State FACE™ Fatality Narrative

Indoor Shooting Range Instructor Killed in Fire

INCIDENT FACTS

REPORT #: 71-276-2026s REPORT

REPORT DATE: April 15, 2026

INCIDENT DATE: February 16, 2025

WORKER: 33 years old

INDUSTRY: Indoor Shooting Range

OCCUPATION: Instructor

SCENE: Range Classroom

EVENT TYPE: Fire, Explosion

Image 1. Angle grinder where fire started.

SUMMARY

- A 33-year-old instructor died in a fire at an indoor shooting range. He worked there for six years as an instructor and operated a gunsmithing and holster making side business at the range.
- The instructor was working in the second-floor classroom inside the range. He was using an angle grinder to modify a metal cart for his side business. It is unknown why he was working there and not in the workshop, which was designated for metal work.
- He brought the grinder that day, and the owner believed the cart had been brought previously. The classroom contained flammable and combustible materials including ammunition, solvents, paper, and range sweep-off dust that contained unspent gunpowder.
- Three coworkers and seven customers were in other areas of the range.

SUMMARY

- One worker went to the classroom and saw the instructor cutting the cart with the grinder, with no visible smoke or fire, then returned to the lobby. About a minute later, ceiling tiles began to fall and fire erupted from above. He ran toward an exit door and was blown through it, suffering burns and a head injury.
- At the same time, the two workers on the first floor heard rushing air followed by an explosion through the stairwell, possibly fueled by combustible dust above the ceiling.
- Alarms sounded as the fire spread rapidly. The injured worker directed customers to the exit and reentered several times but could not reach the instructor.
- The instructor was later found about 32 feet from the fire's origin. It is believed he was trying to reach the front exit where others were calling to him. He died from smoke inhalation and burn injuries.

CONTRIBUTING FACTORS

Following the incident, investigators found:

- Fire investigators reported the fire started in the classroom as indicated by burn patterns. They concluded that the source of ignition was either sparks from cutting metal or an electrical short circuit. The grinder was found unplugged.
- The employer had an accident prevention program (APP), but it did not include safe use of angle grinders as they were not used by workers. The employer believed the instructor knew that he should do metal work or hot work only in the workshop.
- One second-floor exit door and stairway were closed due to break-ins.
- One worker described seeing large accumulations of settled dust in the space above the ceiling tiles.

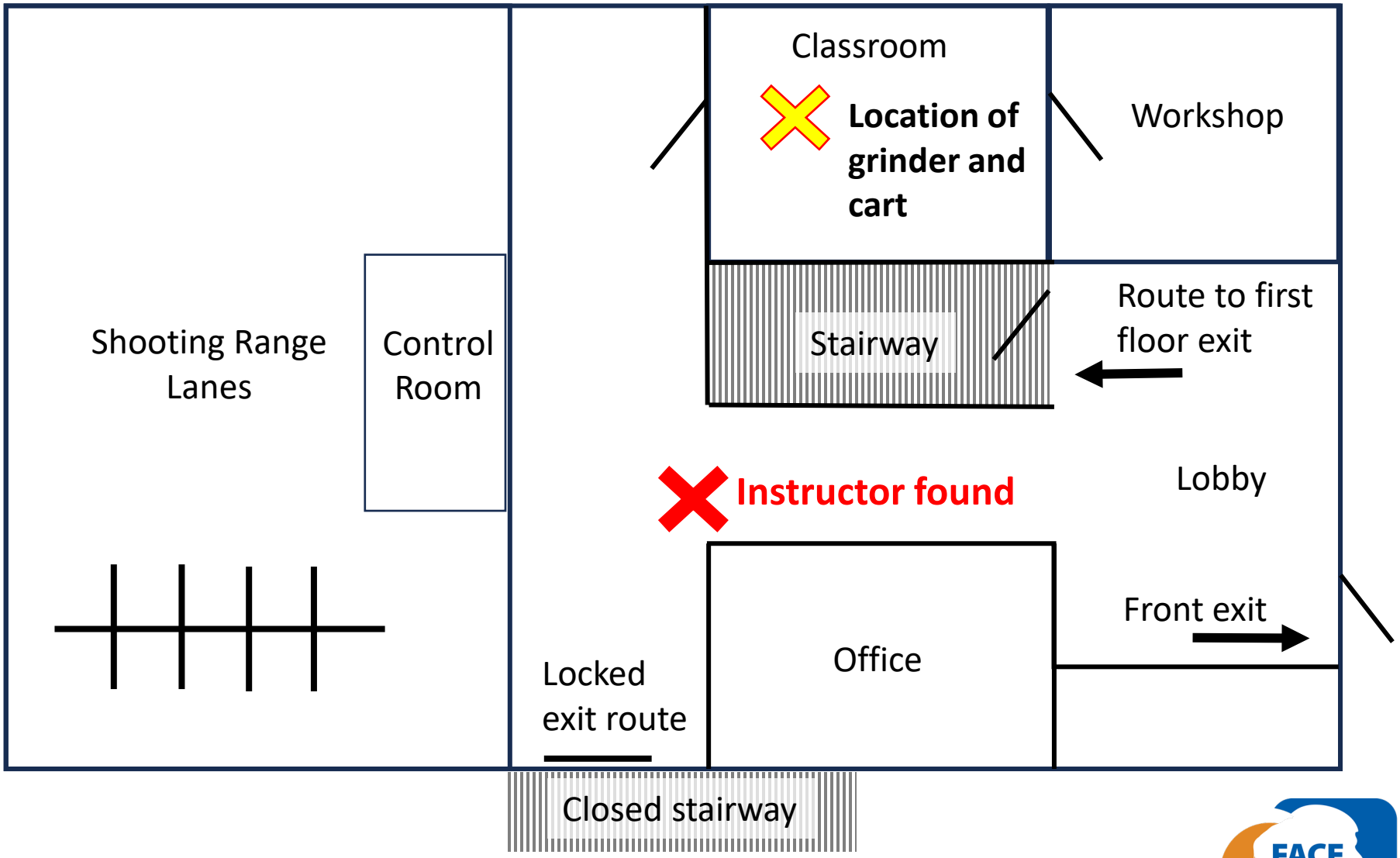

Diagram 1. Second floor where fire started and instructor was found (not to scale).

Image 2. Retail area in the second-floor lobby where one coworker was when the fire started and front exit the worker was blown out.

Image 3. Stairway and entrance to second-floor corridor leading to classroom, workshop, lobby, and firing range.

Image 4. Classroom where fire started and door to the instructor's workshop, lobby exit, and stairwell to first floor on the left.

Image 5. Area where instructor was modifying the cart and fire started.

Image 6. Angle grinder instructor was using to cut the cart.

Image 7. Metal cart the instructor was modifying.

Image 8. Section of metal cart the instructor was cutting.

Image 9. Burn pattern on wall of workshop adjacent to classroom showing how the fire spread between rooms.

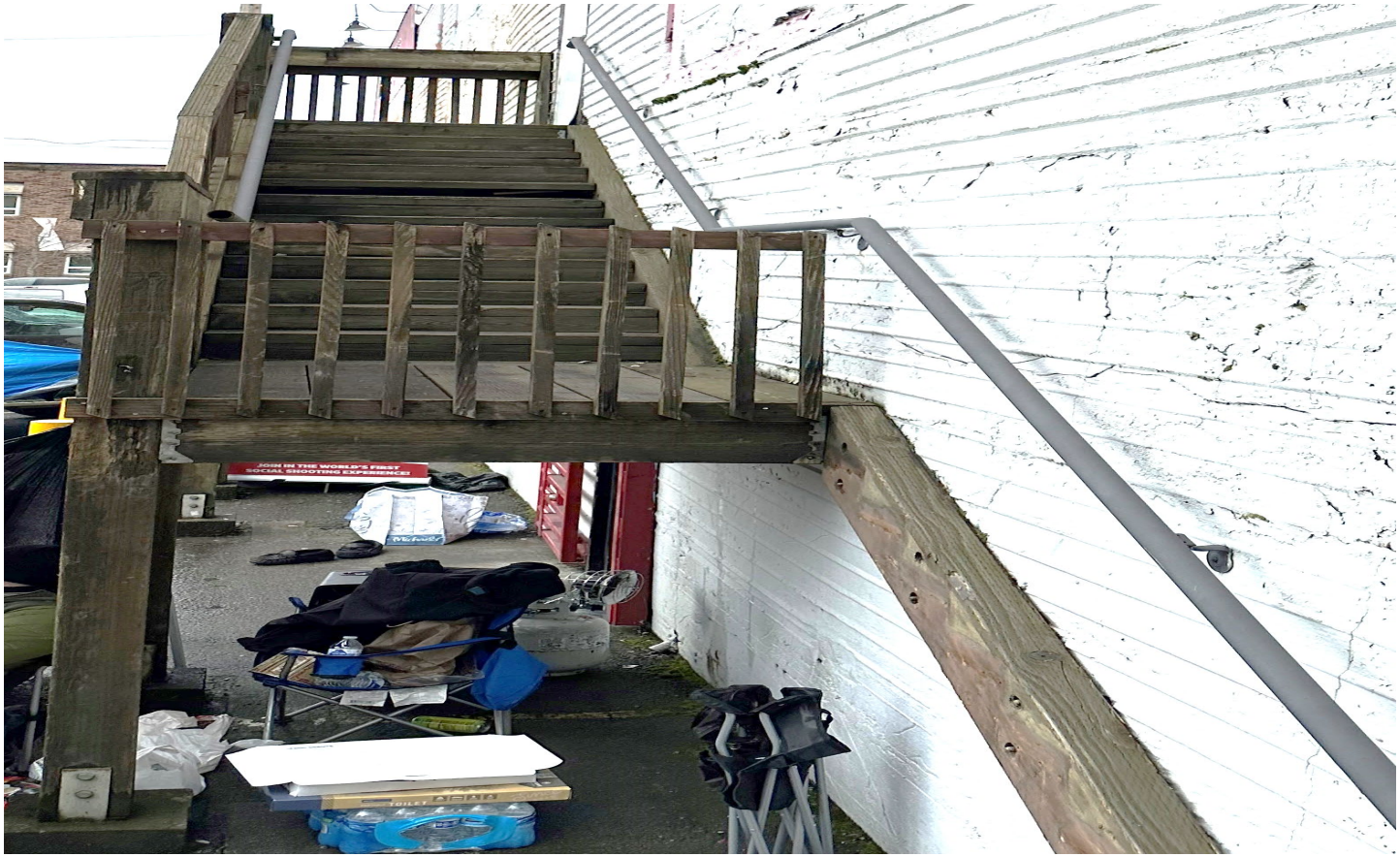

Image 10. Closed external stairway leading from locked second-floor exit door.

REQUIREMENTS

Employers must:

- Provide a workplace free of recognized hazards. See WAC 296-800-11005
- Follow the requirements in NFPA 51B – Standard for Fire Prevention in Use of Cutting and Welding Processes referenced in WAC 296-24-680 Welding, cutting, and brazing. Washington Administrative Codes (WACs) do not contain grinder-specific language. Grinding is considered hot work by the NFPA.

RECOMMENDATIONS

- **Restrict hot work to designated areas**. Establish and enforce a hot work program restricting torch cutting, welding, brazing, and use of spark-producing tools to areas designated for hot work. Ensure work is permitted and monitored. Areas should be free of flammable and combustible materials and equipped with ventilation to effectively exhaust dust, gas, and fumes. Install dry chemical extinguishers specified for ordinary combustibles, flammable liquids/gases, and electrical fires (Class ABC). Develop and follow an accompanying training program.
- **Develop a range cleaning and waste disposal program.** Add a cleaning and waste storage and disposal program to your APP. Collect and dispose of settled dusts frequently and safely. Include a focus on storing flammable and combustible materials in a fire safe area and promptly disposing of them.
- **Maintain exit routes to permit prompt evacuation during an emergency.**

FATALITY NARRATIVE

Indoor Shooting Range Instructor Killed in Fire

WASHINGTON State FACE Program
Fatality Assessment & Control Evaluation™

REPORT #: 71-276-2026
REPORT DATE: 4/15/2026
INCIDENT DATE: 2/16/2025
WORKER: 33 years old
INDUSTRY: Indoor Shooting Range
OCCUPATION: Instructor
SCENE: Range Classroom
EVENT TYPE: Fire, Explosion

Angle grinder where fire started.

View slides for this fatality narrative

INDOOR SHOOTING RANGE FATALITY NARRATIVE

Indoor Shooting Range Instructor Killed in Fire

SUMMARY

A 33-year-old instructor died in a fire at an indoor shooting range. He worked there for six years as an instructor and operated a gunsmithing and holster making side business at the range. The instructor was working in the second-floor classroom inside the range. He was using an angle grinder to modify a metal cart for his side business. It is unknown why he was working there and not in the workshop, which was designated for metal work.

He brought the grinder that day, and the owner believed the cart had been brought previously. The classroom contained flammable and combustible materials including ammunition, solvents, paper, and range sweep-off dust that contained unspent gunpowder.

Three coworkers and seven customers were in other areas of the range. One worker went to the classroom and saw the instructor cutting the cart with the grinder, with no visible smoke or fire, then returned to the lobby. About a minute later, ceiling tiles began to fall and fire erupted from above. He ran toward an exit door and was blown through it, suffering burns and a head injury.

At the same time, the two workers on the first floor heard rushing air followed by an explosion through the stairwell, possibly fueled by combustible dust above the ceiling.

Alarms sounded as the fire spread rapidly. The injured worker directed customers to the exit and reentered several times but could not reach the instructor.

The instructor was later found about 32 feet from the fire's origin. It is believed he was trying to reach the front exit where others were calling to him. He died from smoke inhalation and burn injuries.

Download the fatality narrative:

https://lni.wa.gov/safety-health/safety-research/files/2026/71_276_2026_ShootingRangeFire.pdf

RESOURCES

OSHA Guidance on Fire Safety

OSHA Model Fire Safety Plan

DISCLAIMERS

The WA FACE Program is supported by funding from NIOSH (grant #5U60OH008487).

These report slides are the product of NIOSH’s Cooperative State partner. The findings and conclusions in each report slides are those of the individual Cooperative State partner and do not necessarily reflect the views or policy of NIOSH.

This narrative was developed by the Washington State Fatality Assessment and Control Evaluation (WA FACE) Program and the Division of Occupational Safety and Health (DOSH), Washington State Dept. of Labor & Industries to alert employers and workers of a tragic incident in Washington State. It is based on preliminary data ONLY and does not represent final determinations regarding the nature of the incident or conclusions regarding the cause of the injury.

CONTACT US

Washington FACE
PO BOX 44330
Olympia, WA 98504-4330
1-888-66-SHARP (toll-free) or 360-902-5667

Washington State FACE: http://www.lni.wa.gov/safety-health/safety-research/ongoing-projects/work-related-fatalities-face

WASHINGTON
State FACE Program
Fatality Assessment & Control Evaluation™

FACE Fatality Assessment and Control Evaluation Program