

Special Report

For

**Prince William County, Virginia
Department of Fire & Rescue**

Kevin J. McGee, Fire & Rescue Chief

By

National Fallen Firefighters Foundation

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**Line-of-Duty Death Procedures
Review and Recommendations**



Program Objective

To determine if there are viable options or improvements to current Line-of-Duty Death (LODD) procedures in place in the Prince William County Department of Fire & Rescue and whether those same options can be incorporated into the National Fallen Firefighters Foundation (NFFF) policies and/or procedures for sharing with all fire/rescue departments.

Methodology

Per meetings between Chief Kevin McGee and NFFF Executive Director, Chief Ron Siarnicki, it was determined that several members of the Prince William County Department of Fire & Rescue were interested in sharing their opinions regarding LODD procedures, which were employed the day of and in the months following the April 16, 2007, Marsh Overlook fire which claimed the life of Technician I Kyle Wilson. These members had specifically expressed interest in sharing their feelings with a person or group independent of Prince William County.

It was agreed that a cross-section of personnel who were directly involved in or who were impacted to different degrees by the events occurring on and after April 16, 2007, would be a tremendous source in identifying the strengths and weaknesses of LODD procedures in effect at that time.

Action

Representing NFFF were John Proels and Dan Jarboe, both retired chief officers with over 25 years active fire/rescue service. John is our primary coordinator of the Local Assistance State Team (L.A.S.T) program, and Dan is a part-time consultant with many years of investigative experience. Both have direct involvement with the Public Safety Officers Benefit (PSOB) Program.

Interviews were scheduled over a five-day period between June 23 and July 1, 2008, taking place in the Manassas office of Health and Safety Battalion Chief Tim Keen.

In all, twenty-one personnel were interviewed, ranging from Technician I through Assistant Chief. Most personnel were provided with a series of questions in advance of the meetings to give them an opportunity to offer recommendations.

Questions were limited to those involving LODD procedures and employee assistance as they were employed or not during and after the Marsh Overlook incident. Operational issues were not included as part of this review.

Focus of Questions

Questions were focused on the following general areas:

1. The notification process for both the victim's family and departmental personnel.
2. The role of line-officers at the station, battalion and command level in providing for the mental health of personnel under their respective commands.
3. Whether existing written policies and procedures are in need of revision or if there is a need for new ones with respect to Line-of-duty Deaths or serious injury.
4. Whether sufficient support for the well-being of personnel at various levels was in place on the scene at Marsh Overlook and at significant times following the immediate incident to include the hours immediately following the incident, time leading up to the funeral, times leading up to the anniversary, during holiday periods and at the time of the release of the investigative report.
5. Whether support was provided to or was at least available for family members of personnel who were impacted in different ways by the Marsh Overlook incident and whether such support is routinely available.
6. Those personnel who had a direct role in the Emergency Operations Center (EOC) were also asked their opinions of the NFFF L.A.S.T. team and whether they were a valuable resource to Prince William County commanders.

Findings

1. Notification Process (Family)

There was a general agreement that family notification in the Marsh Overlook incident did not go according to policy and procedure. Most personnel seemed unaware of specifics regarding how Mrs. Wilson was actually first contacted, or by whom. Mrs. Wilson worked in the emergency room of a local hospital, which receives many of their patients from Prince William County Department of Fire and Rescue ambulances.

It was agreed by most that there were extenuating circumstances in this case which made it more difficult to assemble desired information and personnel to make the notification before other sources.

It was also recognized that in the electronic age in which we live, information flows much more rapidly than even the usual speedy fire department grapevine of yesteryear!

At present, all personnel are able to personally designate individuals who should accompany department officials to make family notifications in the event of their serious injury or death. This is accomplished by completion of and annual updating “Personal Information Forms.” These forms are kept under lock and key in the Office of Personnel.

Since the Office of Personnel is not staffed on nights or weekends, it is necessary for an official to respond there to retrieve the emergency notification form and relay the information to Command officials. This was the case in the Marsh Overlook incident. Although it was done in relatively quick fashion, and the pertinent information was relayed to the Chief of Department at the scene via fax, valuable time was still being used in an effort to satisfy the deceased firefighter’s wishes before proceeding to notify his parents.

Virtually all personnel interviewed wish to maintain the policy of allowing them to select emergency notification designees. At the same time, nearly all feel that it is equally important for the department to have a predetermined, specially trained officer or team ready to move quickly in such situations.

NOTIFICATIONS (Departmental Personnel):

Personnel who were not directly involved in the incident seem to have learned of Marsh Overlook events by various means.

Personnel advise that there is a “voice mail” system available to all members of the department, but some admitted to rarely checking their respective messages.

Some recalled a message being transmitted by vocal to all stations, but none of the members were really sure.

- 2. Roll of the Station Officer/Battalion Chief/ Senior Command Officers in providing for the emotional well-being of those under their respective commands.**

It was agreed by nearly all that the first-line supervisor really can hold the key to the future well-being of the largest portion of the workforce due to immediate daily or shift-to-shift hands-on contact. All agreed that training for recognition of employee behavior changes must begin

at the lowest levels and progress as employees advance in rank and responsibility. In general, the role of company officers in facilitating the healing process cannot be overstated. In order for a company officer to show appropriate support and concern, they may need additional information and training on grief, mourning, and the road to healing.

Responsibility for overseeing and assuring the mental and emotional well-being proceeds directly with the chain-of-command.

3. Whether existing written policies and procedures are in need of revision or if there is a need for new ones with respect to Line-of-Duty Deaths or serious injury.

All personnel interviewed stated that they were aware of the department's written procedures regarding LODD/Serious Injuries and Funerals. Each of the persons interviewed stated they knew that, when someone on the scene made a call to their family and gave the name of the firefighter believed to be missing, this person was violating the departmental procedures. No one interviewed could offer a solution to solve this type of violation.

4. Was sufficient support provided to personnel at all levels on the scene, immediately following, during the days directly after, and during other significant periods such as the time leading up to the funeral, holidays and the time leading up to the release of the investigative report?

ON THE SCENE:

The response to the support given on the scene was clearly a very emotional issue for those members who were on the scene with the first alarm. All stated that they had been removed from the scene without being allowed to find and remove the fallen firefighter. Many stated that they felt like cattle that were herded to a garage in the immediate vicinity of the incident. Once in the garage they felt like they were not provided with information on what was happening on the scene.

The majority of the members, who agreed with the above, followed a similar path in completing the interview when responding to the interviewers' questions. When asked if they felt they were removed from the scene for their well-being, they all stated they were sure of that. When asked why they thought they were taken to the garage, some of the personnel felt that they were being taken there to make sure that they could not see what was happening on the scene, and this left some of them with a feeling of failure and guilt. With further discussion most agreed that the garage was probably the only suitable location that

was large enough to accommodate all of them and keep them out of the high winds that the area was experiencing that day. All agreed that the Fire Chief did, in fact, stop by the garage but felt that they were intentionally not being told what was going on and what was going to happen to their apparatus on the scene. Most now realize that there was little to no information available at that time other than what they already knew. Some of those interviewed felt that there was a lack of communication with those members who had been relieved, and they spent the remainder of the day not knowing what would happen next.

Some of the members stated that they thought that they should have been given the opportunity to stay on the scene or go to the garage. When questioned if they felt that this type of personal choice should be utilized to manage the emergency scene, they all agreed that this was an emotional response and they understood that the decisions of that morning were made in the best interest of those involved. The majority of the members were very appreciative that they were returned to the scene to participate in the ceremonial removal of Fire Technician I Kyle Wilson.

THE REST OF THE DAY

After the removal of Fire Technician I Wilson from the scene, all of the first alarm personnel were taken by bus to Fire Station 2 for debriefing and instructed to compile a written report of their activities of that morning at the Marsh Overlook incident. All were afforded the opportunity to make phone calls to their families, have something to eat and, in some cases, receive dry clothing.

All agreed that they had been briefed on the mental health assistance that was available to them and how to request any help they felt they needed. All stated that they did not take advantage of this assistance at that time mainly because they did not want to talk about it at that time.

TIME LEADING UP TO THE FUNERAL:

The majority of those interviewed felt this was the worst time for all members of the department. Most stated that they felt they were having difficulties such as not eating, not sleeping and more dependency on alcohol than normal. All interviewed stated that they knew resources were available to assist with these types of problems, but none of them requested help. Some of those interviewed felt it helped to go to work and stay busy, yet some felt they should not have been at work. Again, none of those interviewed requested assistance of any kind.

A majority of the Prince William County Department of Fire & Rescue members had not been issued full dress uniforms at the time of the Marsh Overlook incident. Each of the members interviewed stated that they felt that the purchase of dress uniforms was the single most important accomplishment of the department during the time before the funeral. Each stated they were proud to see the entire department in full dress uniforms paying their final respects to their fallen brother.

A common theme that was heard by many of the members was that they felt that they should be treated like a police officer, in that the police officer is immediately placed on administrative leave after having been on a traumatic incident, such as a shooting or police officer being shot. When asked if they felt it would be possible to place the entire first alarm assignment on administrative leave, most agreed this would be excessive.

Several members expressed that they thought that peer counselors, such as the ones from New York City Fire Department (FDNY), should have been brought in at that time. All persons interviewed stated they were aware of the Community Services Unit and acknowledged that their counselors were coming to visit at the stations. This unit provides behavioral health counselors to fire stations. These counselors make regular visits to their assigned station in order to become familiar with the firefighters and allow the firefighters to become comfortable with them.

Many of those interviewed stated that they felt that Chief Officers that they normally did not see were being sent out to visit stations. They were undecided as to whether they were there to assist in the healing process or to evaluate what was being said about the way things were handled by the department.

THE WEEKS AND MONTHS LEADING UP TO THE ONE-YEAR ANNIVERSARY:

All members interviewed agreed that there were behavioral health counselors available to those who requested it, and most were aware of someone who was helped by this system. At least one person was personally utilizing this system and credited it with allowing them to continue working for the fire department. Most agreed that more people could have benefited from these services but did not want to ask for help or speak to someone they didn't know about their problems.

Transfer of personnel from one station to other was a common theme of frustration of those interviewed. Most felt this separated those who were on the Marsh Overlook incident from each other, thereby creating

a situation where they did not have anyone with whom they thought they could talk. Many felt that those not on the first alarm that day did not understand those who were.

Several of those interviewed stated that they felt slighted by what they referred to as the “Hierarchy of Grief.” They stated that the department based all of their decisions regarding this line-of-duty death on where you were at the time of the incident. An example given was that only Company 12 would be allowed to wear Kyle’s picture on their helmet as a sign of grief. Those who worked on the other side of the county were considered less in need of any assistance. The common statement was that grief is a personal process to each individual and each individual’s needs should be determined and not assigned by their location on the day of the incident. All agreed that symbols such as departmentally approved baseball caps with the name of the fallen, stickers, decals, etc., play a role in the healing process.

There were several members who stated that the department was not supportive of the firefighters who wanted to go to the International Association of Fire Fighters (IAFF) Memorial Service in Colorado. These members felt that the department should have sent them and provide the financial support necessary for this travel. When discussing this concept, each member was asked if they felt it was appropriate for taxpayers’ funds to be used for this type of travel and each one of them, after a moment of thought, stated that they did not think that the taxpayers should pay for the travel.

The other item of concern was that some of the firefighters did not have dress hats, and their request for them to be provided was denied due to lack of funds. They then purchased their own hats.

DAYS BEFORE THE RELEASE OF THE REPORT:

Most interviewed agreed that this was handled well by the department. It allowed members to see and review the report before they saw it in the news media. There was a mention that the station officers of Station 12 and 10 got a separate showing, and they felt they should have seen it with their crews.

Many of those interviewed felt that it was inappropriate to post the audio recordings of the emergency radio traffic of this incident on the internet. All understood that the news media could not be prevented from using these recordings, but all stated that they felt it was inappropriate for the department to post it on their own web site. Most stated that they felt it damaged the relationship between the members of the department and the surviving family members.

5. Was support provided to or at least available, for family members of personnel who were impacted in different ways by the Marsh Overlook incident and whether such support is routinely available.

All members interviewed agreed that they were aware that there was help available for their family members if they needed it. None of those interviewed requested any of these services and either felt it was their job to take care of those at home or they credited those at home with helping them get through it.

There is a support group, Embers of the Heart, that was created expressly to support the families of all fire department personnel, and most of those interviewed hope it will survive the test of time.

6. Those personnel who had a direct role in the Emergency Operations Center were also asked their opinions of the National Fallen Firefighters Foundation's Local Assistance State Team (L.A.S.T.) and whether they were a valuable resource to Prince William County Department of Fire & Rescue commanders.

Most members interviewed did not participate in the Emergency Operations Center, but one participant said that, "I am not very familiar with the L.A.S.T. operation, but I know that they were there the whole time doing anything they were asked to do." He also stated that he knew that many sections of the L.A.S.T. Manual were of particular help at the Emergency Operation Center and in the weeks and months following the incident. In an operation such as this, when resources are available locally, this is exactly what we would want to hear.

CONCLUSIONS:

The Prince William County Department of Fire & Rescue suffered the devastating loss of Fire Technician I Kyle Wilson on April 16, 2007, in the line-of-duty, while operating at the structure fire at 15474 Marsh Overlook Drive.

The Prince William County Department of Fire & Rescue had written procedures regarding Line-of-Duty Death/Serious Injury, Number 4.0.4 dated March 17, 2004, and Funerals, Number 4.0.3 dated March 17, 2004.

Notification of next-of-kin was hampered by the mother of another firefighter calling Fire Technician I Wilson's mother at the emergency

room of a local hospital, where she worked, to offer her condolences before the official notification could be made.

The Prince William County Department of Fire & Rescue had a completed Employee Emergency Contact Form for Fire Technician I Wilson on file in the department's Office of Personnel. This office was closed at the time of the incident, thus requiring a Chief Officer to come from home, unlock the office and file cabinet and get the contact information to the Fire Chief on the scene of the incident.

The Prince William County Department of Fire & Rescue has made the mental health of their members a priority. This is evident in the behavioral health services, the employee assistance program, and the liaison with other county agencies which can provide health services to their members. These programs and services have been created over many years and were available to the Prince William County Department of Fire & Rescue members at their time of need.

The Prince William County Department of Fire & Rescue was assisted by the FDNY Counseling Services Unit several months after the Marsh Overlook incident. This assistance involved peer counselors from FDNY CSU visiting stations and talking with firefighters about the incident and their problems in dealing with it. These counselors are also trained to recognize individuals who may need specialized help and assist them in getting referred to that help. Each of those interviewed spoke positively about this experience, but felt that this type of assistance should have been brought in earlier for the best results. All agreed that The Prince William County Department of Fire & Rescue should look at the idea of expanding the current Community Service Mental Health Unit to include fire service personnel trained to be peer counselors to work with the mental health professionals currently assigned to each fire station.

All of those interviewed stated that they were aware of all of the behavioral health services available to themselves and their co-workers. They agreed that the bulk of this knowledge came from written orders and through direct contact with behavioral health counselors that they had met, who were on station visits as part of their program. There is clearly a lack of understanding of the grief process by most of the uniformed members. It is doubtful that an understanding of the grief process can be obtained through a written order or procedure. Those interviewed agreed that there should be some formal training for members in the behavioral health area which would not only assist each member with understanding and dealing with the grief process but would assist them in dealing with and assisting their co-workers during these very difficult times. Possibly the most important aspect of this training would be to create an understanding of the very difficult and

emotional decisions that the department's administration must make at these times.

The Prince William County Department of Fire & Rescue utilized a regional assistance plan, of the Council of Governments, to staff their Emergency Operation Center until after the funeral of Fire Technician I Wilson. This allowed for the department to continue providing service to the public and deal with the preparations for a line-of-duty funeral.

Several of those interviewed stated that they felt that the notification of on- and off-duty members was not handled in a quick and efficient manner. They stated that many on-duty members first heard of it from police officers, hospital staff, and firefighters at other stations. Many off-duty members heard it from the news media. All agreed that there needs to be a review of current procedures to increase the efficiency of this procedure.

RECOMMENDATIONS:

- 1. The Prince William County Department of Fire & Rescue should consider having the Personnel Emergency Notification Information for all employees readily available on a 24/7 basis. The on-duty Communications Supervisor should have immediate access via file or computer database (preferred). This information could be limited to only that information that would be needed to make an emergency notification and any other information currently on file could continue to be maintained in the Office of Personnel.**

The communications supervisor could then provide information to a designated Command Officer to include family contact information and designated "preferred" members selected by the injured or deceased member. This is a recommendation that should be emphasized in the NFFF training programs.

- 2. The Prince William County Department of Fire & Rescue should have a "duty officer," preferably at the chief officer level, available 24/7 to oversee the department and coordinate extraordinary events to include LODD procedures.**
- 3. The Prince William County Department of Fire & Rescue should consider the concept of having several officers receive specialized training to deal with the emotional aspects of making family notifications, creating a "pool" or team that can be activated on short notice. If the department is authorized to create a position of duty-officer to ensure 24/7 availability, such training would be appropriate for those individuals.**

This is a recommendation that should be emphasized in the NFFF training programs.

- 4. The Prince William County Department of Fire & Rescue should review their current written procedures on LODD/Serious Injury and Funerals to evaluate if they need to be updated or if they need additional procedures to effectively deal with any possible LODD in the future. This is a recommendation that should be emphasized in the NFFF training programs.**
- 5. The Prince William County Department of Fire & Rescue should evaluate the possibility of expanding the current Community Service Mental Health Unit to include fire service personnel trained to be peer counselors to work with the mental health professionals currently assigned to each fire station. This concept could be accomplished with the utilization of fire department personnel who would volunteer their services and would be trained on duty over several months. This is a recommendation that should be emphasized in the NFFF training programs.**
- 6. The Prince William County Department of Fire & Rescue should consider providing an in-service type training class to all of the department's officers and supervisors on behavioral mental health issues that would increase their knowledge and ability in the area of identifying personnel with problems that should be referred to mental health specialists. This training should also reinforce the current relationship between Community Services Unit health care specialists and their assigned fire station, as well as offer the fire officers a better understanding of their role in the overall mental health of their employees. Training provided to all levels of the department should reinforce that most of what is helpful to members following a line-of-duty death can be learned by asking firefighters about their needs, listening with an open mind and without defensiveness while responding in a timely fashion with action. This is a recommendation that should be emphasized in the NFFF training programs.**
- 7. Prince William County Department of Fire & Rescue should consider providing all members of the department with training on the Understanding of the Grief Process and how they can use this knowledge to assist themselves and their co-workers. It is extremely important that members have a good understanding of this process if we are to expect them to pull together and work through these trying times. This training should start with the recruit training process and be reinforced at regular intervals throughout the member's career or time of service. This is a recommendation that should be emphasized in the NFFF training programs.**

- 8. Prince William County Department of Fire & Rescue should continue using departmentally-approved symbols such as baseball caps with the name of the fallen member, stickers, decals, etc. to assist in the healing process. These symbols should be available to all members, and it is recommended that timeframes not be placed on the use or display of these items.**

- 9. Prince William County Department of Fire & Rescue should evaluate the use of the audio radio traffic recordings on the department's internet sites and other department-sponsored media. This information is certainly available elsewhere for those who want to hear it, but this would clearly take the strain off of those members who do not wish to listen in support of the member's family.**