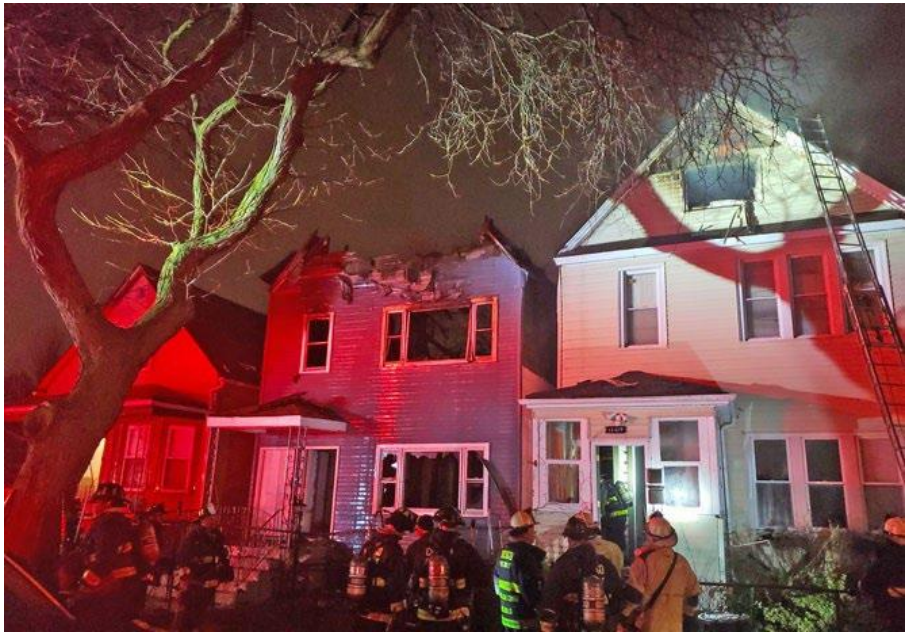
LINE OF DUTY
DEATH REPORT
REPORT SLIDES

F2023-05

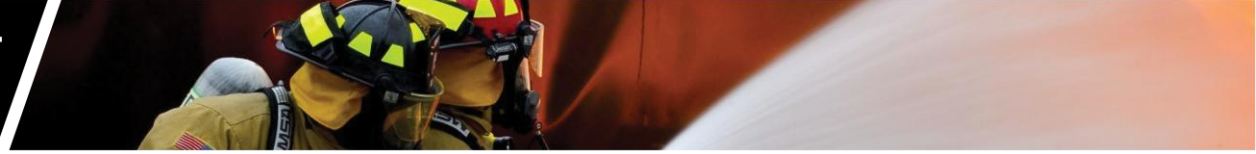
Firefighter Dies After Becoming Lost in the Attic at a Residential Structure Fire – Illinois

Summary

- On April 4, 2023, a 49-year-old firefighter died after becoming lost in the attic of a residential structure.
- At 03:23 hours, the Office of Emergency Management and Communications (OEMC) transmitted a Still Alarm (first response) for a residential structure fire for Box 142016.
- Battalion Chief 22 (BC22), Engine 75 (E75), Engine 115 (E115), Tower Ladder 24 (TL24), and Truck 27 (T27) were dispatched.

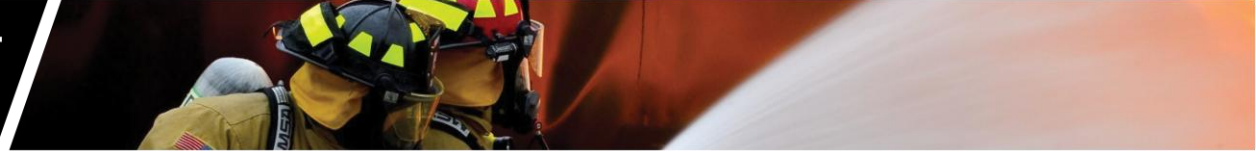


A firefighter was lost in the attic of the white residential structure (Delta 1 exposure). (Courtesy of the fire department)



Summary

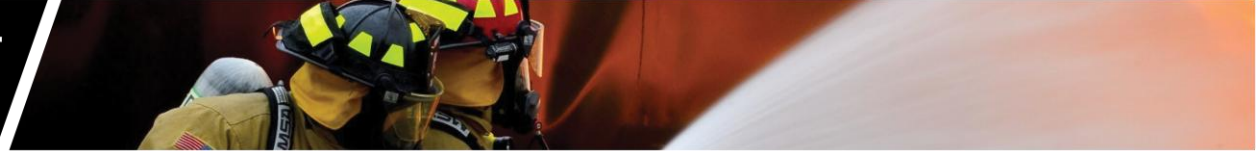
- OEMC transmitted a Working Fire Dispatch (confirmed fire, additional resources deployed) for Box 142016 at 03:25 hours with several additional units dispatched.
- E75 arrived on-scene at 03:26 hours and advised this was a working fire.
- E75 stretched a horseshoe hose load (100-feet of 2½-inch and 100-feet of 1¾-inch) to the fire building (middle building in Photo 1) but there was a delay in getting water due to a lack of water pressure.
- TL24 and BC22 arrived at 03:29 hours.
- A member of TL24 forced the door of the fire building for E75.



Summary

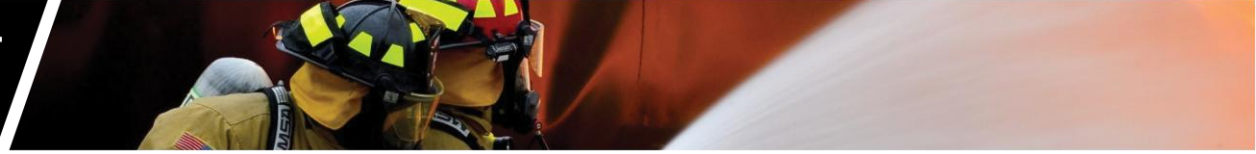
- The E75 nozzle and E75 officer were going up the stairs to the 2nd floor where the fire was located.
- The stairs were compromised, and they were ordered out of the building.
- The Incident Commander (IC) requested a Still and Box Alarm for Box 142016 at 03:31 hours and the OEMC dispatched several additional units.
- E75 hydrant (establishes water supply to the engine) (deceased firefighter) was assigned to take the hoseline from E75 nozzle to knock down the fire showing from the Delta 1 exposure (side of the structure shown on the right in photographs) (white building to the right in Photo 1).
- At approximately 03:37 hours, E75 hydrant and E75 officer went into the Delta 1 exposure and worked their way to the attic.

The fire building is the structure behind the tree. Bravo 1 exposure is to the left and Delta 1 exposure is to the right (with the traffic cones in the yard). The entrance and access to the 2nd floor on each structure is the door on the side Alpha/side Bravo corner. (Courtesy of the fire department)



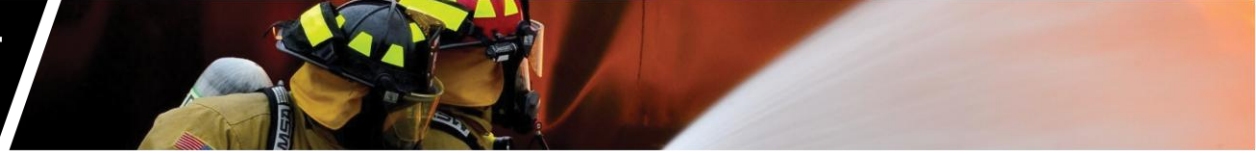
Summary

- The conditions in the attic were hot with heavy smoke, and there was fire in the side Alpha/side Bravo corner of the attic.
- E75 hydrant was attacking the fire, when E75 officer's low-air alarm or end-of-service-time-indicator (EOSTI) sounded.
- IC ordered an evacuation of the Delta 1 exposure at 03:55 hours.
- The E75 officer told E75 hydrant that they were to leave the attic, which E75 hydrant acknowledged.
- When E75 officer got down to the 1st floor, E75 hydrant was not behind him.



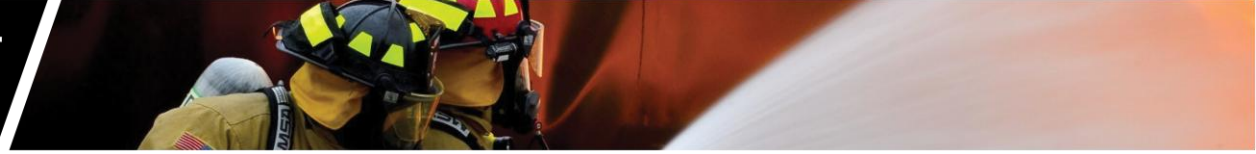
Summary

- He radioed E75 hydrant with no response and also called IC asking the location of E75 hydrant.
- IC transmitted a Mayday at approximately 04:04 hours.
- Squad 5 (SQ5) entered the Delta 1 exposure and went to the attic.
- SQ5 found E75 hydrant in the knee wall of the attic on the side Charlie corner at approximately 04:11 hours.
- A master stream flowing from TL24 into the attic was shut down.
- SQ5 and a member of T27 got E75 hydrant out of the attic while his EOSTI was sounding.



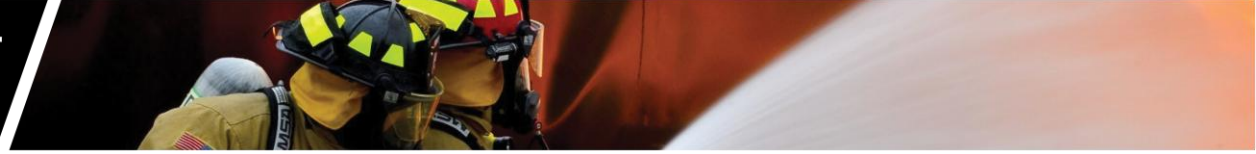
Summary

- They brought him down the stairs and out of the building at 04:18 hours.
- While coming down the stairs, E75 hydrant had his SCBA facepiece on, but it became dislodged.
- E75 hydrant was transported to a local trauma center at 04:28 hours where he was subsequently pronounced deceased.
- The medical examiner later reported his cause of death to be carbon monoxide (CO) toxicity from smoke and soot inhalation, with contribution of thermal injuries and hypertensive arteriosclerotic cardiovascular disease.
- The fire at Box 142016 was declared under control at 06:10 hours.



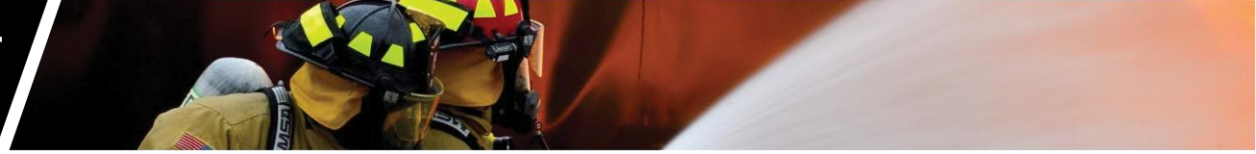
Contributing Factors

- Size-up and risk assessment
- Crew integrity
- Personnel accountability
- Rapid intervention team/crew
- Simultaneous interior and exterior operations
- Occupational medical evaluations
- Wellness and fitness program



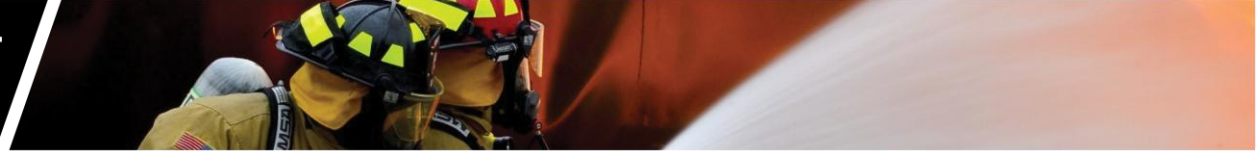
Recommendations

- Ensure initial and ongoing size-ups and risk assessments are conducted throughout the incident.
- Company officers and firefighters maintain crew integrity when operating in the hazard zone.
- Ensure ICs immediately establish divisions/groups with a supervisor to communicate conditions and provide accountability.
- Ensure a rapid intervention team/crew is dedicated, assigned, and in place before interior firefighting operations begin and throughout an incident.



Recommendations

- Ensure interior and exterior operations, such as water application, are not conflicting.
- Ensure that firefighters undergo cardiovascular disease screening as recommended in NFPA 1582.
- Implement a mandatory wellness and fitness program for fire department members that is consistent with NFPA 1583, Standard on Health-Related Fitness Programs for Fire Department Members, and the International Association of Fire Fighters/International Association of Fire Chiefs (IAFF/IAFC) Wellness-Fitness Initiative.



Contact Us

Fire Fighter Fatality Investigation and Prevention Program
Surveillance and Field Investigations Branch
Division of Safety Research
NIOSH 1000 Frederick Lane, MS 1808
Morgantown, West Virginia 26505-2888

FFFIPP Webpage

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