

The "attitude" of safety within Stafford County Fire and Rescue requires immediate attention. The incident involving the rotary saw was a very serious event that had potential for fatal results. The responsibility of the incident is shared by the saw operator and the firefighter, who was struck. Of further concern, is the manner in which the incident was addressed by the officers, where the focus seemed to be more on squelching the event rather than addressing the inappropriate behavior. Training on safe-scene operations very well may have been offered, but certainly was not demonstrated at this incident. Universally, there does not appear to be a culture of safety within the organization. This is documented by seat-belt usage, personal protective equipment issues, lack of understanding of rapid intervention teams as well as "Two-In, Two-Out" requirements, ladder placement, poor communications, and failure to adhere to procedures. In the case where the second engine did not supply the first engine with water, the results could have been catastrophic. Had there been more fire involvement, the structure probably would have been lost, by the firefighter's own admission. The action of the engine operator was not malicious in the opinion of the review team. His primary focus was to supply his own line rather than supply the first engine, as directed by procedure. This ignorance could very well have placed the firefighters on the interior of the structure in serious jeopardy. A comprehensive safety initiative should be the immediate priority of the department. Again, we do not question the past efforts of the county, but note the current attitude based on what was learned through this review. There should be a zero tolerance policy in place for any member of the organization who does not adhere to safe work practices. If this does not occur, it is not a matter of if another event is going to occur, but when.

The communication systems of Stafford County Fire and Rescue may require attention. The radio system itself does not appear to provide adequate countywide coverage to ensure an effective and safe operation. Critical, potentially life-threatening radio traffic could be missed with the current coverage. There are limited procedural processes in place that govern how operational situations should be addressed. These issues contribute to "work-around" solutions, confusion and freelancing. The review team recommends that an evaluation of the current radio system be conducted and that communication procedures be established.

END OF REPORT