

Incident Investigation of Firefighter Death During a Training Fire Port Everglades, Florida



**Prepared by the
Bureau of Fire Standards and Training
Florida Division of State Fire Marshal
BFST Safety Investigative Report 03-01**

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Incident Investigation - Training Fire at Port Everglades
Miami-Dade Fire Rescue Department and City of Hialeah Fire Department
August 8, 2003, Hollywood, Florida
Prepared by the
Florida Division of State Fire Marshal
Bureau of Fire Standards and Training

Summary of Incident

On August 08, 2003, a 37-year-old firefighter trainee died during a “live-fire” training exercise on the property of a commercial marine training facility. The “live-fire” exercise was being conducted in a structure designed and constructed of marine shipping containers to represent a sea-going vessel. This was the first “live-fire” experience for the trainees in a class leading to state certification as Firefighter II. Five (5) trainees along with three (3) instructors and an observer entered the enclosed structure. The five (5) trainees were to follow a fire hose through a two-story ship simulator into a section designated as a “fire-box”. The trainees were to take turns operating a nozzle in various patterns. They were told to avoid getting water on the fire. The trainees were instructed to follow the fire hose through a series of three (3) watertight hatches. Then they were to cross an open grated floor over the engine room fire, down a ladder and through a simulated engine room. The engine room contained a gas-fueled fire. The trainees would then enter into the “fire-box”. This was the fourth squad of trainees to perform this evolution on this particular day. They were instructed not to crawl over the metal grating (see photo 3 in Addendum 3) but to stay on their feet and “duck walk” since the metal structure had gotten very hot. They were also told to avoid holding the handrail on the ladder to prevent burns through their gloves.

Two of the instructors reportedly sustained minor injuries and/or experienced equipment/apparatus problems and prematurely left the structure through a side exit. They did this without advising the Incident Commander.

The remaining instructor stated that he attempted to lead the trainees out of the structure via the route used to enter the structure, by following the fire hose, which had been laid on the floor. Conflicting reports were given as to whether or not an order was given to do this. There was not an instructor following the group to monitor their progress. As part of their training regimen, the trainees were to crawl on hands and knees (except as noted above), following this fire hose, in order to exit the structure. Reportedly, some of the trainees were standing upright instead of crawling and having difficulty exiting the structure. The first trainee to reach the exit stated that the instructor they were following was no longer in sight. The decedent apparently became disoriented and made a wrong turn into an adjacent room. The trainees indicated that severe heat was encountered, and several people received second-degree burns to their hands and knees, while they were attempting to exit the structure. Upon exiting the facility a Personnel Accountability Report (P.A.R.) was taken and the decedent was noted missing. After two searches of the structure the missing trainee was discovered near a side exit. He was unresponsive, with no pulse or respirations. He was removed from the structure and transported to a local trauma center where he was pronounced dead. The decedent reportedly had severe

burns on both hands and sloughing to both knees and hands. He was described as cyanotic from the neck up. Other members of the same entry squad received burn injuries and one member lost consciousness after exiting.

Summary of Findings to Reduce Risk of Similar Incident

1. Agencies conducting live-fire training must comply with NFPA 1402 and 1403.
2. All fire agencies in the State of Florida conducting Minimum Standards Training must also be in compliance with Florida Administrative Code 69A-37.
3. All participants' protective clothing, PASS and SCBA must be inspected by the Instructor-In-Charge or Safety Officer for proper use and serviceability prior to any entry.
4. The training ground must be the safest and most controlled environment possible.
5. The initial exposure to “live-fire” conditions in recruit training needs to be very controlled, with immediate egress capabilities, at ground level.
6. Instructor to Trainee ratios must be maintained at a sufficient level to ensure constant monitoring and to render immediate assistance if needed.
7. Prior to being permitted to participate in “live-fire” training evolutions, trainees must be provided with a walk-through of the facility. They must become familiar with the course to be followed, the evolution plan, and the correct response to critical failure of the exercise.
8. Prior to being permitted to participate in “live-fire” training evolutions, instructors must be provided with a written pre-burn plan. They must be apprised of the Incident Command process, training goals, personnel accountability process, emergency plans and facility/locale familiarization.
9. There must be a planned response to a “Man-Down” situation. This would include a rapid intervention team (RIT) and emergency medical care with transport.
10. There must be a formal communications system in place at all times.
11. There must be a clear and identifiable Incident Commander and Instructor-in-Charge (if not same person) on site and closely monitoring activities.
12. There must be a clearly identified Safety Officer.
13. Emergency ventilation must be planned to limit fire spread and to improve tenability in the event such action is necessary. Normal room venting shall not be through the primary or secondary egress point.

Purpose/Background of Investigation

Under Florida Statute 633.808, the Division of State Fire Marshal (DSFM) is charged with the responsibility to “Investigate and prescribe by rule what safety devices, safeguards, or other means of protection must be adopted for the prevention of accidents in every firefighter employee place of employment or at any fire scene; determine what suitable devices, safeguards, or other means of protection for the prevention of occupational diseases must be adopted or followed in any or all such firefighter places of employment or at any fire scene; and adopt reasonable rules for the prevention of accidents, the safety, protection, and security of firefighter employees engaged in interior firefighting, and the prevention of occupational diseases.” The Bureau of Fire Standards and Training (BFST) of the Division has the responsibility for the

implementation of this law. (Other agencies and entities have investigated this incident for different purposes.)

The Bureau of Fire and Arson Investigation (BFAI) of the Division of State Fire Marshal investigated this fire at the time of the incident for the purpose of determining any criminal offense. The National Institute of Occupational Safety and Health (NIOSH) investigated this incident for the purposes of preventing similar incidents. The Florida State Attorney's Office investigated to determine criminal violations/activity. The Hollywood Fire Department has legal authority to investigate fire related deaths in their jurisdiction. The Broward County Sheriff's Office (BSO) conducted a death investigation and coordinated the efforts of all investigating agencies.

The Bureau of Fire Standards and Training's charge for this report is to disseminate information to reduce the chance of a similar incident occurring. Florida Statute 633.808 states the Division is charged with the responsibility to provide training. If necessary, prepare legislation to reduce the chance of a similar incident from occurring, and to investigate the incident for violation of Florida law or administrative rule within its authority. This report is a result of interviews conducted and documents collected by BFAI, BFST, and the Hollywood Fire Department. It should be noted that it was necessary to subpoena one instructor in order to interview him about this incident.

The Involved Structure

The topic structure is constructed of metal marine shipping containers that have been assembled to represent a sea going vessel. It is a three-story building that features maritime fixtures. These fixtures include watertight doors, shipboard style stairs, grating, simulated engine compartment, vents, and other shipboard features. It was designed as a restricted use facility for fire and hazard training for use by able bodied and experienced personnel, per the legend on the facility's plans. According to the facility's management, NFPA standards 1402, 1403 and 204M were consulted in the design of this facility. However, the standards were exempted per notation on plans used for permitting. NFPA Life Safety Code 101, Chapter 30 was used to determine life safety features.

The property had been contracted by the Hialeah Fire Department Training Center to conduct "live-fire" training for a class of new trainees from the Miami-Dade Fire Rescue Department. Previous training burns had been conducted in this facility. It should be noted that similar burn injuries had occurred at this facility involving Miami-Dade Fire Rescue and many of the same instructors at this incident. This was the first fatality at this facility.

The facility's personnel constructed the topic structure. There was an air vent above the "fire-box" area controlled by a "dead man" chain. However, there was a cement block attached to the handle to prevent the vent from opening (see the attached floor plan). The training fire was in a metal "fire-box" connected to the exterior of the structure and fed from outside. To reduce the loss of heat and smoke these particular personnel added pallets to the fire from inside.

The Training Session

The written statements and information obtained from witnesses in the initial interviews indicate that “live-fire” training exercises were known to be extremely demanding on trainees. Much of the training program appears to have been run in a “boot camp” mentality. They were told any injury could mean termination from the department. This training exercise was conducted by the Miami-Dade Fire Rescue Department as part of their recruit class that was contracted at the Hialeah Fire Department, a state certified training center. Fifteen (15) trainers from both agencies participated in these exercises. Some of the trainers were not state certified instructors. The personnel assisting the training officer also served as interior “safety personnel” during the training evolutions. The following identifies assignments for the training exercise:

ASSIGNMENT		
INCIDENT COMMANDER/ ACCOUNTABILITY OFFICER	I-1	Undetermined – conflicting reports by instructors
LEAD INSTRUCTOR	I-7	Undetermined – conflicting reports by instructors
SQUAD D LEAD INSTRUCTOR	I-2	Lieutenant
FIRE ROOM SAFETIES (Area):	I-3, I-4	1 Firefighter (I-3), 1 Captain (I-4)
SQUAD D:	R 1-5	5 Recruit Trainees
OBSERVER:	I-5	Lieutenant (testing a new thermal imaging camera)
REAR SAFETY	I-6	Captain
MIDDLE SAFETY	I-8	Firefighter
ADDITIONAL INSTRUCTOR	I-9	Lieutenant

Squad “D” was the fourth squad to enter the structure. There were three prior evolutions with no breaks between the evolutions to allow the all-metal structure to cool. Members of the third squad received burn injuries during their rotation. As Squad D entered the structure, a Lieutenant (I-5) who was testing a thermal imaging camera joined them. I-5 stated he was not to be counted on the accountability list. However, I-5 was assigned to monitor a ladder opening to ensure no trainees fell through the opening. The trainees did not complete a pre-burn walk through to become familiar with the structure. The trainees were told not to touch any surfaces or to grasp the handrails on the ladders to avoid burns. A second firefighter (I-8) was assigned as a “Middle Safety”; he was not a state certified instructor. He exited the prop during the evolution claiming he had problems with his gloves and was teased by the other instructors present. The “Lead Instructor” (I-2), a Lieutenant from Miami Dade, entered the structure first, and the decedent followed him after a delay. A second and third trainee entered after a delay as directed by I-1. Each trainee entering the structure was intentionally delayed so no trainee would see or hear anyone else from the moment they entered the structure until arriving at the “fire-box”.

Per statements by the instructors they did not monitor the trainees’ movement or encourage their progress.

According to I-1's testimony, the Accountability Officer, referred to some as the Incident Commander, a Lieutenant from Miami- Dade checked off the trainees on a roster as they entered the structure (Figure 2 - point #1). I-1 was not wearing protective clothing and SCBA.

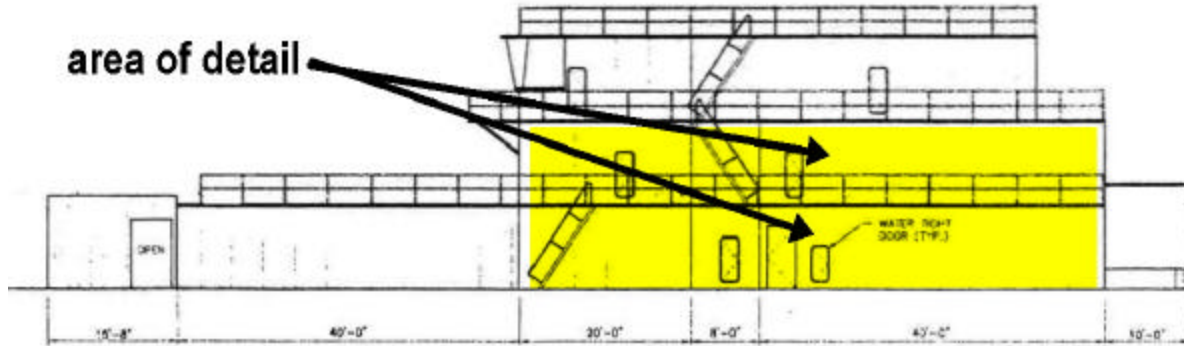


Figure 1 Port view of prop – shaded area is the areas shown in the floorplans in Figures 2 and 3 – this diagram provided by CH2MHill

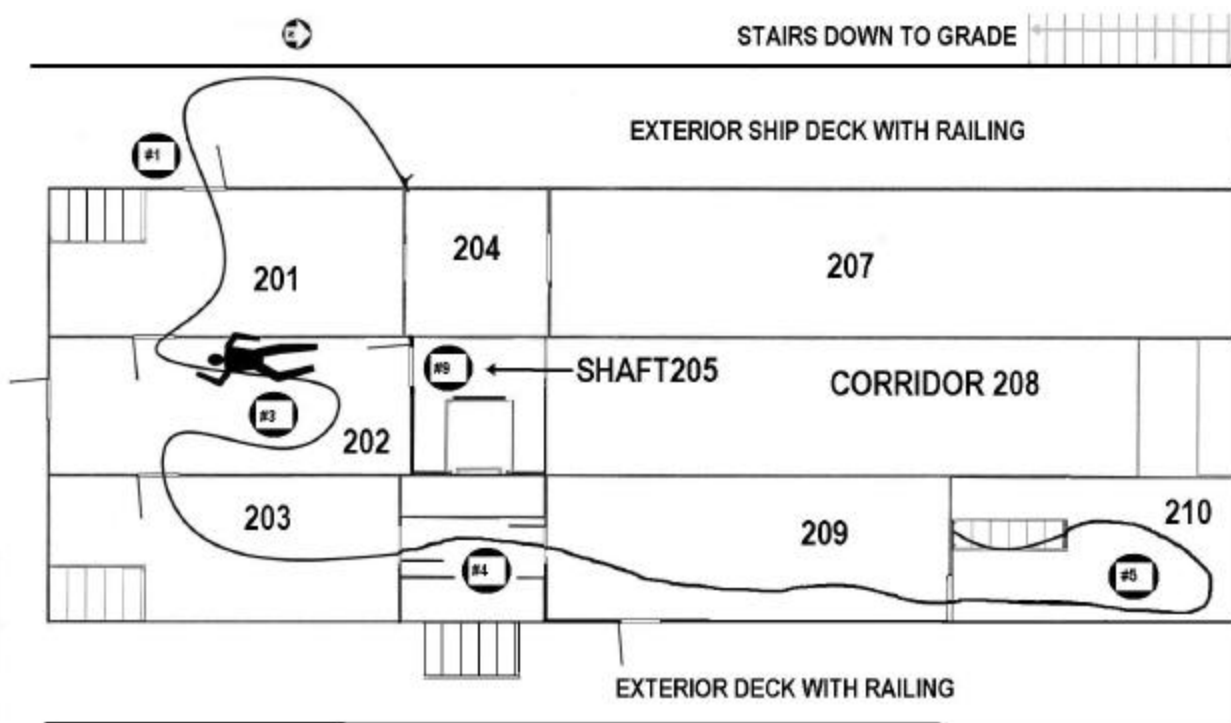


Figure 2- Gray Manatee Main Deck Detail – DSFM diagram

Instructors and observers were not included on the accountability roster. The trainees were simply told to get on their hands and knees and follow the hose to the “fire-box” (Figure 3 - point #2). The hose entered the structure on the second level (Figure 2 - point #1); one level above ground, and entered the first of three rooms. The hose entered the second room and made a loop in the room before traveling to the next room (Figure 2 - point #3). After traversing three doors the hose traveled across a grated floor (Figure 2 - point #4) where trainees stated they could see flames below them. This catwalk traversed over a simulated engine that had a LPG fire under it. (Note: This structure was not designed or approved as a gas-fired training facility). The heat at this point was so intense the trainees had to get onto their feet and “duck-walk” across the grated floor to a ladder where they had to turn around and descend the ladder (Figure 2 - point #5) to the lower level. Once on the ground level the trainees continued to follow the hose across a concrete floor (Figure 3 - point #6). The trainees had to follow the hose through another door where they found themselves in the room with the “fire-place” (Figure 3 - point #2).

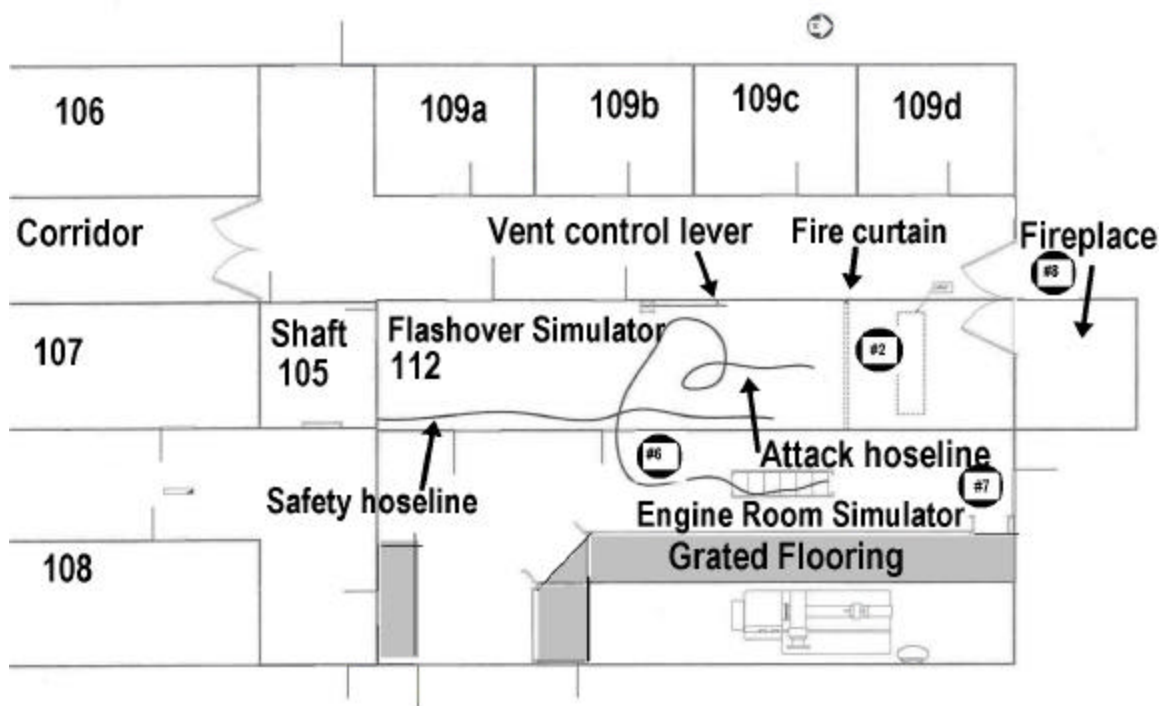


Figure 3- Gray Manatee Grade Level Deck Detail – DSFM diagram

The instructions to the trainees were to move to the nozzle and perform several hose stream patterns without wetting the fire. Upon completion of that task the trainees were to move to the back of the line. The trainees were directed not to extinguish the fire but to aim their fire streams above or around the “fire-place” (Addendum 3 – photo 2) the first trainee accidentally got the “fire-place” wet. At this point the trainees were told they would have to perform two rotations, and to stand-by in the fire area while the fire intensified. I-2 is quoted by several trainees as shortly thereafter saying the environment was too hot and told the group to hurry up so they

could get out of there. I-2 was observed to have his hands under his armpits to protect them from the heat, and to be moving about to gain more comfort in his heat saturated protective clothing. Additional wood pallets used as fuel had been placed against a wall (Figure 3 - point #7) in the “engine room” and periodically added to the fire between squads. Normal procedure per the facility owner was to store the pallets outside and feed the fire from an exterior door (Figure 3 - point #8). To prevent the loss of heat between evolutions by opening the exterior doors while the fire was restocked, the pallets were stored inside.

The trainees were halfway through their second rotation when someone is said to have radioed I-2 that they had been inside for 20 minutes and it was time to “get out now”. Now out of sequence, the trainees turned around to exit using the same route they entered. The first trainee to leave followed I-6 up the ladder, and the other trainees followed. I-6 confirmed that he was the first person up the ladder and the first to reach the entry door on the second deck. I-2 and I-8 assigned to the “fire-box” area exited through a side door directly from the fire-box through an on-grade side exit. By retracing their entry path, the trainees had to leave by using the stairs and going over the grating in a higher heat environment, and then going through the five (5) watertight doors versus the one door the instructors used. Upon observing the departure of the two instructors via the side door, a Hialeah Chief Officer outside that was not assigned to a specific function for this evolution, donned his protective breathing apparatus with his protective clothing and entered the prop and saw the last two trainees ascend the ladder. He then followed the trainees and met the trainees and the instructor in Room 203 on the main (exit) floor. At that point all students were accounted for. The exterior door was visible through the next two compartments from the door leading from 203 into 202 (and then 201). It is believed that four of the trainees, the instructor and the Chief then exited directly, not following the hoseline.

There are conflicting reports as to what occurred at the exit point. However, when everyone was outside it was discovered one of the trainees was missing. It is believed that the decedent lost track of the hose and wandered out of the second room he was traversing and into a chase (Figure 2 – point #9) where heated gases and smoke were venting. Handprints on the walls indicated the decedent was trying to find his way out. The Chief and I-3 reentered and searched the rooms that had been used including the burn room, using a thermal imager. While the others were looking for him, the decedent apparently found his way back to room 202 before the second search and collapsed at that point. After two attempts to retrace their path, the trainee was discovered inside the second room by I-6. I-9, who had entered to help search, grabbed the decedent and started to pull him out and I-1, without protective clothing or SCBA, entered room 201 and helped pull the decedent to the outside. The decedent’s PASS device did not sound while inside, it is believed he was mobile until just before he was found. Once outside, attempts were made to revive the decedent without success. A student advised the facility office to call 911.

Adjacent to the training facility is a Broward County Fire Rescue station. An on-duty firefighter at the station observed the decedent being dragged out of the building, and summoned the engine company that was in quarters. The medical rescue unit was not in quarters, but responded from a relatively short distance in the port complex. The decedent was transported to a nearby trauma center by an advanced life support unit that responded to the incident. Another student lost consciousness after exiting and was cared for by other trainees that included certified paramedics

and EMTs. Several trainees in that group and the previous group received burn injuries and four were transported. The other injured students were very reluctant to be transported or even treated by on duty fire rescue, apparently out of concern from prior comments made by instructors that if they “bailed” from the live fire drill or got hurt, they should leave their gear on site and walk out. One injured student had reached the exit ahead of the remainder of the squad, but returned back to leave with the squad rather than face termination. ¹

Findings

The following conclusions were found to be significant:

1. This was not a BFST Certified Training Facility.
2. Although not approved for gas, a gas-fueled fire was used in this training.
3. NFPA 1402 and 1403 were not complied with.
4. A Safety Officer was not assigned to monitor activities.
5. A formal safety plan was not in place.
6. The personnel assigned as “safety personnel” were also assigned to maintain the fire.
7. There was no readily identifiable Instructor-In-Charge.
8. The training staff was unaware of the identity of the Instructor-In-Charge.
9. The Instructor-In-Charge failed to identify and correct safety hazards.
10. There was not a written pre-burn plan.
11. A pre-burn walk-through was not conducted for the trainees, this did not afford them the knowledge of alternate escape routes and exits.
12. Instructors failed to inspect trainees’ clothing prior to the evolution.
13. The trainees were relegated to check each other’s clothing prior to the evolution.
14. There was not a RIT provision or team assignment.
15. There was not a formal EMS plan, and the local provider was not advised.
16. There was not a means of monitoring the temperature of the environment.
17. The ventilation means available in this incident had been rendered unusable.
18. The environment was determined to be excessively hot by the Lead Instructor, but the evolution was not terminated.
19. There were two separate fires within the structure burning simultaneously.
20. The exercise was more advanced than for initial recruit training.
21. The instructors fed the “live-fire” from inside the burn-room.
22. Fuel pallets were stacked inside the structure in a room adjacent to the fire-room contrary to facility written procedure. This prevented the fire area from being vented between teams.
23. Pallets used as fuel did not have a specifically identified prior use.
24. Other, non-organic materials such as polypropylene rope were found in the “fire-box” by investigators.
25. It was reported that on previous days, non-organic materials such as plastics were burned, inclusive of fire hose and vinyl records.
26. Instructors who were not state certified were used.
27. Not all personnel assigned to these evolutions had specific training for “live-fire” training or familiarity with the structure.
28. Observers and spectators were allowed free access to the structure without accountability.
29. Instructors did not closely monitor trainee movement.

30. Instructors did not follow the trainees out to ensure they all reached the outside safely.
31. When the two instructors at the “fire-box” left, they did so from an on-grade side exit, but making the trainees leave by using the stairs and going over the grating in a higher heat environment, and then going through the five (5) watertight doors versus the one (1) door the instructors used.
32. Instructors leaving the trainees unattended failed to notify the Incident Commander.
33. There was not a clear distinctive means of identifying trainees/instructors.
34. The trainees were required to climb up and down a ship’s ladder without prior ladder training.
35. The trainees were not afforded the knowledge of alternative escape routes/exits.
36. The cause of death was listed by the county medical examiner as “cardiac arrhythmia and exposure to heat contributed to by mild myocarditis and sclerosis of the AV node artery”.

Remediation Plan

Under Florida Statute 633 the Division of State Fire Marshal hereby directs Miami-Dade County Fire Department and the Hialeah Fire Department Training Center to comply with the following:

1. The 1992 edition of NFPA 1403 is law in the State of Florida (see Addendum 2) and must be complied with during “live-fire” exercises.
2. A detailed training plan shall be prepared for recruit training that shall specify progressive exposure to fire, heat and smoke conditions with proper safeguards in place.
3. A detailed policy of instructor conduct, mutual respect, trainee safety, trainee/instructor expectations, and other appropriate policies for operating recruit training shall be adopted, published and enforced.
4. Firefighters, Instructors, and Safety Officers shall be provided with “live-fire” training inclusive of safety and flashover/backdraft phenomenon.
5. Firefighters shall have further documented training for firefighter survival skills inclusive of rapid intervention team training, emergency procedures and departmental personnel accountability procedures.
6. A written remediation plan must be submitted to the Division for approval within 30 days of receipt of this report.

Bureau of Fire Standards & Training Recommendations

1. The current edition of NFPA 1403 should be adopted as state law by the Legislature as part of the Firefighter Occupational Safety and Health Act with additional specific instructor certification and training requirements.
2. The Bureau of Fire Standards & Training shall develop a training program leading to a certification to be required for the instructor and Safety Officer for “live-fire” training involving structures or fires beyond incipient levels. This program shall exclude wildland fire training under Division of Forestry or National Wildfire Coordinating Group or similar training programs.
3. To observe basic fire behavior, trainees should be exposed to very basic props or scenarios and respectfully build to more complex scenarios that approximate realistic conditions.

4. When “live-fire” is used:
 - It is a requirement to have all interior crews being trained, be equipped with a charged hoseline.
 - At all times a safety team must be in place to monitor the fire. They must be supplied with a hoseline of sufficient water flow (minimum of 95 GPM) to extinguish a fire involving the entire fire room.
 - At all times a safety team must be in a position to monitor the progress of the crew being trained.
 - A fire room shall not be used unless there are two separate means of egress available, and known to all participants.
5. Training fires must be ventilated sufficiently to reduce the chance of unexpected flashover. And, to maintain visibility at the floor level.
6. Adequate emergency ventilation must be provided and verified operational for the fire room and any combustible attic space above.
7. All firefighters, regardless of tenure, should be trained to constantly identify hazards and alternative escape routes during interior fire suppression operations, inclusive of training exercises. Prior to “live-fire” training drills, firefighters need to identify two ways out of each area.
8. “Live-fire” training in any structure must include planning for secondary means of egress or escape in case of unexpected fire condition changes. The use of rooms with limited access should not be considered.
9. Firefighters need specific training to recognize the signs of a flashover, backdraft, proper ventilation techniques, and/or water application to reduce the chance of flashover.
10. The Instructor-In-Charge or Safety Officer, prior to entry into a “live-fire” training evolution, shall inspect all participants. They must ensure that the protective clothing, SCBA and PASS are being worn in accordance to manufacturer’s instructions and are in serviceable condition.
11. It shall be the Instructor-In-Charge or Safety Officer’s responsibility to coordinate the overall burn building fireground activities to ensure proper levels of safety.
12. Formal communication plans must be in place inclusive of alternate channels, Incident Command communications versus crew-to-crew, emergency operations, medical operations and scene to dispatch.
13. Formal training for instructors conducting “live-fire” training burns is required.
14. There shall be a formal safety program in place and specific safety rules enforced.
15. There shall be a designated Safety Officer who has authority to halt any training evolution at any time to ensure the safest environment.
16. The responsibilities of the Safety Officer shall include, but are not limited to, the following:
 - Prevention of unsafe acts.
 - Elimination of unsafe conditions.
17. The Safety Officer shall not be assigned other duties that interfere with safety responsibilities.
18. There must be a pre-burn briefing for all participants, trainees and instructors.
19. Observers and spectators shall be restricted to an area outside the operations area perimeter established by the Safety Officer.
20. All sources of ignition shall be removed from the operations area, other than those that are under the direct supervision of the person responsible for the start of the training fire.

21. All fuels that are utilized in “live-fire” evolutions shall have known characteristics that are as controllable as possible.
22. Unidentified materials, such as debris found in or around the structure that could burn in unanticipated ways, react violently, or create environmental or health hazards shall not be used.
23. Pressure-treated wood, rubber, plastic, and straw or hay treated with pesticides or harmful chemicals shall not be used.
24. The fuel load shall be limited to avoid conditions that could cause an uncontrolled flashover or backdraft.
25. The training exercise shall be stopped immediately when the Instructor-In-Charge or Safety Officer determines through ongoing assessment that the combustible nature of the environment represents a potential uncontrollable hazard.
26. Emergency medical services shall be available on site to handle injuries. The local EMS provider, if unable to be on scene for stand-by, needs to be made aware of the training inclusive of access, air transport unit landing sites, etc.
27. The fire shall be ignited by the Ignition Officer in the presence of and under the direct supervision of the Safety Officer.
28. All instructors shall be qualified to deliver firefighter training according to the authority having jurisdiction.
29. The Instructor-In-Charge shall be responsible for full compliance with this standard.
30. Instructors shall take accountability (P.A.R.) to include all participants when entering and exiting the building during an actual attack evolution conducted in accordance with this standard. Anyone leaving the exercise prematurely, including trainees, shall notify the Incident Commander.
31. Instructors shall monitor and supervise all assigned trainees closely during the “live-fire” training evolution.
32. Where concurrent, multiple, “live-fire” evolutions are being conducted in a specifically designed burn building, the identity of the Instructor-In-Charge shall be clear to all participants.
33. No employer shall discharge, intimidate, or coerce any employee by reason of such employee’s report of injury or request for medical attention due to injury.

Conclusion

The training ground must be the safest, most controlled environment in any profession. Trainees reported feeling threatened with termination if they failed an event, or reported injuries. Other personnel that had been previously involved in recruit training verified this.

Conditions were clearly beyond the training level of the trainees, and safety and emergency procedures obviously were not sufficient or not followed.

At the time this report was prepared, the Office of the State Attorney, 17th Judicial Circuit of Florida, had not determined if criminal charges would be filed relative to homicide or culpable negligence.

Miami Dade Fire Rescue needs to adopt detailed “live-fire” training policies inclusive of NFPA 1403

The recommendations of the Bureau of Fire Standards and Training as listed are being addressed as of this writing, with initial proposals for the training and certification to follow. Recommendations for revisions to the Florida Administrative Code will be forthcoming after constituent input.

Report Preparation

This report was prepared in accordance with FS 633.801 – 633.821 by the Division of State Fire Marshal, Bureau of Fire Standards and Training. The following personnel contributed to this report.

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The “boot camp” reference was used a number of times to describe the demeanor of the recruit training program, both for this and earlier classes. A correlation can be made between military combat training and fire suppression training due to the need for rapid, unhesitant reactions to changing conditions, the inherent danger of the actual situations, and the need for self reliance while at the same time remaining an integral member of a team. Following injuries and even fatalities during boot camp training, the US military revised their training doctrines. Rigorous physical training, both to prepare for the demands of combat and to weed out the less able or motivated can be valid. The preparation of trainees for the discipline of working as a team under harsh conditions can have value to build confidence as individuals and as a team. However, *when it undermines the trust of the trainees towards the instructors or is to the point of endangering the trainees, it undermines discipline and destroys a positive training environment.* Paraphrased from TRADOC Pamphlet 350-36 "Training - TRADOC Trainee Abuse Prevention Program"; Department of the Army; Headquarters, United States Army; Training and Doctrine Command; Fort Monroe, Virginia 23651-1047 30 January 2003

Addendum 1 – NFPA 1403

The NFPA, National Fire Protection Association Standard 1403, is the law in Florida as the Department of Environmental Protection has adopted it. As such, it must be followed whenever the Fire Service conducts a training fire, regardless of the type of structure. The Bureau of Fire Standards and Training is currently working on revisions and amendments to that standard to better protect the members of the fire service in Florida. Until that process is complete and the revisions / amendments are adopted into law, the standard as adopted by the Department of Environmental Protection must be followed. Primary to any training evolution should be the understanding that the training ground **MUST** be the safest environment possible. If it is necessary to jeopardize realism for safety, safety must always prevail.

Addendum 2 – Current Florida Administrative Code 62-256.700, as of February 2004.

(5) (a) The burning activities are conducted by a full-time municipal fire control agency in accordance with the National Fire Protection Association document, "Live-fire" Training Evolutions in Structures (NFPA 1403)," as revised February 10, 1992, and hereby adopted and incorporated by reference as the accepted practice for fire training instruction. Nothing herein shall be construed as relieving any person from complying with any other applicable laws, rules and ordinances, including Chapter 590, Florida Statutes, and rules of the Division of Forestry.

NOTE: As of January 2005, the Florida Department of Environmental Protection is reviewing this section of the Florida Administrative Code, and recommendations have been made by the fire service and by the Division of State Fire Marshal to specifically reference other sections of the Florida Administrative Code dealing with fire service instructor qualifications and recognition of a fire department.

Addendum 3 – Photos of Facility and Scene



Photo 1: “Fire-Box” interior, note open hatch left to add pallets from exterior



Photo 2: Sign on door advising of gas props



Photo 3: Grate floor trainees “duck walked” over, fires were on the level below



Photo 4: Stairs that trainees used to get from the entry (upper) level to fire level



Photo 5: “Fire-Box” exterior, note open hatch to add pallets from exterior