CITY OF YUMA

Fire Department
Guidelines

Subject: INVESTIGATION OF LINE-OF-DUTY DEATH	Effective Date: Mar 20, 2000 - N	DG.# 210.01
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INTRODUCTION

Investigation of a line-of-duty death 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. A "close call" shall be interpreted as a warning and treated as an actual event.

It is important to discover, identify, research, and fully document every causal factor or potential causal factor. The investigation shall present the facts of what happened, identify causal factors, and recommend appropriate corrective actions. Restraint is key. Speculation fuels the rumor mill and can taint the investigation.

The results shall be in the form of a printed report, photographs, illustrations, diagrams, and video tape. The City of Yuma Fire Department will work in concert with outside agencies that will assist in the investigation.

DEFINITIONS

Line of Duty Death:	The death of an active duty officer by felonious or accidental means during the course of performing fire department functions while on duty.
Survivors:	Immediate family members of the deceased officer to include spouse, children, parents, siblings, fiancée and/or significant others.
Liaison Officer:	The officer that serves as the bridge between the agency and the family and will essentially reflect, through his attitudes and deeds, the level of concern of the agency.
Traumatic Injuries:	A wound or other condition of the body, caused by EXTERNAL FORCE, including injuries inflicted by bullets, explosives, sharps, blunt objects, or other PHYSICAL BLOWS, chemicals, electricity, climatic conditions, infectious diseases, radiation, and bacteria, BUT EXCLUDING STRESS AND STRAIN.

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OBJECTIVES

1) The most important objective of any line-of-duty death is to prevent the same situation from occurring again, including;
    *Identifying inadequacies involving apparatus, equipment, protective clothing, standard operating procedures, supervision, training, or performance.
    *Identifying situations that involve unacceptable risk
    *Identifying previously unknown or unanticipated hazards
    *Identifying actions that must be taken to address problems or situations that are discovered.

2) Ensure lessons learned from the investigation are effectively communicated to prevent future occurrences of a similar nature.

3) To satisfy the requirement of the Public Safety Officer Benefits (PSOB) Program and other entitlements.

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

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 or near fatal incident. Conversely, there may also be a desire to absolve an individual of responsibility or to protect the reputation of the Yuma 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.

A report based on factual information will stand on its own merit. Facts, conclusions, and recommendations shall be well supported. Accusations of negligent acts and determinations of personal responsibility of 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 will be 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.

A further complication may arise from any suggestions of criminal responsibility for the incident.

THE INVESTIGATION TEAM

In the event of a line-of-duty death, the Incident Commander shall, upon realizing or being notified, inform the Fire Chief who in turn shall assemble an investigative team. If the Fire Chief is unavailable, the next succeeding officer shall be notified. The Incident Commanders shall make every attempt to maintain the integrity and security of the incident scene. The Incident Commander shall make every effort to assist the team in any manner necessary.

The Investigation Team shall be comprised of one member from the following agencies:

Any two member departments from Yuma County Fire Officers Association
Yuma Fire Department appointed by the Fire Chief
Yuma Police Department appointed by the Police Chief
Investigator from Risk Management
Investigator from NIOSH (if breathing apparatus or protective equipment involved) Contact Chris Reh @ 513-841-4374
Investigator from DOT (if fatality involves apparatus accident) Contact: Ralph Craven (DOT) 702-425-4300
Investigator from OSHA – 602-542-5795

The Investigative Team shall establish, through consensus, who shall be the Team Leader. It is **IMPERATIVE** that all members remember the ultimate objective, to find the cause of the accident and how it can be prevented from happening again. Egos and friendships must become secondary.

IMMEDIATE ACTIONS

Immediately following any serious line-of-duty injury or death, the Incident Commander shall:

1. Notify the survivors, *before any information is let to the media.* This shall be done by the most senior officer available, and in person. Time, place, and date of notification shall be documented.

Notifiers should be alert to the emotional condition of the survivors and provide necessary support. Avoid exploring the survivor's feelings. Suggested communication is as follows:

NOTIFYING THE FAMILY

At the door: Identify yourself and ask to come in.

Inside: Make sure you are talking to the right person.

Begin With: "I have very bad news" or Very sorry to tell you...."

DO NOT SAY

"I know how you feel"

"It was God's will."

"Life will go on." "

"You're lucky. You had so many years together."

"You're young. You'll find Someone else.

"He would have wanted to go this way."

"Be brave. You're a firefighter's family."

Be Clear and Direct:

"Your husband died responding to a fire" or "Bob was killed in a building collapse."

Allow the family to express their emotions. Try to answer their questions.
Say "I don't know" if you don't.

2. Isolate and secure the scene, allowing no one to enter but those with a justified reason. The Incident Commander shall notify the Police Department as necessary for security. If personnel remains are present, the scene should be left undisturbed until all physical evidence has been documented, photographed, and measured.

3. All items that could have a bearing on the investigation shall be impounded and turned over to the investigation team. In fatality cases, protective clothing and SCBA is extremely important. All items shall be handled as if it were a criminal investigation.

4. Document the condition of the safety equipment. Anyone finding or moving a victim shall pay particular attention to the following:

BREATHING APPARATUS
Was victim wearing SCBA?
Was the face piece in place?
Was there pressure remaining in the cylinder?
What was the position of the valves?
Were the straps in the normal use configuration?
Note damage to SCBA apparatus

Were any components missing? And where were they found?
Date of last test?

PERSONAL ALERT SAFETY SYSTEM (PASS DEVICE)
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 other communication equipment with him/her?
Where was the portable radio found?
Was it in operating condition?

PROTECTIVE CLOTHING
Was the victim wearing full protective clothing?
Note and document damage to the protective clothing.
Had the victim removed any items of protective clothing?
Where was it found?

4. The scene shall be photographed and diagramed in the same manner a crime scene would be documented. Large color prints would be considered primary documentation. Video may also be utilized to augment the still photography.

5. To meet the requirements of the Public Safety Officer Benefits Program, steps must be taken to insure that cause of death is accurately reported. Any autopsy should be requested where cause of death is **not** clearly a traumatic injury. **In all cases, a toxicological examination with a test for specific levels of carbon monoxide (CO) in the blood expressed in an exact percent should always be requested.** The toxicology test is crucial in the event of a collapse of a member at or following an incident without a physical injury present. (This test may not be performed if the member has been hospitalized for more than a few days under heavy sedation, as it will be inconclusive). PSOB regulations state that CO levels of 10% or higher, 15% for smokers, will be considered a traumatic injury that is a substantial factor in a heart attack. Request an alcohol level test be conducted, as well.

6. Identify witnesses for the investigation team to follow-up with, including names, addresses, phone numbers, their role in being on location, and their relation to the victim.

7. The chief officer in charge of the scene shall activate the Critical Incident Stress Debriefing Team. The request shall be directed to the proper authorities.

SECOND STAGE ACTIONS

Completing the immediate actions may require several hours. The second stage of actions will usually begin several hours later, after the investigation team has assembled. The following list of actions shall be the general course of action taken during the secondary investigation stage.

1. The Investigation Team shall conduct interviews with every fire department member involved in the event. All interviews shall be recorded and all personnel being interviewed shall be advised of such, including

obtaining written consent.

2. Any statements made to the news media shall be investigated aggressively to determine the source and to clarify issues early. The Investigation Team shall obtain and review reports of all news broadcasts and other accounts of the incident.

3. The Investigative Team shall obtain recordings of all telephone and radio traffic pertaining to the incident.

4. The Investigative Team shall attempt to establish and ultimately be able to fully describe:

   a. Who did what, and who saw what
   b. At what location, and at what time

5. The Investigative Team shall examine physical evidence, including protective clothing and equipment. Qualified personnel shall be consulted to assure proper evaluation of each piece of equipment. The Investigative Team, as well as all personnel involved in the security and collection of the physical evidence shall ensure a "chain of custody."

6. The Investigative Team shall review SOP's, training materials, maintenance records, reports from similar incidents, and other documentation to evaluate:

   a. How the situation "should" have been handled
   b. Whether or not it was handled as "expected"
   c. Whether or not this would have had an impact on the outcome

7. Expert assistance shall be utilized whenever necessary, such as, apparatus failures, particularly aerial devices, where mechanical engineers and/or a metallurgist would have superior knowledge as to limitations. Manufacturers will have a vested interest in finding the cause. Therefore, independent expert advisors shall be used. Contact Ralph Craven (DOT) 702-425-4300.

8. Legal issues will involve nearly all aspects of a line-of-duty death. Issues of potential liability, and violations of occupational health and safety laws will be a consideration in almost every case. These factors shall not be allowed to restrict the investigation.

9. Every "component" of the incident shall be followed to the root cause. For instance, the evidence may suggest that an individual was not properly trained to handle a particular situation. This shall be investigated to determine if the individual had been trained, was trained correctly, or had taken actions that were inconsistent with training that had been provided.

AGENCIES TO NOTIFY

a. Police Department for possible criminal activity
b. Workers Compensation Board, through the City's Risk Management Department
c. Public Safety Officers Benefit Program @ 202-724-7620 or 202-307-0635
d. Supplemental Insurance companies
e. US Fire Administration and the National Fire Academy @ 301-447-1272 and 310-447-1123
f. NIOSH (if breathing apparatus or protective equipment involved) Contact: Chris Reh @ 513-841-4374
g. DOT (if fatality involves apparatus accident) Contact: Ralph Craven (DOT) 702-425-4300

LIAISON OFFICER

Typically, the notifying officer shall continue as Liaison Officer. If this is not possible, a Liaison Officer shall be appointed. Above anything, all arrangements shall be in support of the family. The duties include:

Provide guidance to the survivors.
Travel and lodging for out of town family.
Determine church preference, in any, remembering the numbers of people that may be involved.
Assist with funeral arrangements, if asked (Refer to Yuma County Fire Chiefs Funeral Policy).
Coordinate with Funeral Directors or Department Chaplain.
Request outside agencies to notify of intentions to attend funeral so as to allow for preparation.
Record all agencies attending services.
Arrange with the personnel department for the filing requirements of the Public Safety Officer Benefits (PSOB).

THE REPORT

The Investigation Team shall present its findings to the Fire Chief as a completed document. Optimally, the entire Investigative Team should be present. The presentation shall include all video, photographs, tapes, and written documentation.

Risk Management, along with the members of Staff shall review the report. Risk Management and Staff shall pay particular attention to the recommendations to prevent future occurrences. Risk Management and Staff shall have the option to request the Fire Chief refer the report back to the investigation team if the report is considered inaccurate or inadequate. The ultimate responsibility for accountability and completeness rests with the Fire Chief. All parties should consider endorsement of the document.

The report shall then be presented to the members involved directly with the incident. Afterward, the report shall be distributed and reviewed with the entire department in hopes of preventing a recurrence.

Copies shall also be made available to the NFPA, USFA, IAFC, IAFF, and other departments or agencies that could help serve fire departments to prevent recurrence.

NEWS MEDIA

The news media can generate an atmosphere of tension surrounding an investigation, fueled by speculation and accusations. Media inquiries shall be referred, without exception, to the department's Public Information Officer or the Fire Chief. While the investigation is in progress, no findings shall be released, only that the investigation is ongoing. Certain documents, such as the Medical Examiner's report shall be released as public record at the same time they are available to the Investigation Team.

When the final report is released, copies shall be distributed to the media. If the case is a high profile case, new conferences may be set up.