UFF Position Statement:

Safety Investigation Reports: Addressing Line of Duty Deaths and Injuries Post Incident (AKA After Action Reports)

Data driven decision making is a desired action at all levels of a fire department. It is important to capture the data that your department generates in order to use that information to build policies, guides, bulletins and training regimes that can improve the effectiveness and safety within your department while improving your department's public service capabilities.

One data source that may often be overlooked are the events that result in a line-of-duty injury (LODI) or line of duty death (LODD) incident. At the Federal level, the National Institute for Occupational Safety and Health (NIOSH) investigates many, though not all, LODDs. In some states, the state fire marshal's office may be tasked with investigating the LODD. Regardless of outside investigative resources, it is beneficial for fire departments to create a Safety Investigation Team to review any incident resulting in a LODI or LODD. The team should develop a report, including any lessons learned, and a list of action items to be shared with the entire department. Other fire departments may also benefit from investigative reports that are available to be shared.

Conducting a safety review of incidents where a serious firefighter injury occurred, or an incident where multiple firefighters were injured, is most important as lessons learned from these LODI incidents may prevent a LODD incident in the future.

Fire officers and firefighters pay a high physical and emotional price for a line-of-duty incident. Therefore, it is critical to collect and analyze data from the incident and to develop department wide learning from the information generated in an effort to limit the likelihood of a future occurrence.

Similar investigative reviews should be considered to examine high-risk civilian rescues and victim recoveries to determine if lessons learned or best practices can be established for those events.

Safety Investigation Report Process

Based on the type of incident, fire chiefs can assemble Safety Investigation Teams to include experienced leaders within the department and trusted experts outside of the department. Members from within the department should be assembled and protocols developed prior to an incident, to assure response readiness when needed.

Core incident investigation needs:

1. Establish the facts of the incident, including:

    - What happened?
    - What was the event situation when the LOD incident occurred?
    - When and where did it happen?
    - What task was being done?
    - Who was involved?
    - Were there any witnesses?

2. Gather all necessary background information, for example:

    - Policies
    - Procedures
    - Manuals
    - Photos
    - Videos
    - Written statements from personnel who responded to the incident
    - Radio recordings
    - Gear worn by injured personnel
    - Tools and equipment used by injured personnel
    - Incident reports
    - Fire Marshal's Office origin and cause investigation report
    - Training records for crews involved
    - Apparatus and equipment specifications
    - Building layout and material information

3. Consider all potential contributing factors:

    - Environment: Did environmental conditions (e.g. weather, high heat, dense smoke, scene lighting, noise, floor surfaces) contribute to the incident?
    - Structural compromise: Did the underlying emergency situation change suddenly?
    - Equipment/tools: Did the equipment or tools contribute to the incident?
    - Strategy and Tactics: Did the approach to the incident contribute (e.g. hazard not identified, known hazard not addressed)?
    - Actions at scene: Did the crews, officers, chiefs or civilians contribute to the incident (e.g. poor communication, insufficient staffing, civilian vehicle crash into existing scene of emergency)?

4. Determine the primary cause(s) or most prominent contributing factor(s) of the LOD incident. The primary cause or contributing factor is the element most closely linked

with the LOD incident. (The element without which the event would not have occurred)

5. Identify the root cause or system failures that underlie the primary cause(s) and contributing factor(s).[1]

6. Develop an action plan to overcome all the factors that contributed to the incident. The plan should start with the primary cause(s) and work through each of the contributing factors and underlying causes.

7. Share the findings in the form of a report and/or training bulletin with your department and others as appropriate. The goal is improvement and prevention of future LOD incidents.

[1] One technique for identifying the root cause is the 'Five Whys'. This technique involves asking "Why did this happen?" and continuing to ask "Why" for each response until a conclusion is reached that does not generate another "why" and the underlying cause becomes apparent.