

**Investigative Report
Line of Duty Injury
On March 20, 2011
Charlotte County Fire /EMS
Punta Gorda, Florida**



**Safety Investigation Report
Prepared by the Safety Section
Bureau of Fire Standards and Training
Florida Division of State Fire Marshal
Florida Department of Financial Services**

Issued: 11/18/11

Safety Investigation Report

I. Authority and Purpose, and Scope

The Department of Financial Services, Division of State Fire Marshal (“division”) is authorized by the provisions of Section 633.806, *Florida Statutes*, to conduct investigations into the causes of firefighter employee injuries and death for the purpose of enhancing firefighter occupational safety and health in the State of Florida, and to make recommendations to the Legislature, firefighter employers, and insurers as to the best means of prevention.

II. Scope

The scope of this investigation is to determine the facts surrounding a line-of-duty injury that occurred in Charlotte County on March 20, 2011 and make recommendations for reducing the potential for future incidents of this type.

III. Background and Methodology

The division became aware of the injury informally on March 20, 2011 through second hand information. Formal notification was received from Charlotte County Fire / EMS (“CCFEMS”) on March 21, 2011. Information was acquired and a joint investigation was conducted with Florida Forest Service which at that time was known as the Florida Division of Forestry (“DOF”), and CCFREMS. On April 19, 2011, a meeting was held at CCFEMS with all identified witnesses, participants and the injured. Computer assisted dispatch records, fire reports, post-scene photographs, written statements and individual interviews with the DOF and CCFEMS firefighters were acquired. These activities and resources form the basis of this report.

IV. Executive Summary, Findings and Recommendations

CCFEMS was conducting fire suppression operations at a brush fire located at State Roads 74 & 31 in Charlotte County. CCFEMS Brush Truck 16 (“BT16”), with a crew consisting of a Lieutenant (LT), a firefighter and a firefighter/paramedic was returning to the fire line as directed by incident command. BT 16 was paralleling a fence line toward the assignment with the LT driving and the firefighter/paramedic walking ahead of the unit as a guide to help identify and avoid potential hazards. While negotiating around a small pond, BT16 slid sideways and became stuck on a steep, muddy embankment. Their location was at the rear left flank of the fire about 30 feet from the pavement of Bermont Road and a structural fire engine was close by. The fire was coming toward them but was not aggressive. BT 16 was not in immediate danger at that time. Unable to self extricate, BT 16 radioed command for assistance and was told that resources would be made available to assist them. About 20 minutes after BT 16 became stuck, a forestry tractor arrived.

The Division of Forestry tractor (“FO 45”) was a 2000 type 2 John Deere 650H model tractor with a blade, plow and winch. This was not the operator’s normal unit but a reserve acquired from the Region 4 Mitigation Team. The FO 45 had been assigned to re-enforce the left flank of

the fire via radio. Enroute to that location, FO 45 came upon BT16 and decided that the first priority was to assist BT16.

Action

FO 45 approached BT 16 from the rear, made its way around the driver's side of BT 16 and removed some trees to provide an area from which to work. This area was up-grade and about 40 feet away from BT 16. FO 45 maneuvered until the operator was satisfied with the lining up of the plow and tractor with BT 16 and then stopped. There was no communication between the units; only expectations based upon past experience. BT 16 expected FO 45 to remain where it was with the operator bringing a chain to BT 16. FO 45 expected to back down and connect up to a tow strap from BT 16. Between 15 and 20 minutes had expired from the time FO 45 arrived and was in position to assist.

INJURY

When FO 45 stopped, the LT stepped in front of BT16 to attach a 12 foot tow strap to the driver's side tow hook on the front bumper¹. This placed the LT between BT 16's bumper and FO 45's plow. Unbeknown to the LT, FO 45 began backing toward BT16. Backing with the plow is difficult at best and the plow was moving side to side while backing up. During this period, the BT 16 firefighter was at the rear of BT 16 and the firefighter/paramedic was on the driver's side of BT 16. Both were unassigned. As the LT was working on the strap, he saw the plow bar out of the corner of his eye. When he looked up FO 45 was slowly sliding down towards him. The LT stood up & yelled "Stop" and then tried to get out of the way. The LT was pinned between the FO 45's plow & the bumper of BT 16. FO 45 regained traction, pulled forward and the LT was able to move clear of the plow and bumper several feet before he fell to the ground.

AFTERMATH

The LT was transported by medical helicopter to the hospital for treatment. FO 45 was tested and used on scene for suppression activities after the incident by another DOF operator. FO 45 was also completely inspected by DOF mechanics with no deficiencies noted other the idiosyncrasies that exist between units and models.

FINDINGS

Finding 1. The FO 45 operator acted independent of orders from incident command based upon a concern for the safety of BT 16 and its crew.

¹ There is a discrepancy with regard to when the tow strap was attached. The FO 45 operator believed the strap was already in place before he started to back toward BT 16. The LT who actually started to place the strap stated that when FO 45 stopped, he started to connect the strap. The LT's version was utilized.

Finding 2. Communication issues continue to be a consistent finding in safety investigations. In this case, radio, verbal and visual communications between FO 45 and BT 16 were inadequate.

Finding 3. There was no command presence evident.. The BT 16 officer was engaged in connecting the strap rather than overseeing the operation while the officer's 2 subordinates remained un-involved and under-utilized.

Finding 4. The DOF operator's lack of familiarity with FO 45 caused the availability of a winch aboard FO 45 to be overlooked or ignored. Use of the winch would have simplified the extrication of BT 16.

RECOMMENDATIONS

Recommendation 1 – The principles of incident command must be followed at all times.

Recommendation 2 – Improving communications continues to be a consistent recommendation in our investigations.

Recommendation 3 – DOF and CCFEMS should develop procedures for towing or being towed.

Recommendation 4 - CCFEMS should engage in a review of their command and control procedures at the single unit level.

Recommendation 5 - An agreed plan of action should always be in place when 2 or more agencies are working together.

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