



**National Fire Fighter
Near-Miss Reporting System**
www.firefighternearmiss.com

2005 Program Kit

INTRODUCTION

Dennis Smith is a former New York City firefighter, founding editor of Firehouse Magazine, best selling author and chairman of the First Responders Financial Company. He also serves as the chair of the National Fire Fighter Near-Miss Reporting System Task Force.

Dear Colleagues:

I worked for many years in a fire company in the South Bronx, Engine Co. 82, where we responded to more than forty alarms every day. About a third of those alarms were false alarms, about a third for emergencies like a drug overdose or a shooting, and a third for actual fires.

You have seen the same things I saw in those days – acts of heroism and caring that can never be forgotten. There was a time in my life when I thought it was a good thing to dance around the edge of life. We accepted injury the way a boxer accepts a bruised eye—it comes with the territory. We responded to those alarms, and the objective of each alarm was to be there fast, to be out front, to not only accept the challenges found in a burning building, but to seek them out. To many of us, even today, firefighting is a continuous battle that roars on as we believe we are fearless. We love the sirens and the company logos, and we yearn for the challenges of the job.

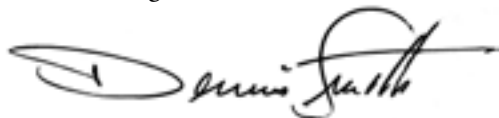
But we also have a deep and serious side to what we think about ourselves. We know we must train to do our job, that what we do is dangerous, and that inherent danger is the price that we pay for being in the job. We simply accept it.

We don't have to allow the idea of inevitable injury and possible death to exist in our firehouses. We must make the choice to grasp our own hearts and make them pulse with a new kind of concern for our brothers and sisters.

The impulse of a firefighter to help is not a lonely impulse, but it is shared and agreed upon in every firehouse conversation, every shared meal, every training drill, and every company meeting. There is only one reason to wear the uniforms of our departments, and that is to be there when we are needed.

When I was asked to chair the task force for the creation of the National Fire Fighter Near-Miss Reporting System, I saw that the mandate was equally shared by the other members of the task force. Safety experts on the task force told us that we can, without doubt, reduce injuries and fatalities with near-miss reporting. There is a real program here; it is not talk and idea, but something on the table in front of us that has worked demonstrably in the airline industry. The fire service community must buy into this program. From the department chief to the rookie, put your arms around it and make it work for you.

There is no greater call than to put your life on the line for someone else, and our families pay dearly for this ideal. We can repay them a little and honor those we have lost by saving some in the future who might learn about a near-miss incident, remember it, and be prepared the next time. We must have the courage to make a commitment to save the lives of our brothers and sisters.



Dennis Smith

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CD Contents

The CD enclosed on the front cover contains documents to be printed, copied and shared. Please make copies of the CD to share with others.

1. Report text
2. PowerPoint presentations
3. Near-miss reporting form
4. Sample endorsement letter and article
5. Poster, Web site banner ads and newsletter ads
6. *Crew Resource Management*

NATIONAL FIRE FIGHTER NEAR-MISS REPORTING SYSTEM

The National Fire Fighter Near-Miss Reporting System (www.firefighternearmiss.com) was created to turn near-miss experiences into lessons learned for everyone in the fire service community. Lessons learned from near-miss experiences seldom make it past a firehouse kitchen table. Today, a lesson learned in one firehouse can be shared with fire departments across the country through the virtual firehouse kitchen table, the National Fire Fighter Near-Miss Reporting System.

The goal of The National Fire Fighter Near-Miss Reporting System is to improve firefighter safety by collecting, sharing and analyzing near-miss experiences. The reporting system is voluntary, confidential, non-punitive and secure. The reporting system collects information that can assist in formulating strategies to reduce the number of firefighter injuries and fatalities.

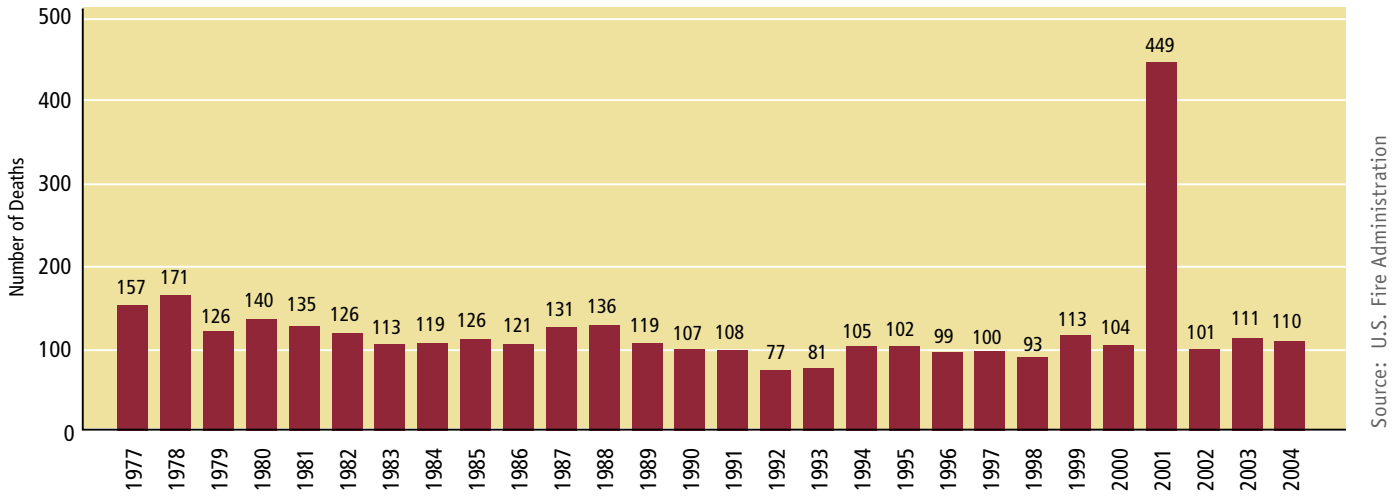
Firefighter Injury and Fatality Statistics

Firefighter injury and fatality statistics have steadily increased over the last 15 years when compared to a decrease in the number of structure fires. Improvements in personal protective gear, equipment and training have not impacted the rate of firefighter injuries and fatalities. In fact, better protection, aggressive tactics, lighter weight construction and improved handling capabilities of heavy apparatus are putting firefighters at greater risk.

Firefighter injuries also strain the emergency services delivery system. A recent study published by the National Institute of Standards and Technology provides an additional incentive for redoubling efforts to impact firefighter fatalities and injuries. According to the 2005 NIST Report on Consequences of Fire Fighter Injuries, non-fatal firefighter injuries and prevention efforts cost anywhere from \$2.8 billion to \$7.8 billion per year. Aviation near-miss reporting experts have stated that near miss data collection, analysis and event sharing in the fire service can reduce these costs.

The word “firefighter” is used in the name of the program and used in this report to represent all members of the fire and emergency service. The term “firefighter” includes: firefighters, engineers, drivers, company officers, chief officers, fire chiefs, EMTs, paramedics, HazMat technicians, fire explorers, fire marshals, fire investigators, fire police, pilots, dispatchers, etc.

ON-DUTY FIREFIGHTER FATALITIES



Definition of a Near Miss

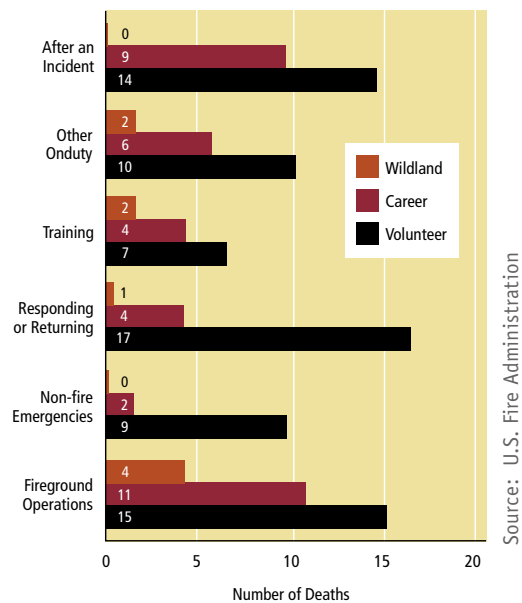
A near miss is an unintentional unsafe occurrence that could have resulted in an injury, fatality or property damage. Only a fortunate break in the chain of events prevented an injury, fatality or property damage. Situations that qualify as near misses are essentially in the eyes of the reporter.

Near-miss Reporting

Near-miss reporting systems are used to gather information to prevent unsafe occurrences from happening in the future. Near-miss reporting systems focus on identifying patterns that exemplify systematic problems, which can then be addressed. The aviation, military and medical industries credit the use of near-miss reporting systems as significant contributors to a reduction in errors, injuries and fatalities.

Online resource: For more information on the importance of near-miss reporting, read *To Err is Human: Building a Safer Health System* available as a free download on www.nap.edu/readingroom.

CAREER, VOLUNTEER AND WILDLAND DEATHS BY TYPE OF DUTY (2004)



"The National Fire Fighter Near-Miss Reporting System will be beneficial to firefighters all over the world."

Edward A. Kelly
President
Boston Firefighters Local 718

NEAR-MISS REPORTING AND CREW RESOURCE MANAGEMENT

The National Fire Fighter Near-Miss Reporting System is modeled after the Aviation Safety Reporting System (ASRS). Since 1976, ASRS has analyzed more than 650,000 incident reports submitted by pilots, air traffic controllers, cabin crew, maintenance technicians and others in the aviation industry. ASRS uses the information it receives to address reported hazards, to conduct research on operational safety problems, and to facilitate an understanding of aviation safety-related issues. ASRS provides data on the quality of human performance which serves as the basis for further research and recommendation on procedures, operations, training, facilities and equipment. The aviation industry credits the analysis of data from near-miss reporting as one of the key contributors to an increased aviation safety level over the past 30 years. ASRS has been used as the model for near-miss reporting in other industries such as medicine, maritime, rail and others.

Aviation and the Fire Service

In 1999, the aviation industry presented the topics of Crew Resource Management (CRM) and near-miss reporting at a wildland fire conference. There is a striking similarity between emergency service crews and flight crews. The work unit structure is composed of a crew with a leader and one or more crew members. The crew works under a hierarchy often influenced by time on the job. Crews can spend considerable time performing routine actions and then have to perform under stressful conditions. Factors cited as contributing factors in aviation disasters are the same factors contributing to firefighter fatalities: communication failures, poor decision making, lack of situational awareness, poor task allocation and leadership failures.

Definition of Crew Resource Management

CRM is a tool created to optimize human performance by reducing the effect of human error through the use of all resources, including human resources, hardware and software.

Five Principles of Crew Resource Management

Communication: Understanding the communication model (sender-message-medium-receiver-feedback), the value of speaking directly and respectfully and the importance of communication responsibility. Recognizing and neutralizing the effect of barriers to effective communication that inhibit the success of the other four principles.

Situational Awareness: Maintaining attentiveness to an event while keeping in mind the effects of perception, observation and stress on self and individuals.

Decision Making: Concentrating on giving and receiving information so appropriate decisions are made.

Teamwork: Emphasizing team performance by focusing on “leadership-followership” so all members of a team understand their role on the team and the need for mutual respect.

Task Allocation: Knowing the strengths and weaknesses of the team so work can be assigned to the team member most capable of successfully completing the task. Also emphasizes dividing labor so no single team member, including the team leader, is overworked.

“The Near-Miss Reporting System is a systematic, grass-roots approach to distill data and provide a laser like focus on cause, which will go a long way in not only changing unsafe behaviors, but also ultimately in saving lives. We are well into the first step; everyone is talking about it. Momentum will follow and with it the knowledge necessary to improve practices.”

W.H. “Bill” Halmich
Fire Chief
Washington Fire Department (MO)



Safety Pyramid

Originated by Dr. H.W. Heinrich in the 1930s and modified in recent years, the safety pyramid illustrates that for every worker fatality there are 10,000 unsafe acts. Near-miss reporting concentrates on the unsafe acts and property damage areas because of their frequency. One lesson learned from the aviation industry is that reporting events that *could* have resulted in an injury results in fewer injuries, accidents and errors. The reduction in injuries, accidents and errors translates to fewer fatalities and improved performance.

***“For every worker fatality
there are 10,000 unsafe acts.”***



The Link between CRM and NMR

A task force was formed in 2001 to explore how CRM and near-miss reporting could be applied to the fire service in hopes of improving overall firefighter safety. The two programs, CRM and near-miss reporting, were identified by the aviation and military task force members as instrumental in improving their industries' safety performance records. There was unanimous consensus that the programs could have a positive impact on the fire service. The task force recommended further exploration of near-miss reporting for the fire service.

In 2004, the International Association of Fire Chiefs (IAFC) was awarded a grant from the Department of Homeland Security's Assistance to Firefighters Grant Program to create a national near-miss reporting system for the fire and emergency service. A supporting grant was awarded from Fireman's Fund Insurance Company. Additional support was given by Deputy Chief Billy Goldfeder and Gordon Graham, founders of FirefighterCloseCalls.com. The National Fire Fighter Near-Miss Reporting System is administered by the IAFC in consultation with the National Fire Fighter Near-Miss Reporting System Task Force.

Online resource: *Crew Resource Management* is available on the enclosed CD. It is also available for free at www.iafc.org/downloads/CRM%20Manual.pdf.

Three ways to submit a report:

1. Electronically on www.firefighternearmiss.com.
2. Mail or fax a report form, which is available on www.firefighternearmiss.com.
3. Request report forms by calling 703/273-9815 ext. 364 or by e-mailing nearmiss@iafc.org.



How the reporting system works:



1. Firefighter Submits Report

2. Reviewer #1

- Opens and reads report
- Removes all identifying characteristics
 - Will contact reporter if there are any questions regarding report (if reporter gives contact information)
- Codes report into database
- Forwards to reviewer #2

3. Reviewer #2

- Reads report and insures de-identification
- Returns report to Reviewer #1 for posting

6. Fire service community collects, shares and analyzes near-miss experiences

5. Report is posted

4. Optional contact information is removed from report and destroyed

Original report is destroyed





HOME PAGE

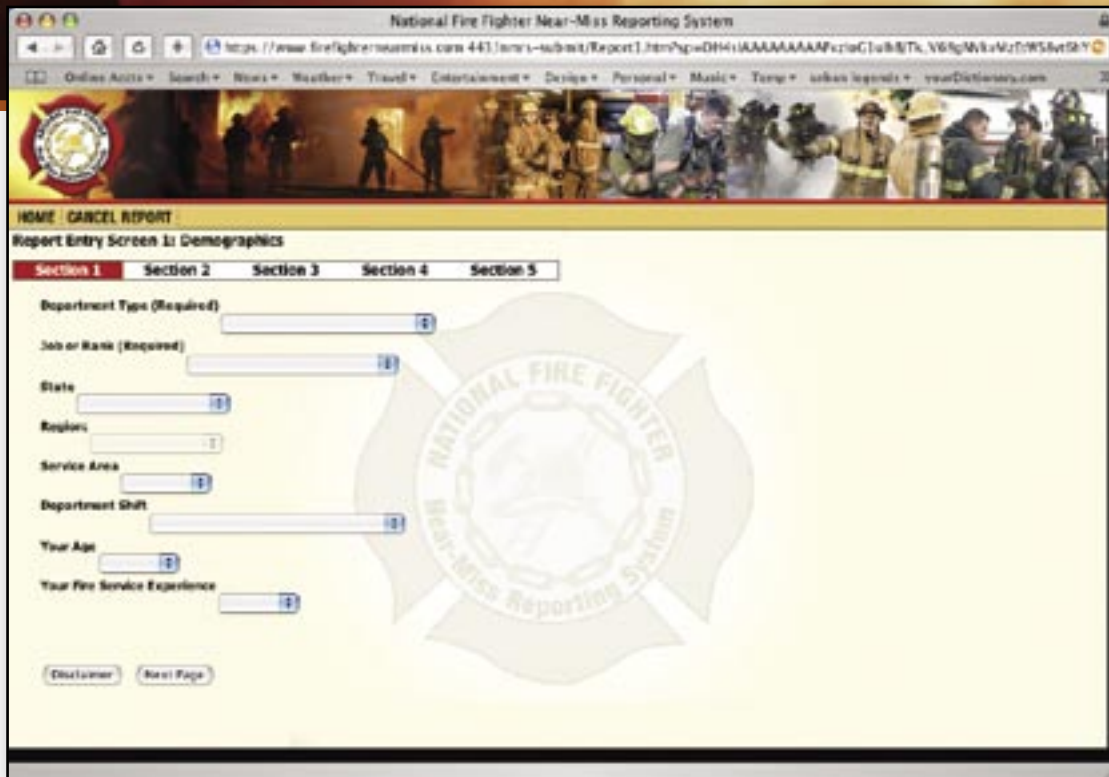
From the home page of firefighternearmiss.com, reporters have the following options:

- | | | |
|-----------------------------|----------------|-------------------------|
| • Submit Your Report | • Links | • Search Reports |
| • Print Blank Report | • FAQ | • Contact Us |

“Near-miss reporting is indicative of the changing attitudes that departments across the nation are having toward safety. No longer is fighting fires about who can enter the most dangerous building, or how far we can push the envelope of safety, but instead the focus has turned to making sure everyone goes home after their shift, and as a family man, I very much appreciate that. The Near-Miss program helps link departments across the nation and helps us all identify common and unique situations that can cause a safety concern. While there is never going to be a way to eliminate all dangerous situations in our profession, having a resource such as firefighternearmiss.com can help keep us all aware and focused on potentially hazardous situations and help us fulfill our goal of ‘everyone goes home.’ ”

Will Schwisow
Firefighter
Hobbs Fire Department (NM)

SUBMIT YOUR REPORT



Section 1: Demographics

The seven questions in this section are designed to provide the reviewers and project administrators with a basic understanding of the reporter. This information is not designed to identify any specific reporter or department.

Department Type: Reporters select the type that best describes their department. If the department doesn't fit any of the descriptions, "Other" can be selected and a description can be entered.

Job/Rank: Reporters select their current job or rank. If they had a different job or rank when the near miss occurred, that information can be included in the event description. If the job or rank does not appear, "Other" can be selected and a description can be entered.

State: Reporters select the two letter abbreviation of their current residence. The FEMA region will automatically fill in to the Region field. The state will not be included on the report when it is posted. Only the FEMA region will be posted on the site.

Service Area: This is a self-declared field and reporters should select the service area that best describes the area their fire department serves.

Department Shift: Reporters select the work shift in their department. It applies to career departments (hours on/hours off, days/nights, straight days) and volunteer departments (stand-by, duty night, respond from home). If the work shift does not appear, "Other" can be selected and a description can be entered.

Your Age: Reporters select their current age range.

Your Fire Service Experience: Reporters select their current fire service experience.



Section 2: Event Information

The eight questions in this section ask general questions about the near-miss event.

Event Type: There are six categories in this field: fire emergency event, non-fire emergency event, on-duty activities, training activities, vehicle event and other. The first five categories mirror the five main categories where firefighters suffer injuries and fatalities.

Event Date: Reporters enter the date of the near miss. The date may be approximated if the reporter doesn't remember the exact date.

Event Time: Reporters enter the time of the near miss. The time may be approximated if the reporter doesn't remember the exact time.

Event Participation: There are three choices in this field: involved in the event, witnessed event but not directly involved in the event and told of the event, but neither involved nor witnessed event.

Hours into the shift: Reporters select the appropriate range. If responding from home, reporters can select 0-4 hours.

Do you think this will happen again?: Consideration should be given if an individual or if the department responded to the near miss by doing something to prevent re-occurrence.

Contributing Factors: Reporters can select up to five of 20 contributing factors.

Loss Potential: Reporters can select up to five of seven critical loss items.

HELPFUL HINT: Type the event description and lessons learned in a word processing program and then cut and paste finished text into the reporting system. This way, if you are interrupted, you will be able to finish your report at a later time.



Section 3: Event description

This section contains a free text field that asks the reporter to provide a narrative about the near miss. There are topics on the bottom of the page to provide the reporter with suggestions of items to address in the narrative.



Section 4: Lessons learned

The key to any near miss report is the lesson learned. Reporters are asked to describe what they learned from the experience that can help prevent the same thing from happening to another firefighter.



Section 5: Optional contact information

This field is **OPTIONAL**. If the reporter provides contact information, it is kept confidential. It will only be used for a reviewer to contact the reporter if the event description needs clarification. The reporter may also be contacted by program administrators to request feedback on the reporting system. The contact information is then destroyed.



Post Submission Screen

When the report is submitted, the reporter is given the option of viewing other reports with a similar event type. Also on this screen are Web site links that may be useful.

Print Blank Report

Reporters can select this menu option to open an Adobe Acrobat form version of the reporting form. This form can be completed and then mailed or faxed.

Search Reports

Visitors to the site can select this menu option to search previously submitted reports. "Type of event" must be selected and one other field. If a state is selected as one of the search criteria, the reporting system will search reports based on the FEMA region rather than the individual state. This is one additional layer of protection for the reporter's identity.

Links

This page contains useful Web links for the fire service community.

FAQ

This page contains the answers to frequently asked questions.

Contact us

Visitors to the Web site can send suggestions, comments or questions (anonymously or with contact information) to project administrators.

TOP TEN TIPS FOR REPORT WRITING:

- 1.** You can submit reports at the station, at home, a public library or anywhere else with Internet access.
- 2.** Use simple language and generic terms.
- 3.** Keep sentences short.
- 4.** Include the details that are relevant to the end result.
- 5.** Don't be afraid to tell the story. The reviewers will take out all identifiable terms.
- 6.** Set the scene. You want the reader to experience the event just how you experienced it.
- 7.** Tell what lessons you learned: how the event changed or may change the way you operate, how it changed what equipment you carry, even how it changed your personal perspective on safety.
- 8.** Tell what lessons your department learned—how SOPs were changed, how training was changed and what changes were made in how your crews operate.
- 9.** If there were no changes made, suggest what you think are possible solutions. Great reports give the problem and the solution from the person who is the expert—you.
- 10.** Use the suggestions at the bottom of the event description and lessons learned sections.

Depending on the length of the event description and the lesson learned, it takes on average about 10-15 minutes to submit a report.

SAMPLE REPORTS

FIRE EMERGENCY EVENT

REPORT NUMBER: 05-0000536
REPORT DATE: 09/20/2005 13:02

Event Description

We responded to a reported smoke investigation. Upon arrival, it was a working fire in a multiple level house. Firefighter 1 donned all PPE including SCBA and waited at the front door of the structure. The Chief thought that there were two people ready to enter and advised to advance. Firefighter 1 thought that a second firefighter was going to meet him in the structure. Firefighter 1 waited on the inside for the rest of the team. When Firefighter 2 saw that the line had advanced, he assumed that there was a two person crew and requested another assignment. Firefighter 1 saw the fire, began to place water on the fire, and extinguished it without incident. The firefighter failed to communicate and maintain accountability. In addition, crew integrity was not maintained. Although this incident did not end up with an injury or worse, the potential for not working as a team increased the chances of disorientation or entrapment.

Lessons Learned

Ensure that crew integrity is maintained. Do not advance into a burning structure without the proper resources. Communicate with crew to ensure that all members are aware of the situation and work as a team.

Demographics

DEPARTMENT TYPE: Volunteer
JOB OR RANK: Captain
DEPARTMENT SHIFT: Respond from home
AGE: 25 - 33
YEARS OF FIRE SERVICE EXPERIENCE: 7 - 10
REGION: FEMA Region VII

Event Information

EVENT TYPE: Fire emergency event: structure fire, vehicle fire, wildland fire, etc.

EVENT DATE AND TIME: 09/09/2005 07:30

HOURS INTO THE SHIFT: 0 - 4

EVENT PARTICIPATION: Involved in the event

DO YOU THINK THIS WILL HAPPEN AGAIN? Yes

WHAT DO YOU BELIEVE CAUSED THE EVENT?

- Command
- Accountability
- Teamwork
- Decision Making
- Communication

WHAT DO YOU BELIEVE IS THE LOSS POTENTIAL?

- Life threatening injury

NON-FIRE EMERGENCY EVENT

REPORT NUMBER: 05-0000450
REPORT DATE: 08/15/2005 08:02

Event Description

Dispatched to a one car MVA on a mile long bridge on the Interstate. Half of the bridge is in district. Upon arrival found vehicle out of district, just over crest of bridge. The response was 1 engine and one service/rescue utility body emergency vehicle. One firefighter per unit responding. State police were on scene reporting no injuries. Engine operator was OIC. He parked in low speed lane uphill, behind MVA. I was in rescue truck and staged behind engine in breakdown lane. I distributed road cones in order to block the lane further. Went and tended to the MVA. Found only fluids leaking. Cleaned up scene and then was ordered to leave the scene. I went back to rescue to pick up cones and as I was doing so a vehicle came out from behind a line of traffic into my coned area and nearly hit me. Vehicle swerved back into travel lane dragging several cones.

Lessons Learned

It was early in shift and found OIC to be lacking sleep. The MVA was out of district which the OIC should have alerted that department. The dispatcher was interviewed by Chief and stated that the district the call was in was never requested. On any other calls, fire, MVA with injuries, it is an automatic response with the other district. Apparently the procedure at dispatch does not require the other district when there is an MVA with fluid spill. The other district will provide "blocking" for the first arriving district if requested only. I suggest written agreement between districts on how to block and divert traffic. Suggest that staffing be so that there are less vehicles on scene. We lack any "modern" SOG on these incidents. We never train. The OIC never communicated to me what he wanted done. I did what I thought needed to be done.

Demographics

DEPARTMENT TYPE: Combination, Mostly paid
JOB OR RANK: Fire Fighter
DEPARTMENT SHIFT: 24 hours on - 48 hours off
AGE: 43 - 51
YEARS OF FIRE SERVICE EXPERIENCE: 27 - 30
REGION: FEMA Region I

Event Information

EVENT TYPE: Non-fire emergency event: auto extrication, technical rescue, emergency medical call, service calls, etc

EVENT DATE AND TIME: 01/29/2005 08:31

HOURS INTO THE SHIFT: 0 - 4

EVENT PARTICIPATION: Involved in the event

DO YOU THINK THIS WILL HAPPEN AGAIN? Yes

WHAT DO YOU BELIEVE CAUSED THE EVENT?

- Protocol
- Staffing
- Individual Action
- Procedure

WHAT DO YOU BELIEVE IS THE LOSS POTENTIAL?

- Other

ON-DUTY ACTIVITIES

REPORT NUMBER: 05-0000424
REPORT DATE: 08/09/2005 20:49

Event Description

I was assigned to an engine company. The battery on the truck was low, so it was hooked to a charger. Since we had to wash the truck, I disconnected the clamps from the charger to pull the truck outside. My supervisor then told me to wait to wash the truck, so I hooked the cables back up to the battery. The caps were off the battery. When I touched the battery, it caused a spark, which set off an explosion from the hydrogen gas produced by the battery acid, and plastic shrapnel struck me in the face. I immediately washed my eyes and face, so no permanent injury occurred.

Lessons Learned

Know what you're dealing with. I had no prior experience working with batteries and should have asked for help. I was lucky.

Demographics

DEPARTMENT TYPE: Paid Municipal
JOB OR RANK: Assistant Chief
DEPARTMENT SHIFT: 24 hours on - 48 hours off
AGE: 16 - 24
YEARS OF FIRE SERVICE EXPERIENCE: 24 - 26
REGION: FEMA Region IV

Event Information

EVENT TYPE: On-duty activities: apparatus and station maintenance, meetings, tours, etc.

EVENT DATE AND TIME: 08/09/1980 11:00

HOURS INTO THE SHIFT: 17 - 20

EVENT PARTICIPATION: Involved in the event

DO YOU THINK THIS WILL HAPPEN AGAIN? Uncertain

WHAT DO YOU BELIEVE CAUSED THE EVENT?

- Training Issue
- Human Error
- Situational Awareness
- Individual Action
- Decision Making

WHAT DO YOU BELIEVE IS THE LOSS POTENTIAL?

- Lost time injury
- Life threatening injury
- Property damage

TRAINING ACTIVITIES

REPORT NUMBER: 05-0000381
REPORT DATE: 08/03/2005 13:13

Event Description

Our company was participating in multi-company evolutions at our department's training center. Our assignment was to place a ground monitor in service flowing 1000gpm. We supplied the monitor with a single 5" hose and attached the monitor base. Then we attached the monitor itself after removing it from the top of the engine. I was manning the monitor as the line was charged. I was positioned to the side and was kneeling on the hose as the water reached the appliance. There was no water-hammer and the line became fully charged at a normal speed. The water flowed from the monitor normally for approximately 5 seconds until suddenly the monitor flew violently off of the base assembly. We were using a (manufacturer name deleted) monitor and base. I was not injured in this incident although the force with which the monitor flew off could have caused major injury to my face/head/neck and upper chest had I been leaning over it at the time. I was wearing full PPE consisting of turnouts, gloves and helmet with my chin-strap tightened. This incident occurred because the FF who attached the monitor to the base had slightly misaligned the two components. This misalignment would not allow the monitor to be completely secure. The latch assembly was closed normally and visually the appliance appeared completely normal and appropriately engaged.

Lessons Learned

Lesson learned: Ensure by physically testing that the monitor is absolutely secure to the base before charging. This type of monitor is very popular due to it being extremely versatile. The FF had followed our SOP for setup. I failed to ensure that the monitor was actually attached although it was "locked" when I looked at the mechanism. This was a near-miss. I had no time to react and came very close to being injured. Wear your PPE and DONT LEAN OR LOOK OVER A FLOWING MASTER STREAM.

Demographics

DEPARTMENT TYPE: Combination, Mostly paid
JOB OR RANK: Driver / Engineer
DEPARTMENT SHIFT: Other: modified kelly 9 day cycle
AGE: 25 - 33
YEARS OF FIRE SERVICE EXPERIENCE: 7 - 10
REGION: FEMA Region X

Event Information

EVENT TYPE: Training activities: formal training classes, in-station drills, multi-company drills, etc.

EVENT DATE AND TIME: 02/14/2005 11:00

HOURS INTO THE SHIFT: 0 - 4

EVENT PARTICIPATION: Involved in the event

DO YOU THINK THIS WILL HAPPEN AGAIN? Yes

WHAT DO YOU BELIEVE CAUSED THE EVENT?

- Human Error
- Training Issue
- Situational Awareness
- Equipment

WHAT DO YOU BELIEVE IS THE LOSS POTENTIAL?

- Lost time injury
- Life threatening injury

SAMPLE REPORTS

VEHICLE EVENT

REPORT NUMBER: 05-0000430
REPORT DATE: 08/10/2005 13:38

Event Description

While responding to a fire alarm code 3, my truck was struck in an intersection on the captain's door by a speeding mini-van. I was in the process of getting dressed into my bunker gear when the accident occurred; I was ejected onto the roadway. I have been dealing with minor injuries for the past 2 years, with 1 surgery needed to repair a damaged shoulder.

Lessons Learned

The lesson I learned was never take anything for granted. Yes, I was inside a very large vehicle, but a silly little mini-van, was enough to eject me out of the rig. My department needs to address taking the time before getting in the rig to get dressed, and make sure everyone uses their seatbelts.

Demographics

DEPARTMENT TYPE: Paid Municipal
JOB OR RANK: Captain
DEPARTMENT SHIFT: 24 hours on - 24 hours off
AGE: 34 - 42
YEARS OF FIRE SERVICE EXPERIENCE: 11 - 13
REGION: FEMA Region IX

Event Information

EVENT TYPE: Vehicle event: responding to, returning from, routine driving, etc.

EVENT DATE AND TIME: 11/28/2003 09:00

HOURS INTO THE SHIFT: 0 - 4

EVENT PARTICIPATION: Involved in the event

DO YOU THINK THIS WILL HAPPEN AGAIN? No

WHAT DO YOU BELIEVE CAUSED THE EVENT?

- Human Error
- Decision Making
- Individual Action

What do you believe is the loss potential?

- Minor injury
- Lost time injury

OTHER

REPORT NUMBER: 05-0000289
REPORT DATE: 06/03/2005 15:20

Event Description

Generator did not operate when needed. Routine Maintenance had been done on a weekly basis. No professional inspection had been made of the generator since before Hurricane Isabel. It ran for 5 days constantly during that time. The fluid reservoir had dried and had small cracks in it allowing air in a closed system. Fluid maintained itself at a cold level and was never drawn into the radiator thus when the generator would start it would run for a minute or so then cut off. On routine testing oil and water was checked and a weekly test was done by a remote start. That test lasted only a minute on a regular basis. Not until the generator was put under a long test did the failure come to light.

Lessons Learned

1. Routine inspections are needed but a yearly, if not bi-yearly inspection needs to be performed by a professional company to maintain the readiness of the station generators. 2. After a huge event, like running continuously for five days, these machines should be professionally inspected. They are outside in all sorts of weather, hot to cold, wet to dry. This puts a large amount of stress on all the flexible and rubber components. This could cause them to break down over time. These failures would not be caught by someone who does not deal with these machines on a daily basis.

Demographics

DEPARTMENT TYPE: Combination, Mostly paid
JOB OR RANK: Other : MASTERFIREFIGHTER
DEPARTMENT SHIFT: 24 hours on - 48 hours off
AGE: 52 - 60
YEARS OF FIRE SERVICE EXPERIENCE: 30+
REGION: FEMA Region III

Event Information

EVENT TYPE: Other

EVENT DATE AND TIME: 05/23/2005 02:50

HOURS INTO THE SHIFT: 17 - 20

EVENT PARTICIPATION: Involved in the event

DO YOU THINK THIS WILL HAPPEN AGAIN? Yes

WHAT DO YOU BELIEVE CAUSED THE EVENT?

- Situational Awareness

WHAT DO YOU BELIEVE IS THE LOSS POTENTIAL?

- Unknown

"You might say "I don't have time to go to every station to talk about this program." But if you make the time, talking about the National Fire Fighter Near-Miss Reporting System opens the door for so much more. You are illustrating your commitment to safety by showing the members of your department that their safety is your top priority."

Denise Pouget-Rankin
Assistant Chief
Montgomery County Fire & Rescue Services

A LESSON LEARNED

I read a report about an airbag which had not deployed after a vehicle crash and that night I responded to a similar situation. I recognized the danger and warned my crew, the police department and ambulance personnel. As a result of reading the near-miss report, I was able to pass along information about a potential hazard.

—Commander Kip Stanger, Marietta Fire Department (GA)

REPORT NUMBER: 05-0000185

Demographics:

DEPARTMENT TYPE: Paid Municipal

JOB OR RANK: Fire Fighter

DEPARTMENT SHIFT: 24 hours on - 48 hours off

AGE: 34 - 42

YEARS OF FIRE SERVICE EXPERIENCE: 11 - 13

Region: FEMA Region VI

Event Information:

EVENT TYPE: Non-fire emergency event

EVENT DATE AND TIME: 04/15/2004

HOURS INTO THE SHIFT: 17 - 20

EVENT PARTICIPATION: Involved in the event

DO YOU THINK THIS WILL HAPPEN AGAIN? Yes

WHAT DO YOU BELIEVE CAUSED THE EVENT?

- Human Error
- Situational Awareness
- Individual Action

WHAT DO YOU BELIEVE IS THE LOSS POTENTIAL?

- Lost time injury
- Life threatening injury



Event Description:

After arriving at a vehicle collision, I was giving medical care to a patient who had rear ended another car at a fairly high rate of speed. She was complaining of sharp chest pain, so I was leaning into the car between her and the steering wheel evaluating her medical condition. I made note of and even made comments to my fellow firefighters about the fact that the passenger airbag had deployed, but the driver's did not. We have been informed of this dangerous situation and the injuries it has caused many times in the past but it never entered my mind. When I gave my patient report to the paramedic that arrived on scene, I mentioned this fact to indicate the rate of speed. The paramedic was the first to recognize the danger in the situation. He immediately requested the patient be removed from the car for her safety and ours because of the possible late deployment. Immediately after he said this, I knew I had failed to properly analyze this situation. The positions I had been in with my head in front of this airbag could have seriously injured me and my patient. The scene was not well lit because of a lack of street lights. We were asleep when this call came in so I was not as sharp as usual. I was extremely disappointed in myself for letting something so obvious slip by. I take pride in being aware of my surroundings with safety for emergency personnel being a top priority. This situation won't slip by me again and I hope by sharing this, it won't slip by anyone else.

Lessons Learned

I need to be more vigilant in paying attention to my surroundings. Sometimes the danger can be hiding in something we have become so accustomed to seeing that we forget it is even there. Sometimes we get complacent when we haven't had any "close calls" recently, but we must stay alert at all times so that we don't lose any of our brothers or sisters. Learn from my mistake.

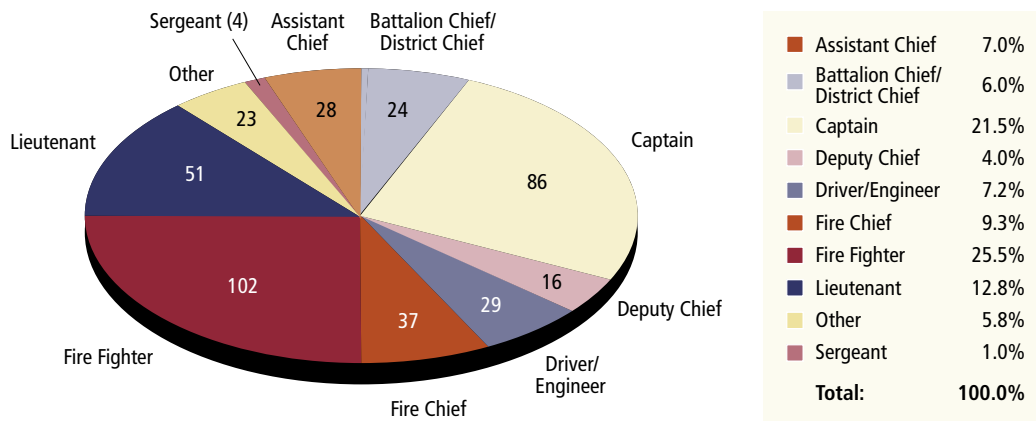
RESULTS

Thirty-eight fire departments participated in the pilot testing phase, which ran from April 22, 2005 – July 31, 2005. The pilot departments were geographically diverse and consisted of varying department types and sizes. (See page 20 for a list of the pilot departments.) The statistics shown on the next two pages are from reports received from April 22, 2005 – Sept 30, 2005.

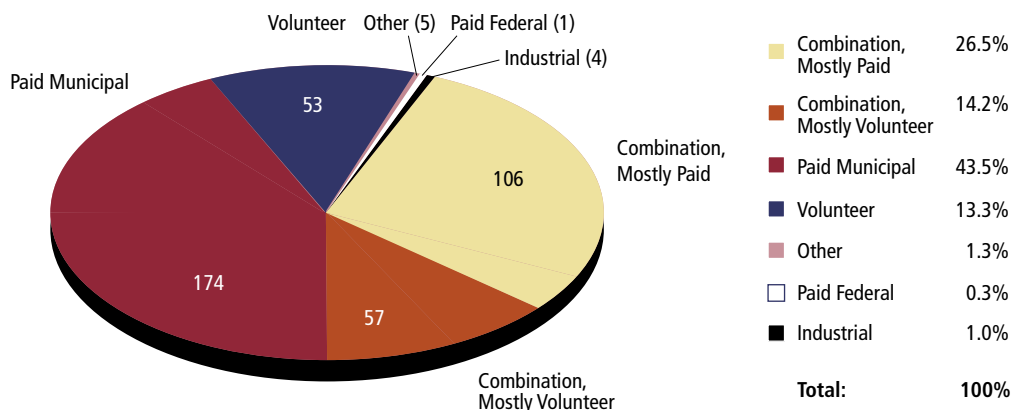
REPORTS BY EVENT TYPE

Fire Emergency Event	203
Non-Fire Emergency Event	62
On-Duty Activities	22
Other	7
Training Activities	32
Vehicle Event	74

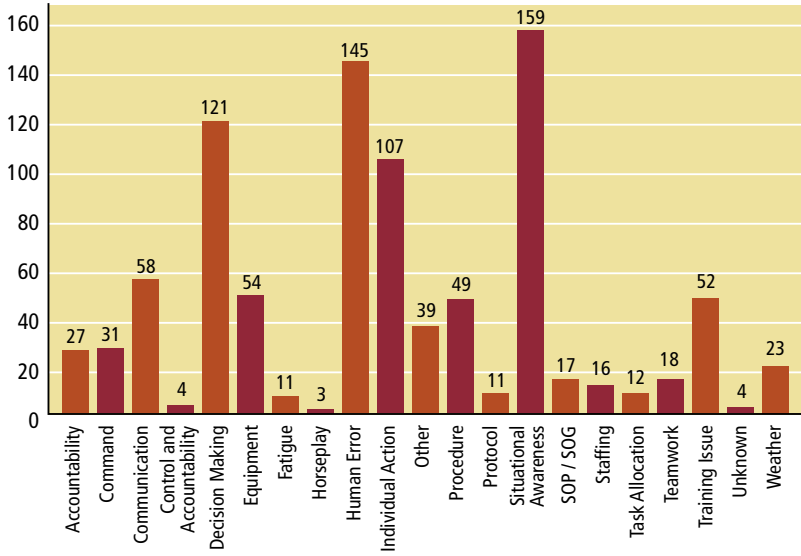
JOB/RANK



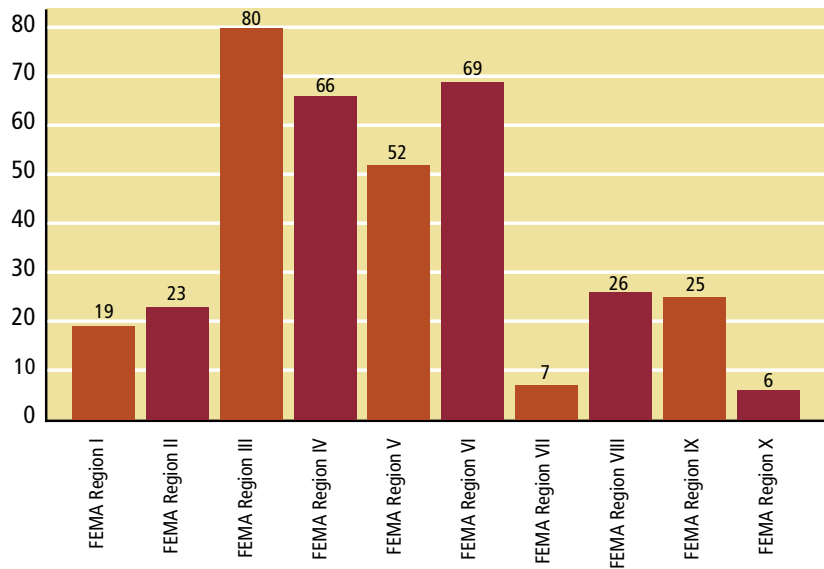
REPORTS BY DEPARTMENT TYPE



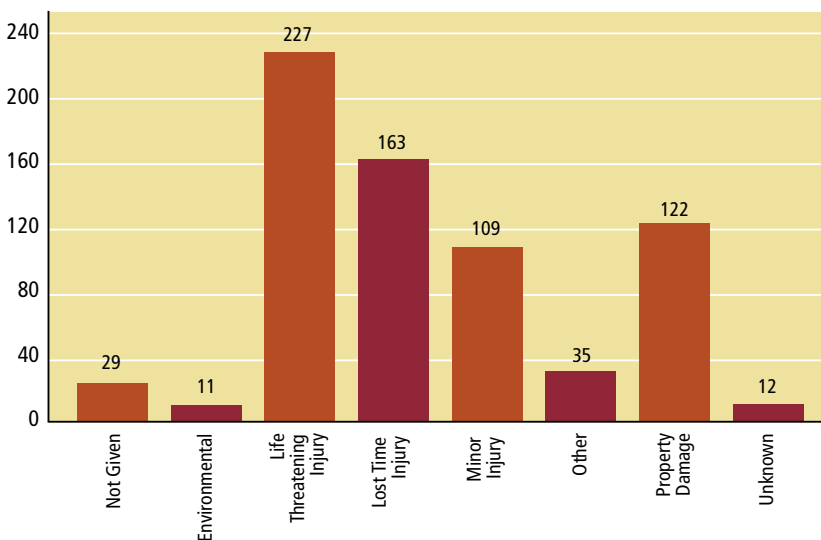
CONTRIBUTING FACTORS



REPORTS BY FEMA REGION



REPORTS BY LOSS POTENTIAL



HOW TO BECOME INVOLVED

If you are the department chief or a chief officer...

- Enter a report.
- Send an e-mail to all members of your department introducing them to firefighternearmiss.com.
- Include an article in your department newsletter endorsing your support of this program.
- Pass along this report to others in your department.
- Search reports on www.firefighternearmiss.com. Select your department type, your department shift, and your FEMA region and assume that every report in that FEMA region came from your department. And ask yourself what you are doing to prevent a re-occurrence.
- If you are a union department, talk to your union president about sending out a joint endorsement letter.
- Have a link to www.firefighternearmiss.com on your intranet site or department site.
- Let your members know that once their report is posted, if they want to, they can give a copy of the printed report to their superiors either anonymously or with their name on it.
- Have your safety officer and training division use information from the site to enhance safety plans and training programs.



If you are a company officer...

- Enter a report and once it is posted, print it and share it with your crew.
- Familiarize yourself with www.firefighternearmiss.com.
- Introduce the program to your crew.
- Encourage a discussion of near misses after a call.
- Print the poster (available on the cd) to post in your station.
- Sign up for "Report of the Week" by e-mailing nearmiss@iafc.org.
- Discuss a report with your crew and ask them if they agree with the lessons learned.

If you are a firefighter...

- Enter a report.
- Visit www.firefighternearmiss.com to read reports from other firefighters.
- If you find a report that has particular relevance to your station or department, print it and share with your company officer.

If you are in a fire-service related industry...

- Have a link to www.firefighternearmiss.com on your Web site.

ACKNOWLEDGEMENTS

The effort to reduce firefighter fatalities and injuries to U. S. firefighters has become the most pressing issue in today's fire service. The funding, development and operation of the National Fire Fighter Near-Miss Reporting System would not have occurred without the generous support of three entities. The IAFC and the Fire Fighter Near-Miss Reporting System Project Team would like to extend their deepest thanks to the following for their contribution to improving firefighter safety:

- Department of Homeland Security's Assistance to Firefighters Grant Program
- Fireman's Fund Insurance Company
- FirefighterCloseCalls.com

The National Fire Fighter Near-Miss Reporting System would not be possible without the dedication, knowledge, professionalism and generous input of the following members of the Near-Miss Reporting System Task Force:

- Garry Briese, Executive Director, International Association of Fire Chiefs
- Chief Alan Brunacini, Phoenix Fire Department (AZ)
- Linda Connell, Director, NASA/Aviation Safety Reporting System
- Chief I. David Daniels, Fulton County Fire Department (GA)
- Captain Scott Ferguson, U.S. Coast Guard
- Deputy Chief William Goldfeder, Loveland-Symmes Fire Department (OH)
- Chief Manuel Gomez, Hobbs Fire Department (NM)
- John Gould, Fire and Aviation Safety Specialist, SAFENET
- Gordon Graham, Graham Research Consultants
- Christopher Hart, Federal Aviation Administration
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- Pat Morrison, Director of Health and Safety, International Association of Fire Fighters
- Tom Phillips, Air Line Pilots Association
- Dennis Smith, Chairman, First Responders Foundation

Thank you to the members of the following departments who participated in the pilot testing of the reporting system. The value of your enthusiasm, encouragement and commitment to this project cannot be overstated.

Arvada Fire Protection District (CO)
Atlanta Fire Rescue Department (GA)
Austin Fire Department (TX)
Baltimore County Fire Department (MD)
Bernalillo County Fire & Rescue (NM)
Charlotte Fire Department (NC)
Clark County Fire Department (NV)
Cy-Fair Volunteer Fire Department (TX)
Downey Fire Department (CA)
Fairfax County Fire & Rescue Department (VA)
Fort Wayne Fire Department (IN)
Freeport Fire Department (NY)
Fulton County Fire Department (GA)
Greensboro Fire Department (NC)
Henderson Fire Department (NV)
Hobbs Fire Department (NM)
Houston Fire Department (TX)
Indianapolis Fire Department (IN)
Long Beach Fire Department (CA)
Los Angeles County Fire Department (CA)
Loveland-Symmes Fire Department (OH)
Magnolia Volunteer Fire Department (TX)
Manchester Fire-Rescue-EMS (CT)
Marietta Fire & Emergency Services (GA)
Midwest City Fire Department (OK)
Montgomery County Fire & Rescue Services (MD)
Mountain View Fire Protection District (CO)
Oklahoma City Fire Department (OK)
Prince William County Department of Fire & Rescue (VA)
Rocky Hill Volunteer Fire Department (CT)
South Farmingdale Fire Department (NY)
South Windsor Fire Department (CT)
Stillwater Fire Department (OK)
Toledo Department of Fire & Rescue Operations (OH)
Virginia Beach Fire Department (VA)
Wallingford Department of Fire Services (CT)
Washington Fire Department (MO)
Western Taney County Fire Protection District (MO)

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WEBSITE: www.firefighternearmiss.com

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PAGE 15 PHOTOGRAPHY CREDIT: Tim Szymanski

It was the right thing then. It's the right thing now.


More than 140 years ago, Fireman's Fund Insurance Company was founded with a mission to donate a percentage of its profits to the fire service. Supporting firefighters made sense then, and it makes sense now. That's why we launched the **Fireman's Fund Heritage**SM program, which not only helps fund the National Fire Fighter Near-Miss Reporting System, but also provides local fire departments with funds for equipment, training and education programs. Since 2004, Fireman's Fund has donated more than \$5 million to the fire service. And that number continues to grow as Fireman's Fund employees and agents continue to direct grants to local fire departments across the nation. To learn more about this unique partnership, please visit www.firemansfund.com.

Fireman's Fund HERITAGESM

*Supporting firefighters for
safer communities*

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Fireman's Fund contributes a portion of profits to support firefighters for safer communities. A company of Allianz 



National Fire Fighter Near-Miss Reporting System

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