provided.

### **Items Currently in Process:**

- In addition to the required Safety Tab on every NFIR, a near-miss program is being developed.
- Pre-plans will be delivered with Tablet Command.
- All Chiefs have iPads with air cards, enabling them to access Tablet Command which has map imagery. Currently working on a solution for all companies to have access via wifi-enabled apparatus.
- Truck Committee has been formed to address roof operations. Division-wide in-service is being scheduled. A class specifically addressing referenced roof construction is being delivered.
- Near-Miss Policy development in process.
- Enhanced safety training for all Department Assistant Chiefs is in process.
- Policy development to outline the process to email significant information to the requisite District Chief, Shift Commander, Division Chief, Deputy Chief of the Department, and the Chief of the Department.
- NIMS adherence at all incidents by all members is being overseen by Incident Commanders and the Shift Commanders.

### **Lesson Learned to-Date:**

- Documentation and information exchange were not pristine.
- Gaps in communication that diluted the full dissemination of information Department-wide
- Department members must follow up verbal directives with written forms of communication when passing along important information to assist with consistency of messaging and starting an appropriate documentation trail. Members must also complete the feedback loop on orders and directions given by superior officers and inform the appropriate C.O.C.
- As time passes, memories fade and are less than precise.
- Supervisors must reiterate the general expectation to follow directives as assigned and keep supervisors informed of pertinent information and progress thereof.

## **Summation to-Date:**

The Assistant Chief, and Incident Commander for the 2012 near-miss incident, submitted the NFIRS report stating that the Assistant Chief and the Lieutenant "...will follow up on this with the Safety and Training Division to get information out about this building and the close call incident." While it appears that both the Lieutenant and the Assistant Chief took steps to achieve these ends, there was no formal written plan to follow through as originally intended. The DFD, on average, administers more than 300 NFIRS reports per day. With this number of submissions, there's not a realistic expectation that the information entered into the NFIR System would reach all intended personnel, nor do so in a timely fashion. Further, the NFIRS is not a sanctioned communication conduit for information exchange within the DFD. The NFIR System has the ability to capture pertinent information that could be accessed by DFD personnel, but it has not been, and should not be, thought of as a means of internal information conveyance. Other official channels are in place to get messaging out as needed.

The FLA information was used by both the Assistant Chief and the Lieutenant to train personnel at the district level, but the FLA was not distributed Department-wide. Therefore, no requisite Department-wide training was carried out as intended. A great deal of communication assumptions were made by both the Assistant Chief and the Lieutenant with no completion of the feedback loop occurring. While localized training appears to have been accomplished by both officers, there are opportunities going forward to enhance the information exchange when important details from these types of incidents occur and information needs to be disseminated in a more expedient fashion.

Finally, in reviewing the information obtained by IA, it is clear that there was no intent to hide or an intentional lack of dissemination of the information regarding the near-miss of the Lieutenant; in fact it was quite the opposite. The Assistant Chief directed the Lieutenant to write up and submit the post incident report to the Safety and Training Division for follow up and, due to the Lieutenant's positive past work performance, the Assistant Chief did not see a need to follow up with the Lieutenant as there had never been an issue previously with the Lieutenant complying with verbal directives. The Lieutenant stated he thought the Assistant Chief would edit and respond back to him. It is clear that both officers recognized the need to educate the Department membership on these types of roofs and were proactively attempting to accomplish that mission in their own ways, but a coordinated effort did not occur. Based upon the information collected, there is no indication that either party willfully withheld any information from being distributed to the membership for educational and/or safety purposes.

In summary, it is the Department's intention to bring clarity to the concerns expressed by our membership related to the FLA created, following the 2012 near-miss incident at Crusher Auto Salvage. It is hoped that the information contained herein has accomplished that mission. Department-wide changes will continue to be implemented as further information and/or processes of safety concerns are recognized.

TAB:kfc/H/FCM/2016/053-2016 PIA Follow-up Regarding 2012 Incident #12-0040771

DISPOSITION: Read at Roll Call for three (3) consecutive shifts.

DISTRIBUTION: Suppression and Support Services (*electronic*)