## Charleston fire department essay sample

Law, Security



On June 18, 2007 " the Charleston witnessed the largest single loss of fire fighters in the country since the September 11, 2001 terrorist attacks." (Smith, 2011) That day the fire service had to witness the unfortunate loss of nine firemen who died in the line of duty. Some would say that the deaths of these nine men were an atrocity to the fire service. The events that took place that day made it evident that there are still places that follow tradition and are afraid of change, even if the change is for the better. The fire service has made sufficient changes in the last twenty years to ensure the safety of all fire department personnel. The National Fire Protection Association (NFPA) " was established in 1896, and is to reduce the worldwide burden of fire and other hazards on the quality of life by providing and advocating consensus codes and standards, research, training, and education." (NFPA, 2011) The NFPA then decided to create safety regulations for the fire service and " in 1987 the first edition of NFPA 1500, Standard on Fire Department Occupational Safety and Health Program was published.

It was established to specify minimum fire service criteria in a variety of areas including emergency operations, facility safety, apparatus safety, critical incident stress management, medical and physical requirements, member fitness and wellness, and use of personal protective equipment (PPE)." (Stull, 2008) One of the primary tools that a department has is the Incident Management System. With the standards listed in NFPA 1500 there are precise directions that will provide guidelines on how to instill properly use IMS. Before the incident even began in Charleston the culture had the fire department set for failure. The mental environment that had been around for many years led to the horrible events that occurred that day. It

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began with the Chief of the department and followed down the chain of command. According to The Chief's Handbook " the Incident Commander's role is to manage the collective efforts of all the incident scene responders and resources under a single incident action plan." (Coleman, 2003)

This was the most important mistake that the Fire Chief made that day. When arriving on scene the Chief never took command of the incident or established a command post. There should have been a clear and precise announcement that the Chief was on scene and had command. He then needed to establish a command post that would allow for visibility of a majority of the scene but still allow for apparatus' room for proper positioning. Instead the Chief removed himself from a position of observing operations to a victim rescue in progress in the rear of the structure. Two things that should have occurred at this point was the Chief needed to appoint his command staff. This would have included an Operations Chief, who would have overseen the procedures of fire attack and rescue operations.

There should have also been a Safety Officer appointed to supervise all operations to ensure that proper safety precautions were being followed. After a Safety Officer was established there should have been a PAR (Personnel Accountability Report) called so that a correct accountability board could have been formed. With the accountability established the scene could have sectors created for attack, ventilation, RIT (Rapid Intervention Team), and medical-rehab. Instead there were three areas of attack with insufficient supplies and improper use of equipment. On this incident there was a Ladder Truck that was being used as a pumper instead of for ventilation like it is designed for. It is clear that tunnel vision and freelancing were obvious hindrances at this point. There was sufficient need for an offensive attack in the beginning of the operation.

This would ensure that all victims would be rescued before conditions worsened. It then would be the responsibility of the Incident Commander to observe the conditions and if the need arises call a defensive attack and have all personnel withdraw from the structure. This is considered in the fire service to be forecasting. Forecasting is the ability to estimate how the conditions are going to evolve in small increments of time. But instead the span of control was not in place and there was no one in position to determine that conditions had dramatically deteriorated. The span of control is defined as " the management concept that one person can only effectively control a limited number of subordinates, as a hierarchal organization grows, more and more intermediary layers must be created to keep this span of control within reasonable bounds." (Vail, 2005) Due to the lack of an Incident Commander there was no one in place to observe the inefficiency of the apparatus and the obvious need for mutual aid and law enforcement support.

By the lack of water supply and water pressure it was noticeable that the available apparatus were not sufficient. There might have been the need for water supply operations and possibly some relay operations. This would have increased the "gallon per minute" that the hose lines were able to discharge on the structure. The road in front of the scene was in need of being patrolled due to the fact that cars were consistently driving over the supply lines interrupting the flow of water. Communication is another integral piece of Incident Command. The communication barriers in place were that there was only one channel that was being used instead of having a fire ground operation channel dedicated solely for operations. The lack of leadership also led to the disorganization with communication. There were fire fighters who were disoriented and felt as they were lost and needed assistance. These messages also relayed information that air bottles were running low. The problem was that no one was in a position to hear and respond to the calls for assistance. There was one " MAYDAY" call and it went unheard by everyone on the fire ground.

When a " MAYDAY" is called all radio traffic is to immediately cease, this allows for the individual to have complete access to the radio therefore allowing any pertinent information be communicated with command or the Rapid Intervention Team allowing for a safe rescue. In this department there are Standards and Operating Procedures (SOP's) that are to be closely followed. These will detail how most instances will be handled and what needs to be accomplished. One of the SOP's specifically states that Company Officers have to take command of any alarm that is called out. This is required to be used to ensure that there is an Incident Commander in place and if there is a need, call for more support or deescalate and leave the scene with the Company Officers. The first arriving Officer will do a complete scene size up so that he has a vision of the condition of the incident. A Chief Officer will arrive and assume command after having a face to face with the Company Officer in charge. This will allow for a proper status update listing accountability, conditions, operations, and equipment status. The Chief Officer will then upgrade the incident if necessary and call in the Fire Chief and establish an Emergency Operations Center (EOC). This will assist in the gaining of mutual aid if needed and will allow for extra man power to man reserve back up apparatus. This will also give the Incident Commander a single point to communicate with. When dealing with communications there is one channel that is primary. Although when there is a major incident it is mandatory to switch to another channel that is dedicated for operations. This allows for dispatch to function on a normal basis without having to fight for air traffic time. The SOP's also state that there will be a Safety Officer on scene that will maintain an accountability board detailing the on scene crews and their

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This is a working board, meaning it is not set in stone and can change when assignments change. The Safety Officer will also observe the condition of the structure and make changes to operations as required. This shows how important it really is to follow the Incident Management System. These guidelines are put in place for good reason not just because a person thought it would be a good idea. It is also important to not become complacent in your position and remember to continue to better your knowledge through training. The development of SOP's is also important to give the members of your organization specific expectations. The lives of the nine firefighters who lost their lives were a horrific careless act. Let's just hope that the lessons that have been learned from this act will serve as lifesaving guidelines for future firefighters in departments who might be similar to the past state of the Charleston Fire department.

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