

	<b>NIOSH LODD Review</b>	
LODD 2012-08	<a href="http://firetrainingtoolbox.com">http://firetrainingtoolbox.com</a>	LODD 2012-08



## *Death in the line of duty...*



A summary of a NIOSH fire fighter fatality investigation

October 11, 2012

# Volunteer Lieutenant Killed and Two Fire Fighters Injured Following Bowstring Roof Collapse at Theatre Fire – Wisconsin

## Executive Summary

On March 4, 2012, a 34-year-old male volunteer lieutenant (the victim) lost his life at a theatre fire after the roof collapsed, trapping him within the theatre. At approximately 1215 hours, an on-duty patrol officer (also chief of the victim's fire department) radioed dispatch for a structure fire (flames visible). The 1st due fire department arrived on scene, set up operations on the A-side of the structure, and directed the incoming mutual aid department (victim's department) to the rear of the structure. No fire was visible from the rear. Both departments attacked the theatre fire from opposite sides (A-side and C-side) of the structure establishing their own incident commander/officer in charge, fireground operations, and accountability systems. The 1st due fire department initially fought the fire defensively from the A-side, while the victim and two additional fire fighters (FF1 and FF2) entered through the C-side, advancing a hoseline until they met A-side fire fighters near the theatre's lobby (area of origin). The 1st due fire department eventually placed an elevated master stream into operation, directing it into the lobby and then onto the roof while fire fighters were operating inside. Roof conditions deteriorated until the roof collapsed into the structure trapping the victim, FF1, and FF2. FF1 and FF2 recalled speaking with the victim immediately following the collapse, but nothing was heard from the victim following the activation of a personal alert safety system device (PASS). All three were eventually located, removed from the structure, and transported to a local hospital, but the victim had already succumbed to his injuries.



**Incident scene when fire was first discovered.**  
(Photo courtesy of Julie Miklaszewicz.)

### Contributing Factors

- Initial arriving units not establishing/performing/implementing an incident management system, an overall incident commander, an incident action plan (IAP), and a 360-degree situational size-up
- Risk management principles not effectively used
- Fireground and suppression activities not coordinated
- Fire ground communications between departments not established
- Incident safety officer (ISO) role ineffective
- Rapid intervention crew (RIC) procedures not followed and/or implemented
- Bowstring roof truss construction not recognized by departments
- Fire burned undetected within the roof void space for unknown period of time
- Uncoordinated master stream operations
- Location of victim following roof collapse not immediately known.

**Download Report at:**  
<http://www.cdc.gov/niosh/fire/reports/face201208>.

For more info on Bowstring roof truss construction go to  
<http://buildingsonfire.com/>