This guide is intended to assist fire departments in planning and conducting an investigation of a line-of-duty death. The same procedures are applicable to other situations that require a thorough investigation with a focus on occupational safety and health, including serious accidents, injuries and situation where a death or serious injury is narrowly averted.

Contents

Introduction
Objectives
Complicating factors
The Investigation Team
Investigative Authority
Team Members
Immediate Actions
  Isolate the Scene
  Impound Evidence
  Document Safety Equipment
  Photograph the Scene
  Arrange for an Autopsy
  Identify Witnesses
Second-Stage Actions
  Conduct Interviews
  Obtain Records
  Develop a Time Line
  Examine Physical Evidence
  Research Documents
  Get Expert Assistance
  Obtain Legal Advice
Analyses and Report Development
Report Presentation
Cooperation With Other Agencies

Appendix A
  Other Participation
Appendix B
  Related Information
Introduction

Investigation of a line-of-duty death of a member is one of the most difficult and important activities that must be conducted by a fire department. This difficulty is compounded by the fact that the investigation must usually be conducted under extremely stressful circumstances and often under pressure for the rapid release of information. It is important for every fire department to have a plan and to be prepared to conduct such an investigation.

The procedures of a line-of-duty death investigation can and should be applied to other situations, particularly accidents that result in serious injuries, or incidents that could have resulted in death or injury under slightly different circumstances. A “close call” should be interpreted as a warning to prevent the same situation from happening again and to ensure that all protective systems are adequate and functional.

A thorough investigation will require both time and effort. It is important to discover, identify, research and fully document every causal factor or potential causal factor. The investigation should focus on factual information. It should present the facts of what happened, identify the causal factors and recommend appropriate corrective actions. In many cases there will be conflicting theories and opinions about the incident. There may also be a number of very different accounts from witnesses and individuals who were involved. The investigation should follow up on every lead or theory to discover the actual facts, as precisely as they can be determined.

The visible product of an investigation is a report, usually in printed form, including photographs, illustrations and diagrams to fully document the incident and the conclusions and recommendations that are reached through the investigative process. The printed document is often supplemented by videotapes, audiotapes, and physical evidence. This official report document may be accompanied by materials that will assist in presenting the report to a live audience. The most important application of an investigation, however, is the manner in which the conclusions and recommendations are used and applied to prevent future accidents and injuries.

It may be necessary to work with outside agencies or to involve independent experts to assist with the investigation of an incident. The involvement of other organizations and need for specialized assistance will depend on the nature of the incident, legal or statutory considerations, the capabilities of the fire department, and other circumstantial factors. Several organizations that could be involved in an investigation are listed in this document.
Objectives

The investigation of a line-of-duty death may serve several different purposes. The most important objective, in every case, is to prevent the same situation from occurring in the future. We should never be satisfied until we can be sure that we are doing everything in our power to prevent accidents, injuries, occupational illnesses and line-of-duty deaths.

Primary Objectives

1. To determine the direct and indirect causal factors which resulted in a line-of-duty death, particularly those factors that could be used to prevent future occurrences of a similar nature, including:
   • Identifying inadequacies involving apparatus, equipment, protective clothing, standard operating procedures, supervision, training, or performance
   • Identifying situations that involve an unacceptable risk
   • Identifying previously unknown or unanticipated hazards

2. To ensure that the lessons learned from the investigation are effectively communicated to prevent future occurrences of a similar nature. (When appropriate, this should include dissemination of the information through fire service organization and professional publications.)

Additional Objectives

3. To satisfy the requirements of the Public Safety Officer Benefits (PSOB) Program and other entitlements (see pages 31-40 of this manual).
4. To identify potential areas of negligence and causal factors that could result in criminal prosecution or civil litigation.
5. To ensure that the incident and all related events are fully documented and evidence is preserved to provide for additional investigation or legal actions at a later date.
6. To provide factual information to assist those involved who are trying to understand the events they experienced.
7. To provide the information to other individuals and organizations that are involved in the cause of fire service occupational safety and health.
Complicating Factors

Investigations are often complicated by factors and situations that could cause the investigation team to lose sight of the true objectives and damage the credibility of the completed report. The investigators must have a firm understanding of their mission and must have the support and independence necessary to perform a thorough and unbiased investigation.

The investigation team may be placed in the uncomfortable position of investigating the actions of friends, co-workers and superior officers. There may be pressure to find a particular individual or one isolated act or omission responsible for the fatal incident. There may also be a desire to absolve an individual of responsibility or to protect the reputation of the fire department. Emotional reactions are natural when a fatality occurs and they can be magnified when accusations are made or when an individual feels personal responsibility. The investigation should attempt to separate the emotions from the facts and present an unbiased analyses of the incident.

The mission of the investigation team must be directed and limited to finding facts and developing recommendations that are based only on the facts. Any instruction that attempts to alter the mission is inappropriate and any suggestion that a bias or cover-up is involved is a serious accusation.

A report that is based on factual information should speak for itself. The facts should be documented and available for review and the conclusions and recommendations should be clearly supported. In most cases a series of contributing factors will be found, leading to a number of recommendations.

Accusations of negligent acts and determinations of personal responsibility or liability are beyond the scope of a fact-finding report. If the report presents facts that lead to a conclusion of this nature, it is up to administrative, regulatory, or legal bodies to initiate appropriate actions.

There are times when significant facts cannot be determined with certainty. The actions of the victim may have been based upon circumstances that only the victim could describe. Other factors may be subject to conflicting theories or contradictory evidence. In these situations it is up to the investigation team to investigate as thoroughly as possible and to differentiate, in the report, between established facts and speculation or expert opinion. A report should never be based on unsupported assumptions.

A further complication may arise if there are any suggestions of criminal responsibility for an incident. In these situations it is essential to work closely
with the appropriate law enforcement agencies to coordinate activities and share information during the investigation. This will depend on the nature of the suspicion and the relationship between the investigating agencies. In most cases it is possible to develop a positive working relationship that allows the investigation of both aspects of the situation to proceed.
Investigation Team

An investigation of a line-of-duty death is not a job for one individual. A thorough investigation will usually require at least 3-5 individuals and may involve a larger team. The fire department should have a plan that identifies an investigation team that will be immediately activated when an incident occurs. Designated team members should respond to the scene of the incident to begin the investigative procedures as soon as possible.

The plan should identify more than one potential team leader and several potential team members. The assignment process should be planned and documented based on the availability of designated individuals and particular circumstances of the incident. The team members should be immediately reassigned from their regular duties to devote their full efforts to the investigation. In larger departments there may be a duty roster system or a primary designated individual and number of potential alternates. Smaller departments may plan to work together, assembling a team from a mutual aid group or from more than one agency.

The ideal team leader should be thoroughly familiar with fire department operations, with health and safety issues, and with investigative techniques. Because few individuals possess true expertise in all three of these essential areas, the team should be assembled to combine the abilities of different individuals who can contribute to the project. The fire department safety officer should be a member of the team and may be the best choice to be the team leader. The team leader should be the individual who is most capable of managing and leading a group effort with these and other needed abilities.

Investigative Authority

One of the most important considerations in appointing the team leader is to delegate the necessary authority to conduct a complete and thorough investigation. While the fire chief has the ability to assign and delegate the authority to any member of the department, a team leader who holds command or management level rank can usually function more efficiently in gaining cooperation and coordinating team efforts. The individual should also be respected for expertise, impartiality and conscientious work. No other officer should have the authority to interfere with the investigation.
Team Members

A list of potential team members should be maintained, based on individual abilities and qualifications. At least one member of the team should be trained and qualified in investigative procedures, preferably with specialized training in accident and injury investigation. A trained and qualified fire investigator or accident investigator can provide the other team members with guidance on the proper collection and preservation of evidence, managing interviews and preparing investigative reports.

The team should include members who are very familiar with the type of activities and hazards that were involved in the incident, with the safety procedures that should apply to the situation, and with the organization and operations of the department. Additional capabilities that may be needed include photographers, video specialists, and experts in other areas that may apply to the particular situation. Some of these individuals may not need to be assigned to the team on a full time basis if their skills are available when needed.

It may not be possible to find all of these qualifications within the fire department. For example, a traffic accident involving fire apparatus will require an individual who is qualified to investigate accidents involving heavy trucks. This individual may have to be “borrowed” from a state or local police agency or it may be necessary to contract with a private investigator.

One of the first concerns of the team leader will be to identify the individuals or the particular capabilities that will be needed to investigate the incident. The plan should identify individuals who would be called upon, depending on the specific situation. If the plan does not identify anyone with expertise in the particular area of concern, one of the highest priorities will be to locate and engage the services of a qualified individual. The plan should provide a mechanism to quickly arrange for the services of any outside assistance that could be needed. The local law enforcement agency may be able to provide valuable assistance, particularly in managing and documenting evidence.

The plan should provide for the immediate response of a designated or provisional team leader and at least one or two additional team members when a fatal incident occurs. The remaining team members should be reassigned from their regular duties to the investigation team within 12-24 hours.
**Immediate Actions**

There are several actions that should be implemented immediately when a line-of-duty death or a serious accident occurs.

**The Incident Commander should direct the following actions:**

1. **Isolate the Scene**
   The scene of the incident should be secured and guarded; only those individuals who have a specific reason to enter should be allowed inside the perimeter. An officer and as many members as are necessary should be assigned to secure the scene. Police assistance may be necessary to establish and maintain scene security. Senior officers should respect the need to preserve the scene for the investigation team and not use their privilege of rank to violate the perimeter.

   The sooner that isolation is implemented, the easier it will be to investigate the scene and to account for any disruptions of the physical evidence. The only reasons to violate this rule would be to provide medical treatment in an attempt to save the victim or to control a fire that could destroy the evidence. If an obviously dead body is present, the scene should be left undisturbed for the investigators. The scene should be maintained until all physical evidence has been documented, photographed and measured.

2. **Impound Evidence**
   All items that could have a bearing on the investigation should be impounded and protected until they can be turned over to the investigation team. In the case of a fire fatality, items such as protective clothing and breathing apparatus will be extremely important in the investigation. Physical evidence should be handled in the same manner as evidence from an arson investigation or criminal investigation. A qualified fire investigator would usually be the most appropriate team member to manage the physical evidence.

   Every reasonable effort should always be made to rescue, treat, and transport a victim to a hospital, if there is any possibility of preserving life. In this process protective clothing, breathing apparatus, and other items may be removed from the victim and could be easily misplaced. The Incident Commander should immediately assign someone to take custody of any items that are removed from the secured area and to turn them over to the investigation team. Any necessary movement of evidence should be noted and recorded.

3. **Document the Condition of Safety Equipment**
   Information relating to the performance of protective clothing, breathing apparatus and other safety equipment is extremely significant in fatalities that occur during fire suppression operations and hazardous materials incidents. This
ICHIEFS

LODD Response Plan

Information should be documented by written notes and supported by photographs. If the victim must be moved, or if it is necessary to remove protective clothing and equipment before the investigation team arrives, it is important to note the condition of pertinent items.

Questions on the Condition of Safety Equipment*
*Note: This list would apply to a firefighter who died in a fire suppression incident. A similar set of concerns would apply to any other type of situation.

**Breathing Apparatus**
Was the victim wearing SCBA?
Was the face piece in place?
Was there pressure remaining in the air cylinder?
Were the valves in their normal positions?
Were straps and other components in their normal use configuration?
Was there any visible damage to the SCBA?
Were any components missing?
Where were they found?
How old was the SCBA?
When was the last test?
If needed, were the repairs made?

**Personal Alert Safety System (PASS) and Radio**
Was the victim carrying a PASS device?
Was it turned on, and how do you know?
Was it functioning when the victim was found?
Did the victim have a portable radio or any other equipment?
Where was it found?
Was it in operable condition?

**Protective Clothing**
Was the victim wearing full protective clothing?
Was any protective clothing damaged?
Had the victim removed any item of protective clothing?
Where was it found?
Did the victim have/wear all the required personal protective equipment?

The investigation team should implement the following steps:

4. **Photograph the Scene**
The scene should be diagrammed and photographed in the same manner that a crime scene would be documented. Large color prints are the preferred method of documentation. If the fire department does not have a qualified photographer, a police photographer should be requested to provide this service, under the
5. Arrange for an Autopsy
An autopsy should be conducted for every line-of-duty death. If the death is fire-related, the medical examiner should be requested to look particularly at blood gases, including carboxyhemoglobin levels and other products of combustion. An alcohol level test is also necessary to meet the requirements of the Public Safety Officer Benefits Program (see pages 31-40 of this manual).

6. Identify Witnesses
It is often impossible for the investigation team to interview all of the witnesses at the scene or immediately after the incident. The immediate priorities should be to obtain essential information from individuals who were directly involved and to identify witnesses for later follow up.

Second-Stage Actions

The immediate actions will generally require several hours and should be conducted according to a documented and established plan. The second stage will usually begin on the following day, when the full investigation team meets to plan the remainder of the investigation and to make assignments for different functions. It is up to the team leader to identify the resources that will be needed and to establish a plan to manage the investigation. There will be information to gather and analyze, witnesses to be interviewed, references to be checked and a report to be prepared.

7. Conduct Interviews
Full interviews should be conducted with every fire department member involved in the event. At a major incident this may have to be confined to those who were at the scene at the time of the fatal event or who were in any way involved with the victim before or during the event. All interviews should be recorded, with the consent of the witness (record that, too), and notes should be documented. The list of witnesses to interview will often grow as different leads are followed. Anyone who has information that could be significant should be encouraged to inform the investigation team and every contact should be interviewed, including members of the general public.

One objective should be to locate and interview anyone who makes a statement reported in the news media. These statements often confuse the issues in the early stages of an investigation; finding the person who made a statement is usually the best way to determine its accuracy. The team should obtain and review copies of all news broadcasts and published accounts of the incident.
The reporters themselves should be interviewed, if their reports suggest some factor not consistent with the information found by the team. These individuals should be approached as any other witness—by requesting their assistance in determining exactly what happened.

8. Develop a Time Line
The compilation of records, radio tapes and other data should allow the team to establish a basic time line for the incident. The time line establishes the sequence of events chronologically, sometimes to the second. Additional information should be added to the time line as it is obtained, until the time line can be used to fully describe:

…who did what, and who saw what,
…at what location, and at what time?

This is one of the basic building blocks of an investigation process.
In establishing a time line it is important to synchronize the time base for different records. Misleading information may result if times are compared from different sources, assuming that the clocks were synchronized at the time of the incident. The investigation team should verify the times that are recorded for a verifiable simultaneous event and apply the appropriate correction factor to all other time measurements.

9. Examine Physical Evidence
All physical evidence, including protective clothing and equipment that was impounded at the scene, should be thoroughly examined by qualified personnel. All findings should be thoroughly documented and photographed. It may be necessary to have certain items inspected or tested by qualified experts or by testing laboratories. It is important to maintain the chain of custody for all physical evidence as it is examined by different individuals and to ensure that reports are obtained and the items are returned to a secure area.

10. Research Documents
All existing departmental standard operating procedures, training materials, and similar sources of guidance that would apply to the situation should be reviewed to determine:

1. How the situation “should” have been handled.
2. Whether or not it was handled in the expected manner.
3. Whether or not this would have had an impact on the outcome.

Records should be examined to determine if the individuals involved had received the proper training in the relevant topics.

All applicable NFPA standards, ANSI standards, OSHA regulations and similar information that could relate to the events should also be studied. NFPA annual reports on firefighter deaths and injuries should be consulted to determine if
similar situations have occurred in other departments and the conclusions from those reports should be compiled. If possible, the full reports from those incidents should be obtained.

Where equipment or apparatus is involved, specifications and maintenance records should be obtained. Operators should be asked if any problems were previously noted and a determination should be made if required inspections and repairs had been completed on schedule. Talk to the maintenance crew.

11. Expert Assistance
There are several situations that will require the assistance of qualified experts. Apparatus failures, particularly those that involve aerial devices, should be examined by mechanical engineers and metallurgists who are qualified to determine the specific cause of the failure. Breathing apparatus should be examined and tested, if it was involved in any manner (see Appendix B).

Expert assistance is available in many different areas. If the needed expertise is not available within the fire department, it is an excellent investment to find the best individual to assist the team in specific areas or to be part of the entire investigation. Where an incident has become extremely controversial, it may be advisable to have a recognized independent investigator participate in the investigation or review the evidence to develop an independent report.

12. Obtain Legal Advice
Legal issues will involve nearly every aspect of a line-of-duty death investigation. Where potential criminal action is a possibility, the safety investigation should be independent, but must be coordinated with the appropriate law enforcement agencies. Issues of potential liability, including product liability and possible violations of occupational health and safety laws, will be a consideration in almost every case. These factors should not be allowed to restrict the investigation, but it is advisable to consult an attorney and to have the report reviewed by the fire department’s attorney before it is released.
Analysis & Report Development

There is no magic formula for how to compile and analyze all of the data necessary to conduct a thorough investigation and prepare a report. It requires time and effort to fully understand, prepare, and develop a comprehensive report on a complicated situation. The team members should work toward a full understanding of the events that occurred, the responsibilities and actions of key individuals, the factors that made the department vulnerable to a fatal incident, and the actions that should have been taken or should be implemented now to prevent a similar occurrence in the future.

Every component of the “puzzle” should be followed back to its root cause. For instance, the evidence may suggest that an individual was not properly trained to handle a particular situation. This should be followed back to determine if the training was available, if the individual was trained, was trained in an improper procedure, or had taken action that was inconsistent with training that had been provided. This could lead to a recommendation for refresher training, for training in a new area, for a change in the procedure that training is based upon, or for a system to ensure that members attend all training classes.

Every contributing or suspected contributing factor should be followed back to a conclusion and tied in with all of the other factors to develop a complete report. The investigation team should continue its efforts until the team members are satisfied that they fully understand what happened, why it happened, and what steps need to be taken to prevent a similar occurrence in the future.

The information should be compiled into a written document, supported by photographs, diagrams, and supporting data to fully present the facts of the incident. Additional supporting information should be maintained in the investigation files.
Report Presentation

The report should be presented to the fire chief as a completed document. In most cases, the presentation of the document should occur at a meeting with all of the team members present. The team leader should present an overview of the report, including all conclusions and recommendations, using audio-visual aids to illustrate the presentation. The fire chief and other staff members should be prepared to ask questions of the team members.

The report should also be presented to the fire department Health and Safety Committee. In most cases the majority of the investigation team members will be members of the Health and Safety Committee or directly involved with the committee’s functions. The Health and Safety Committee should be involved in the development of the investigation procedure and plan.

The Health and Safety Committee should review the full report, paying particular attention to the recommendations to prevent future occurrences of a similar nature. As a representative body, the Health and Safety Committee adds credibility to the investigative process and to the final report. The committee should be asked to endorse the recommendations of the investigation team. The Health and Safety Committee should have the option to request the fire chief to refer the report back to the investigation team, if the report is considered inaccurate or inadequate or if the recommendations are not feasible. The ultimate responsibility is the fire chief’s.

A special presentation of the report for the members who were involved in the incident should be considered. This should be discussed with the critical incident stress team to determine if there are individuals who would have a difficult time attending such a presentation. In most cases, the presentation and discussion of the report with the members involved will help to bring closure to the situation. The final report should then be released to the department. This may involve printing and distributing a document or a presentation by the team at a training session. Every member of the department should see the final report or a presentation of its major points.

Under most state laws, the release of the completed report makes it a public document, accessible to the news media and any interested party. Supporting documents and evidence that remains in the investigative file may or may not be accessible. If there is a known media interest in the report, copies should be made available to reporters who have requested it. Copies should also be sent to organizations that are involved in fire fighter health and safety, including the United States Fire Administration, National Fire Protection Association, and International Association of Fire Chiefs. Copies should also be sent to other fire
departments that have requested information on the incident and to all individuals and organizations that provided assistance in the investigation. (see Appendix A)

**Restricting Release**

While one of the basic principles contained in the procedure is the value of conducting an open investigation and sharing the results for educational purposes, there will be cases where the possibility of litigation being brought against the department is a major concern. In these cases the attorneys representing the fire department will probably be strongly opposed to releasing any potentially damaging information. Anything that the investigation team finds in its investigation could potentially be used against the department and, under litigation discovery procedures, the department can be forced to release all observations and reports, including all evidence compiled in the investigation. The department may be forced to release information even if it has proven to be inaccurate through the internal investigation. There may be certain privileges or other restrictions regarding release of the report. These privileges may arise from privacy laws and be applicable to the description of the decedent and bar release to any but the decedent’s representatives, or bars release if the report bears upon a criminal investigation, or under certain limited circumstances if the report is produced as a result of a critical self-analyses designed to identify methods of improving operations. Any restrictions on the release of the report should be coordinated with the department’s attorney.

The concern over discovery should never restrain a fire department from taking corrective action to avoid another incident. The courts have generally found that taking action based upon knowledge gained from an adverse incident to prevent a recurrence of an event is not an admission of responsibility for the original event. Conversely, corrective action which was recommended, but not implemented, prior to the incident may be construed to be evidence of negligence and possibly even gross negligence. The decision of when to release final report will have to be determined through discussions between the fire chief and the attorneys.

**News Media**

The news media often generate an atmosphere of tension around an investigation, fueled by the speculation and accusations that may surround an incident. The possibility that an individual may have been negligent or that some inappropriate act may have caused a death makes an excellent news story, particularly when fire department members are willing to be quoted. These same feelings may come to the surface when an investigation is perceived as a “cover-up” or a “witch hunt,” which does not help any situation.

Media inquiries should be directed to the team leader or the department’s Public Information Officer (PIO). While the investigation is in progress, it is appropriate
to provide information on how the investigation is being conducted. No findings should be released until the full report is completed and reviewed. Certain information, such as the medical examiner’s report, will be released as public records at the same time they are available to the investigation team.

When the time comes to release the final report, copies should be made available to the news media through the Public Information Officer (PIO). The PIO may recommend a press conference or for the team leader to be available for interviews, if there is a high level of news interest in the report.

In some cases it will be necessary to interview reporters who covered the incident as witnesses. News photographs and videotape have been valuable in several investigations and most news organizations will provide copies if the department will make an official request with assurance that they will be used only to support the investigation and subsequent training objectives.
Cooperation With Other Agencies

A line-of-duty death will require a high level of cooperation among the fire department investigation team and other agencies and organizations that will be involved in investigating or seeking information on the incident. This may include organizations that have a statutory authority or responsibility to investigate the incident and others that have legitimate reasons to be involved or to be interested in the results. There may also be organizations that are requested to assist the fire department investigation team. The best policy is to be extremely cooperative with other agencies that have a recognized reason to be involved in the investigation.

The investigation team assigned by the fire chief should be the authority having jurisdiction over the internal investigative process. If the incident is a fire, the investigation team should be on the scene before fire department operations are completed and should retain control of the scene as long as is necessary to conduct the investigation. If it is not a fire incident, control of the scene may fall within the jurisdiction of another agency and the investigation team will have to seek their cooperation to complete its on scene research.

If the incident is vehicle accident or a situation where some other agency has primary jurisdiction for the investigation, the team leader will have to establish a close liaison with that agency. Most public agencies will recognize the need for the fire department to conduct an investigation and will work cooperatively with the investigation team.

Fire Cause Investigator
A fire cause investigation may be carried out concurrently with the safety investigation. If there is evidence of arson or other criminal acts, the situation will become much more complicated. The investigation of the safety factors involved in the incident must continue, while a high level of coordination is provided with fire investigation and law enforcement investigators. The fire department should retain custody of the scene until both sets of investigators have completed their examination and gathering of evidence.

The best approach to a situation that involves parallel fire cause and safety investigations is to meet with the law enforcement agencies and establish a cooperative relationship. There is no reason to compromise a fire cause investigation, particularly where there is a possibility that criminal activity is responsible for the death of a firefighter; nor should a criminal investigation stand in the way of the safety analysis. The two activities can sometimes be completed independently, where the area of origin and the area where the death occurred
are physically separate. In other cases the investigations can be mutually supportive.

Where a possible arson investigation is involved, the investigation team may have to carefully control evidence and limit the release of information until the law enforcement authority having jurisdiction is comfortable having it released. In most cases the criminal issues, particularly the specific cause of a fire, will not be critical issues in the safety investigation and the release of a safety report should not compromise a criminal prosecution.

**Medical Examiner**

In most areas the medical examiner or coroner has the responsibility to make the official determination of cause of death and may send an investigator to the scene. The on-scene investigative responsibility is sometimes delegated to the police agency. These investigators are generally not experts at investigating fires or fire deaths and will usually be pleased to work with the fire department team to gather their information.

The remains of the deceased should be turned over to the medical examiner for an autopsy. The Public Safety Officer Benefits Program requires certain tests to be reported by the medical examiner and the list should be provided before the autopsy. The results of the autopsy should be incorporated into the investigation report.

The U.S. Fire Administration published a standard protocol for a firefighter autopsy in 1995. The publication focuses on the specific causal factors that are of concern in a line-of-duty death, particularly relating to toxicity and thermal injuries. It is a good idea to establish a relationship with the medical examiner when developing the investigation procedure, since the pace of events when an incident occurs makes this a poor time to explain the need for a special autopsy.

**OSHA**

The employer is usually required to notify the state agency that is responsible for occupational safety and health, or the Occupational Safety and Health Administration of the federal government, of any line-of-duty death. (This will depend on the relationship between the state agency and the federal Occupational Safety and Health Administration.) In most cases this agency will send an investigator to prepare a report on the incident. The orientation and approach of the investigating agency varies considerably from one state to another.

The role of OSHA is primarily to investigate the employer on behalf of the employee. The investigation is intended to determine if the employer was in violation of occupational safety and health laws in a manner that could have
caused or contributed to the death or injury of the employee. The employer is usually considered to be responsible for any violation, even if the victim’s own negligence caused the accident, because it is presumed to be the employer’s responsibility to ensure the employees comply with all health and safety regulations. The employer may be fined or subject to other penalties if violations are found.

The OSHA investigation may take one of several courses. The OSHA investigator will usually invite the union to participate in any discussion relating to the investigation as the representative of the employee. In many fire departments, the union and the department have a joint commitment to an effective health and safety program and share an equal interest in determining causal factors and corrective actions. Where there has been labor-management conflict, particularly over health and safety issues, an OSHA investigation may become a tense situation for management.

The OSHA investigator may not be extremely familiar with fire department standard operating procedures and may have to rely on fire department members to explain the standard operating procedures and to help interpret the regulations that apply. The best policy is usually to be open and cooperative, to demonstrate to the investigator that the department is not trying to conceal anything and is dedicated to a full and open investigation. In many cases, an open invitation to participate and to share in the conclusions of an investigation has created a positive relationship with OSHA investigators.

An OSHA investigator may insist on conducting a completely independent investigation or may refuse to work with management investigators. In some cases the investigator may appear to be committed to finding fault with the department for violations ranging from minor to major. This can create a very difficult situation for the investigation team and requires sound legal advice. This should not deter the fire department from conducting its own thorough and honest investigation and from being willing to share the results with other investigating agencies, although the city attorney may insist on reviewing any report before it is released.

Unfortunately, in some cases, the OSHA report has cited the fire department for violations that were insignificant or imagined because of investigators who were unfamiliar with fire department operations and applicable standards. In other cases major violations have been overlooked. These situations are often difficult to avoid and even more difficult to correct, particularly when the reports are released to the public.
Insurance Carrier
Many cities and fire departments are insured by private insurance carriers, while others are self-insured and have their own loss management offices. The insurer’s organization may be able to assist the team in obtaining expert assistance in particular areas or in conducting some forms of research to support the investigation. The insurer may also have training materials, guides, forms, and other materials that can assist the team in conducting or preparing to conduct an investigation.

In the case of a line-of-duty death the insurance carrier and/or the city’s loss management department will almost definitely want to be kept informed on the progress of the investigation. The insurer may send its own investigation team, particularly where there will be a claim to be paid. The investigator who represents the department’s insurance carrier should be supportive of a good internal investigation and should be looked upon as an asset to the investigation team. The extent of the insurer’s direct involvement will depend on their relationship with the fire department and their expertise in the type of situation under which the incident occurs.

USFA
The United States Fire Administration (USFA) and the National Fire Academy (NFA) are both very concerned with fire service health and safety issues. The USFA has requested to be notified immediately of any line-of-duty death and to be sent a copy of all investigation reports. The USFA also serves as a point of contact for the Public Safety Officers’ Benefits Program.

The USFA contracts with a private sector investigative organization to prepare reports on incident of national interest and significance; this includes most incidents of multiple firefighter deaths and could include single fatalities in unusual circumstances. USFA does not have any investigative authority and the primary objective is to report and disseminate information that would be of interest to the fire service and other agencies, as well as supporting the USFA’s health and safety projects. The report is for informational purposes only and is always submitted to the local jurisdiction for review and approval before it is released. In some cases USFA will request copies of the fire department’s investigative reports or send a contractor to gather information from the local jurisdiction’s investigation team.

If requested by the fire department, USFA has the ability to dispatch a contracted investigator to assist or advise the local jurisdiction in conducting the investigation, in some cases within hours of the occurrence. Most of the USFA contracted investigators are well qualified to assist the investigation team and are probably involved in more line-of-duty death investigations than any other
investigators. The request should be made directly to the USFA by calling 301-447-1000.

**NFPA**

The National Fire Protection Association (NFPA) has a continuing interest in firefighter health and safety, particularly as it relates to the development of NFPA standards. For many years NFPA has sent investigators to prepare reports on major incidents and often to assist local investigators. The NFPA investigation reports are primarily informational and often describe the relationship between NFPA standards and the incident. They are carefully limited to a factual discussion of the incident and are often published in NFPA periodicals and presented at NFPA meetings.

NFPA has no investigative or enforcement powers and participates in investigations only at the invitation or with the approval of the authority having jurisdiction. If requested by the local jurisdiction, NFPA is usually willing to send an investigator to assist the fire department investigation team. NFPA also has a staff of specialists in several different areas of fire protection who are available for consultation on unusual cases.

**Other Investigators**

It is not unusual for a line-of-duty death to become the focus of multiple official and unofficial investigations in addition to those mentioned above. One of the characteristics of our current society is intense interest in establishing fault or blame for an incident. This may extend as far as accusations of criminally negligent acts and demands for criminal prosecution of individuals who are considered to be responsible for a line-of-duty death. While such charges are very rarely filed against fire department or against individual officers or members, the accusations have caused many difficult situations.

In some cases law enforcement agencies and prosecutors have launched their own investigations into incidents, adding unwanted pressure and complexity to an already tense situation. When these situations occur, the best policy for the fire department is to continue conducting its own investigation and to offer to share its findings with other investigators. Whether or not to invite the other agencies to participate along with the fire department’s internal investigation team will depend on several factors, including jurisdiction and the relationship between the organizations. The accusers may attempt to discredit the internal investigation and use their legal authority to conduct their own investigation. At these times it is important to have good legal advise and a well established plan of conducting a thorough and honest internal investigation.
PSOB
The Public Safety Officer’s Benefits Act (Public Law 94-430) is intended to pay a sum in excess of $151,635 (as of fiscal year 2000) to the survivors of any fire fighter who dies or is permanently disabled in the line of duty. A claim must be made to the Department of Justice, either by the survivors or by the involved fire department on their behalf. The responsibility rests with the claimants to submit a claim, so that determination of eligibility can be made. The PSOB staff should be contacted at 202-307-0635 or 1-888-744-6513 as soon as possible after a death occurs to ensure that the proper documentation is assembled and submitted.
Appendix A

IAFC
The International Association of Fire Chiefs does not have a specific role in the investigation of line-of-duty deaths, but is dedicated to assisting its members in any situation where the resources of IAFC could contribute to the investigation or to making the results of an investigation known to the fire service. It is with this purpose in mind that this guide was produced. When an investigation yields information that should be known to all fire service members to prevent future tragedies, the IAFC Health and Safety Committee will assist in that mission. In some situations IAFC has assisted fire departments in locating individuals with the needed expertise to assist in an investigation.

IAFF
The International Association of Fire Fighters is extremely active in occupational health and safety and often becomes involved in investigations that involve the death or serious injury of career firefighters. This has included encouraging state and federal agencies to investigate incidents and engaging independent experts to investigate some situations.

The IAFF Health and Safety Office has resources that can be extremely helpful in situations involving the performance of protective clothing, breathing apparatus and other safety devices. These resources are usually accessible through the union local. A shared labor-management commitment to a health and safety program should support the fire department’s investigation process, as well as providing access to IAFF assistance when it is needed.

However, it is difficult to predict the approach that IAFF will take to any particular incident. Where there is an effective ongoing safety program that involves labor and management, the IAFF will usually be supportive of a well managed internal investigation. Where there is labor-management conflict over health and safety issues, the investigation process may be used as an opportunity to escalate existing labor-management disputes.

NIOSH
The National Institute for Occupational Safety and Health (NIOSH) is an agency of the federal Department of Health and Human Services that is primarily directed toward the development of research data to support the Occupational Safety and Health Administration (OSHA). In this role NIOSH may request permission from the fire department to investigate incidents that involve topics of particular concern or interest, such as confined space incidents and heat stress deaths.
NIOSH is also the agency that tests and certifies respiratory protective equipment and is very interested in situations where breathing apparatus may be a factor in a fatality. Any time that breathing apparatus performance is suspected as a problem in a line-of-duty death, the fire department should contact NIOSH and request to have the apparatus examined.

NIOSH has no investigative authority or regulatory powers and is not intended to find fault or assign responsibility, other than gather information and finding facts to support research and future rulemaking. NIOSH has excellent resources and is usually extremely cooperative in assisting the local jurisdiction with an investigation, particularly if it fits the agenda of current research topics. It will identify lessons and examples and it may indicate actions that could or should have been taken to prevent the incident. In this manner it is very much a parallel to the fire department’s internal investigation.

**DOT**

The U.S. Department of Transportation is primarily interested in two types of incidents where line-of-duty deaths may occur. The investigation of vehicle accidents, particularly where there is a suggestion that vehicle design or maintenance defects may be responsible, is one area where DOT assistance may be extremely helpful. DOT is also very interested in hazardous materials transportation incidents. Department of Transportation assistance may be requested through the U.S. Fire Administration when a local jurisdiction feels that it would benefit from their assistance. In some cases the DOT investigators will arrive under their own investigative authority and ask to participate in an investigation. DOT has the authority to conduct an investigation, in cooperation with local authorities or independently; their cooperation will usually strengthen the resources of a fire department’s investigation team.

**NTSB**

The National Transportation Safety Board (NTSB) is primarily involved in the investigation of accidents involving interstate public transportation carriers. The investigation of accidents involving fire apparatus with public carriers has caused NTSB to take an interest in fire apparatus vehicle design and maintenance, as well as driver training. NTSB is also involved in the investigation of most aircraft incidents. This agency may be contacted and requested to assist in the investigation of a major accident, although in most cases NTSB investigators will respond on their own to incidents that fall within the scope of their investigative authority.
Appendix B

Product Liability
The worker’s compensation plans in most states provide the compensation program as an employee’s only remedy for occupational injury or death. This means that the employee or the employee’s survivors cannot sue the employer for liability, unless the right to compensation benefits is waived or gross negligence can be proven. In most cases this is an effective shield for the fire department against law suits, but it opens a Pandora’s box when equipment failure is suspected of contributing to a serious injury or death. In several cases the survivors have sued the manufacturers of personal protective clothing and safety equipment, apparatus manufacturers, and other parties for damages, usually on the basis of faulty design or failure to meet standards.

This concern makes it extremely important to isolate and impound all such equipment and to maintain custody of it. The manufacturer should be invited to examine the items in the presence of a member of the investigation team, but the items should generally not be removed or released to anyone. The manufacturer’s comments should be requested for the report. If the equipment is to be tested in a laboratory, an independent lab should be used and the chain-of-custody back to the fire department should be maintained.

Post traumatic incident stress
Post traumatic incident stress has been recognized and documented as a significant factor in the fire service. A line-of-duty death is one of the most stressful situations that can occur. All members involved in the incident should go through a critical incident debriefing process and, if necessary, should receive additional support and treatment.

It is important not to overlook the investigation team in dealing with post traumatic stress. The pressures on the team members are as significant as those on the personnel who were involved in the incident and often must be prolonged for several days or weeks. In addition to their own stress, the team members are directly exposed to the feelings and reactions of everyone else who may have been affected by the incident.

It is generally inappropriate to have the investigation team members participate with the other personnel in group processes, since their presence may inhibit others from exposing their inner feelings. The investigators may be seen as an intrusion into the stress management process and may be subject to hostility from some of the participants. It is preferable to provide a separate stress management process for the investigation team, as a group, at regular intervals.
in their work on the case. The critical incident team should assign a liaison to work with the investigation team and arrange for the investigators to receive full support for their stress, both during and after the investigation.

For more information on critical incident stress teams, contact the American Critical Incident Stress Foundation, P.O. Box 204, Ellicott City, MD 21401. The foundation’s hotline is 410-313-2473.

**Recordkeeping**
Detailed notes on all aspects of an investigation form the foundation for a thorough report. A *Witness Control Sheet* containing case number, date, time, name of person interviewed, locations, and remarks (or additional information as needed according to local preferences) should be maintained for all interviews.

**Resource List**
United States Fire Administration
Emmitsburg, MD 21727
301-447-1272
301-447-1000 (after hours)

Critical Incident Stress Debriefing Hotline
P.O. Box 204
Ellicott City, MD 21401
410-313-2473

For further information contact:
International Association of Fire Chiefs
4025 Fair Ridge Drive
Fairfax, VA 22033-2868
703-273-0911
Fax 703-273-9363