The After-Action
By Charles Bailey for tinhelmet
05.05.05

Recently someone asked me just whom I was writing these stories for. I had to stop and think for a minute but the answer is that sometimes tinhelmet is as much for me as it is for the people who read it. By writing down what happened I am forced to think about what I did and whether or not it fits into what should have happened. I think that it crucial everyone to stop and think about what they did and why, especially after a critical or special event has occurred. This is a copy of my self-evaluation after a critical fire incident.

The format I used is a borrowed and modified version of an after-action report from a wildland fire. It really does not matter how we get to the crux of the matter, it matters that we get there. Every single time we go to a fire or other serious emergency something happens that should not have. There is always somewhere where we could improve our operations. That is not to say that everything was wrong, we still have our successes. Things sometimes go very well.

In general the fire department misses out on great learning opportunities. After each fire we have in front of ourselves a set of concrete examples of why things are they way they are or why things need to be changed. The benefit of self-examination is that you don't have to share your screw-ups, the benefit of group examinations is that you have to share your screw-ups. Hopefully by sharing what we did wrong or could have done better the other guy gets to prevent making that same mistake later on.

Putting out fires is truly a team effort and sometimes one member of the team is having a bad day. We cannot all be good all the time. That is why we need the team. It is the job of everyone who straps on a cylinder and runs a line, or throws a ladder, or conducts a search to be tuned into the situation. We should all be able to recognize that vital chain of events, that left unmanaged leads to disaster.

The event I review here was real. I will not say when or where it happened. Some of you may be able to surmise where it was. If you worry about where for more than a second or two you miss the point. This time the point is to help you learn to be self-critical and to capture that information for yourself and for your crew.

I am currently doing a lot of reading and research on both after action reports and other forms of reflective learning. From my study I have surmised that the fire department misses the boat on these things, thinking that the critique a month later is the same thing, thinking that we should not advertise when we screw up, thinking that all the answers to our problems lie in assigning culpability.

The answer lies in training, and lots more of it, training based on demonstrated need, that need having been identified in the after action reports. So be brave, don your tough skin and start writing.

After Action Review

Author: Charles Bailey

Assignment on Incident: Engine Officer

Disclaimer:
This review is from my perspective alone and does not include the perspective of other participants. For that reason it is not to be taken as a comprehensive overview of the incident. My account may be inconsistent with other versions of this incident. There are many versions of the truth and they are all equally true.

Introduction:
At around hours on a box-alarm was sounded for the intersection of I was asleep in the bunkroom and was awakened by the station alerting system. I was pretty tired and moving in what felt like slow motion. While it felt like it took us forever to get out of the station our position in arrival order suggests that it did not take as long as it felt. The intersection of is a close run between the first four companies and we reached that intersection second. When company called their lay-out we were approaching the intersection.

What was planned:
My general plan was to provide support to the initial attack line and/or the search effort. There was a report of persons trapped inside the structure. Command was passed to me but I was still a few blocks away and unwilling to assume that command until I physically arrived on the scene.* I checked with Chief and he advised he was seconds away. I then advised him that I would forego the command and work with my crew. The composition of my crew (with respect to fire experience) was such that I would not have allowed them to operate independent of me. Had I assumed command my crew would have been out of commission.

What actually happened:

- On our arrival I ensured that our position would not impede incoming apparatus.
- I considered stretching the back-up line from our unit but decided it was too far and too complicated a stretch.
- I advised the crew to stretch a line from E.
- I completed a 270-degree check of the structure covering sides, Alpha, Delta, and Charlie.
- On this circle check I noted:
  - Stairway location (based on oddly placed window)
  - Presence of attic
  - Heavy fire on all levels in front ½ of structure
  - Exposed structural members (This was a true structure fire as defined by Brannigan)
- Had conflicting reports on whether everyone was out of the house

- Met crew at front porch and began to mask up
- Waited for water and then walked over to E[redacted] and requested line be charged
- Consulted with E[redacted] officer regarding tactics- agreed they would make entry to knock first floor and we would continue to floor above.
- Waited until E[redacted] knocked visible fire on porch and first floor and then advanced up stairs
- After making landing on stairs we had to fight our way up the stairs, flowing water as we moved.
- Knocked compartment straight ahead, the knocked hallway to right.
- Heard request from crews in on the Charlie Side requesting permission to enter structure.
- Made call to command that we were operating on the interior and that we had knocked the visible fire on the second floor.
- Then the fire flared up on the right, we knocked it twice but it flared back each time.
- Moved to right to see if we could identify source of flare-ups.
- Identified open stairs leading to attic space. (I was anticipating pull-down stairs leading to attic not open stairs)
- Fought our way to top of attic stairs, knocked attic fire down.
- Lineman advised that he was ill.
- Advised command that we had an ill member and that the entire crew was making its way out.
- Found EMS care for ill member and then changed cylinders, advised Chief [redacted] that we were re-entering to assume our original position.
- As we were making our way up to attic the second time encountered crew removing victim #2 from the second floor.
- Reached attic and assumed control on hand line in same position we left it in.
- At this point heavy smoke and no visible fire in attack. Flowed water to cool atmosphere. Could sense “roiling” smoke currents.
- Attic then experienced a rapid progression of fire conditions. We knock it back quickly with the line. It flared- up again twice.
- We lost water pressure in our attack line as the fire was taking off again. I order the crew to exit. As we our making our way out the fire grows and overruns our position. I call command to advise of an emergency situation. I believe I said, “E[redacted] to command correction interior emergency, I have loss pressure in my line and fire has taken over the attic. We are exiting the attic.” [I am sure this is a paraphrase at best]
- There was no response from command.
- As I was exiting the attic with fire chasing me down to the second floor the line became charged again.
- I knocked the fire with the nozzle and called the crew to come back.
- The crew came back seconds later and the nozzleman resumed his position and we fought fire for a few more minutes until one of the crewmember’s low pressure alarm activated.
- We exited as an intact crew and had no further role in the incident.

Operational barriers:

1. Explained delay in charging lines.
2. First three lines came off of first engine
3. Unacknowledged and missed radio traffic, including emergency traffic**
4. Unclear delineation of division group assignments

Impact of barriers:

1. Delay in making entry. [However the delay was not significant enough to affect the outcome of the incident. The fire was well advanced and moving quickly on arrival.]

2. Problem with charging the lines were exacerbated by the first three coming off of the first engine.

3. Missed radio traffic seemed could have led to a delay in assisting us when our position was over run. Luckily, our egress was clear and never compromised making our exit relatively quick.

5. I never knew who I was answering to and for that reason called command when I should have called a sector officer. This ruins the span of control.

Why did the barriers exist:

1. unexplained
2. Poor judgment on my part. Our 400' line would have needed to be extended but the structure was within a reasonable distance for me to stretch a line from my own piece. The only reason I can offer is that I considered pulling it and decided against it based on what I retrospectively believe to be spatial and temporal distortion.
3. Radio has historically had problems when wet.
4. I think command divided the incident face-to-face with arriving chief officers but I just did not know it.

Operational successes:

- A large volume of fire was controlled rather quickly.
- The search effort was aggressive and through and down with the protection of a handline
- I felt as if I was able to maintain a greater situational awareness than I have been able to in the past.
- There was good inter-crew communication between the first and second due engine.
- The attack, at least on the Alpha side was coordinated.
- Side Charlie was disciplined enough to request permission to enter, avoiding opposing handlines.
- Crew integrity was maintained throughout
- The team took positions to manage hose advancement with little direction and maintained those positions.

What can be done next time:

- Ensure radio transmission are acknowledged by sector officer
- Take my own line
- Ask command to clarify who is supervising my sector

Pertinent training issues:

- Do more work on long lines
- Do more work on countering effects of spatial and temporal distortion

** I was responding in unit officer mode and not command mode. I noted my position in the response order but not the response order of everyone else. I was planning for the actions of my inexperienced crew, not for the overall scene management. My command resources were limited. I was passed the command while I was not physically on the scene.*

I take issue, as I have time and again, with unit officers being forced to assume command. In this battalion there is a 24-hour career battalion chief who was dispatched on the run and is in a much better position to handle command functions, even while enroute, than I am as a unit officer.

There was a report of a person trapped, more fire than one handline could handle alone. By taking command I would have placed crews in greater jeopardy. Luckily Chief █ was only █ seconds away but there really should be a review of the parameters of unit officer command. I reiterate my belief that the SOPs should drive the initial response actions for the box alarm and that based on the reports of the first arriving unit officers the battalion chief should be able to handle the command until they arrive on the scene.

*** Over the past two-years I have done considerable work and research on Mayday procedures. I did not feel that I was in a Mayday situation. It could have been a Mayday had we not identified the immediate egress. However, that egress was identified and accessed quickly when we were overrun. I did feel that it was an urgent priority to inform command/our sector supervisor that we had lost water, were in a predicament, and were exiting the area. Some discussion should be had as to whether this was a Mayday scenario but based on my current understanding of the use of Mayday I was not in a Mayday situation.*