

CLOSE CALL REPORTS

Let's talk about near-miss reporting and the three types of investigations conducted by the Safety Section of the Safety and Personnel Services Division. The "Safety Section" refers to the Battalion Chief in-charge of the section, the three shift safety officers, and the pool of "relief" safety officers which consist of field personnel or personnel in other sections of the department used for back-fill of the shift safety officers and special projects. There are three types of investigations conducted by the Safety Section. They are (in order from least to most severe):

- CLOSE CALL/HAZARD: This report is for situations in which a firefighter (meaning all ranks, career and volunteer) came close to getting seriously injured or killed. However, there was no injury at all.
- CLOSE CALL/INJURY: This report is for situations in which a firefighter came close to getting seriously injured or killed, and did sustain a non-life threatening injury.
- SIGNIFICANT INJURY INVESTIGATION: This report is for situations in which a firefighter sustained a serious life threatening injury or has been killed (or died) in the line of duty. The widely recognized acronym for this report is "SIIT" which stands for, "Significant Injury Investigation Team."

The two Close Call Reports (Hazard and Injury) are handled in the same manner with the only real difference being whether one or some of our members were injured or not. For the purposes of this article, we will group those together for ease of understanding.

The Close Call and SIIT reports are based on investigations of job-related duties and hazards associated with the occupation of firefighting and Emergency Medical Services (EMS). These may occur on the incident scene, during training, and during response or returning from a response. These reports do not include routine duties unrelated to the occupation. An example of an unrelated duty would be a firefighter that receives a serious hand injury while cutting potatoes in preparation for dinner. Those situations are captured as part of normal injury reporting and documented on a smaller scale.

"The primary purpose of the investigation reports is to prevent any future injury or death to department members." It is advocated that the reports are used to correct system problems, policies, procedures, best practices, and change individual behavior with the objective of "weaving the fabric of safety into the organization."

The decision to conduct a formal investigation of an injury rests with the Staff Duty Officer. The Staff Duty Officer may consult with other senior chief officers and/or the Fire Chief prior to making the decision (Close Call or SIIT). Once the decision is made, the officer-in-charge of the Safety Section (usually the Battalion Chief) is notified and the

investigation is begun. Sometimes an investigation starts out as a SIIT, but is quickly reduced to a Close Call because the injury(s) is determined to be non-life threatening.

A request to have the Safety Section conduct an investigation of a Close Call in which there is **no injury** may come from a Deputy Chief or above, the Safety Battalion Chief or a Safety Officer. It can come from witnessing or being involved in a significant event in which no one gets hurt. An example may be the partial collapse of a structure in the area where firefighters were working or a vehicle running into an accident scene almost striking a member. The request must be approved by the Deputy Chief of the Safety and Personnel Services Division before the investigation is begun.

Here is a breakdown of the mechanics of how an investigation is conducted and a subsequent report produced.

CLOSE CALL *HAZARD or INJURY*:

Notification is made to the Safety Section to conduct the investigation. The officer-in-charge of the Safety Section becomes the Investigation Team Leader and assembles the members of the investigation team.

The preferred method of investigation is to assemble the team at one location for a planning meeting. The purpose of the assembly is to go over known facts, conjecture, and information. A list of questions, needed evidence, and witnesses are compiled. The team members are given their specific assignments and then go to work conducting interviews, gathering evidence, and gathering other pertinent information.

An alternative method may be necessary due to the circumstances. This alternative method involves the Team Leader reviewing the facts, conjecture and information, and making assignments to team members over the phone or other means. The Team Members then go directly to their assignments (the scene, fire station, etc.) without a planning meeting.

In either case, completion of the assignments may only take several hours or may take several days or even weeks. While the assignments are being carried out, the Team Leader is kept constantly informed of developing facts, issues, and information. The Team Leader and members may identify further witnesses to be interviewed or facts to be gathered.

Once it appears that all the assignments have been completed, the team is assembled to begin putting the pieces of the puzzle together and come up with a comprehensive report on exactly what happened. Sometimes it becomes apparent that more people need to be interviewed or more information needs to be gathered. Again, once that is complete, a draft report begins to take shape. The meat of the report is broken down into findings, discussion of the findings, and the recommendations to prevent the incident from re-occurring.

If it appears that there were violations of policy, procedure, or best practices, a meeting is scheduled between the Investigation Team Leader and the Division or Operational Deputy Chief, whichever is appropriate. The facts and alleged violations are presented to the Deputy Chief for disposition. The disposition may involve discipline of an individual or revision of the policy, procedure, or best practice. For the record, the Investigation Team Leader (a member of the Safety Section) does not recommend, advocate, or participate in any dispositions involving discipline. The decision for discipline rests solely with the Deputy Chief and his or her chain-of-command and is not a discussion that takes place with the Investigation Team Leader.

Once the draft report of the investigation is complete, the report is reviewed by the Fire Chief and each Assistant Fire Chief which is referred to as an “executive review.” At the completion of the executive review, the report is prepared for posting on the department’s Intranet. To see what the close call reports look like, go to the intranet home page, click on “Documents,” and then click on “Close Call Reports.”

SIGNIFICANT INJURY INVESTIGATION:

Notification is made to the Safety Section to conduct the investigation. The officer-in-charge of the Safety Section becomes the Investigation Team Leader and assembles the members of the investigation team. Specialties outside of the Safety Section may be requested based on the situation (Haz Mat, Technical Rescue, Accident Re-construction, etc.). If at all possible, the investigation team is immediately detailed out of their normal work assignment and work hours are based on the needs and direction of the investigation and then day work until the report is complete. A member of Senior Staff is assigned as the Investigation Coordinator and is responsible for keeping key members of Senior Staff informed of the status of the investigation. The Investigation Team Leader gives regular briefings to the Investigation Coordinator.

As mentioned earlier, this type of investigation involves life-threatening injury or death to one of our members. This may require certain entities to take legal priority over the SIIT investigation. These may include, but are not limited, to the Fire Investigations Branch of the Fire Prevention Division, law enforcement (County Police, Alcohol Tobacco and Firearms (ATF), State Police, etc.), the National Institute for Occupational Safety and Health (NIOSH), and the Virginia Occupational Safety and Health Administration (VOSHA). If other entities are required to be involved, the SIIT will act in a support role and provide resources as requested.

If there is no legal requirement for “outside” (outside the Safety Section) entities to be involved in the investigation, the Safety Section is the primary entity. The investigation takes place in a similar manner as a close call except the team is deployed immediately due to the severity of the situation. This may require units to be placed out-of-service for interviews. It may require personnel to be held on overtime to complete the interviews. It may also require certain personnel to be detailed out of their normal assignments or placed on administrative leave for several days in order for the team to have full access to them for the purposes of the investigation. It may require the scene to be secured until

evidence can be processed. Evidence collection becomes formal and bound by a “chain-of-custody.” The Evidence Technician from the Fire Investigations Branch may be requested for evidence processing and handling.

Once all of the evidence and interviews are complete, the entire team assembles to put together a timeline and chain of events. Much like the close call investigations, the focus of the report is broken down into “Findings, Discussion, and Recommendations.” The primary purpose of the report is to prevent the incident or circumstances relating to the injury or death from ever happening again. A secondary purpose is to document what happened and maintain the report and associated evidence for 30 years post-retirement.

Once a draft of the report is complete, it is submitted for executive review. Once the executive review is complete, the report is prepared for public posting on the intranet.

After the final report has been posted, the Fire Chief appoints a “Recommendation Implementation Committee.” The ad hoc committee is made up of various ranks and sections of the department that have the charge of making the recommendations happen. The selection of the committee is based on the recommendations. For example, a finding of a problem with radios and a recommendation to fix that problem would have a member of the Communications Section assigned to the committee. This may vary and include policy changes, equipment changes, and procedural changes. Once the recommendations of the report are implemented, a final disposition report is produced by the committee to be included with the SIIT report and the committee is disbanded.

NEAR-MISS REPORTING:

The last thing to talk about is “Near-Miss” reporting. A “Near-Miss” is very similar to the definitions for investigations given the above, except that the report is completed anonymously by an individual. A near-miss event is defined as an unintentional unsafe occurrence that could have resulted in an injury, fatality, or property damage. Only a fortunate break in the chain of events prevented an injury, fatality, or damage. Situations that qualify as near misses are essentially in the eyes of the reporter. If you are involved in or witness an event you believe is a near miss, then you are encouraged to submit a report. Go to www.firefighternearmiss.com to learn more.

The National Fire Fighter Near-Miss Reporting System is a voluntary, confidential, non-punitive and secure reporting system with the goal of improving firefighter safety. By collecting and analyzing information on near-miss events, improvements can be made in command, education, operations and training. Firefighters can use submitted reports as educational tools. Analyzed data will be used to identify trends which can assist in formulating strategies to reduce firefighter injuries and fatalities. Depending on the urgency, information will be presented to the fire service community via program reports, press releases, and email alerts. The email alerts are received by the Battalion Chief of the Safety Section and sent to the “FIRE” distribution list in Outlook. You may also subscribe to the email alerts on the website.

Reporting your event to the national system can help prevent injuries and save the lives of other firefighters. Firefighter fatalities and injuries have been occurring at a near steady rate for the last 15 years, despite improvements in PPE, equipment, apparatus, and a decrease in structure fires. Near-miss reporting systems in other industries, especially aviation, credit near-miss reporting with saving lives. Since near-miss reporting has worked so effectively in other industries, the natural conclusion is that it will have similar results for the fire service. The Safety Section encourages the members to use the Near-Miss reporting system.

If you have any questions about any of the information above, please feel free to contact me at Daniel.gray@fairfaxcounty.gov .